PRODUCTIVITY COMMISSION DRAFT REPORT ON MENTAL HEALTH

Collective Submission from the Primary Health Networks Cooperative

CONTENTS

1 INTRODUCTION

This submission is the Primary Health Networks (PHNs) collective response to the Productivity Commission draft report on Mental Health released 31 October 2019. Individual PHNs or groups of PHNs may also be providing separate submissions on the Commission's draft report.

Primary Health Networks (PHNs) were established by the Australian Government with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time. There are 31 PHNs across Australia that have been in operation since 1 July 2015

The PHN Cooperative proudly acknowledges Australia's Aboriginal and Torres Strait Islander community and their rich culture and pay respect to their Elders past and present. We acknowledge Aboriginal and Torres Strait Islander peoples as Australia's first peoples and the traditional owners and custodians of the land and water on which we rely.

We recognise and value the ongoing contribution of Aboriginal and Torres Strait Islander people and communities to Australian life and how this enriches us. We embrace the spirit of reconciliation, working towards the equality of outcomes and ensuring an equal voice.

The PHN Cooperative also acknowledge all people wo have personal experience of mental illness and their families and carers. The voice of people with lived experience is essential in the development of our work.

This submission will consider the extensive Productivity Commission draft report around the themes of integrated care, stepped care and person-centred care, local commissioning and governance structures, workforce, Medicare Benefits Schedule and data.

PHNs agree with the majority of the findings and draft recommendations contained in the draft report. We support:

- The expansive approach of considering the social determinants of mental health and suicide prevention.
- Making separate short term and medium-term recommendations to address both the immediate need and complex systemic problems.
- The new whole-of-government National Mental Health Strategy to improve population mental health proposed to be developed by the Council of Australian Governments (COAG) Health Council. However, we also note the previous inability of successive governments to have acted on the social determinants of health.
- The prioritisation of true integrated care to build an effective outcome focused health system, consistent with international evidence and existing recommendations including the 2017 Productivity Commission '*Shifting the dial*' [1] report.
- The expansion of the National Mental Health Commission to become the national evaluation body of government and non-government mental health programs and services.

[1] Productivity Commission. 2017. Shifting the Dial: 5 Year Productivity Review, Report No. 84, Canberra. Available at https://www.pc.gov.au/inquiries/completed/productivity-review/report.

- Increased funding flexibility that allows collaborative regional commissioning bodies to implement innovative structures and mechanisms that better meet local needs.
- The development of diverse health workforce to address the varying needs of people in need of mental healthcare.
- Local workforce integration and identification of service gaps coordinated and administered through existing health and community structures.
- The need to strengthen and develop the peer workforce, mental health nursing workforce and an indigenous mental health workforce.
- A rigorous evaluation of MBS-rebated psychological therapies, incorporating clinician information provision requirements, and the collection of outcome data from clinicians and consumers.
- The provision of mental health treatment and service provision built on an effective and up to date evidence base. Governments should prioritise and incentivise mental health research, evaluation and data collection from patients, carers and health services.
- The provision of mental healthcare services on the basis of a person's clinical need with appropriate flexibility and local community resourcing to provide care.
- Service provider funding being conditional on and in alignment with the stepped care model.

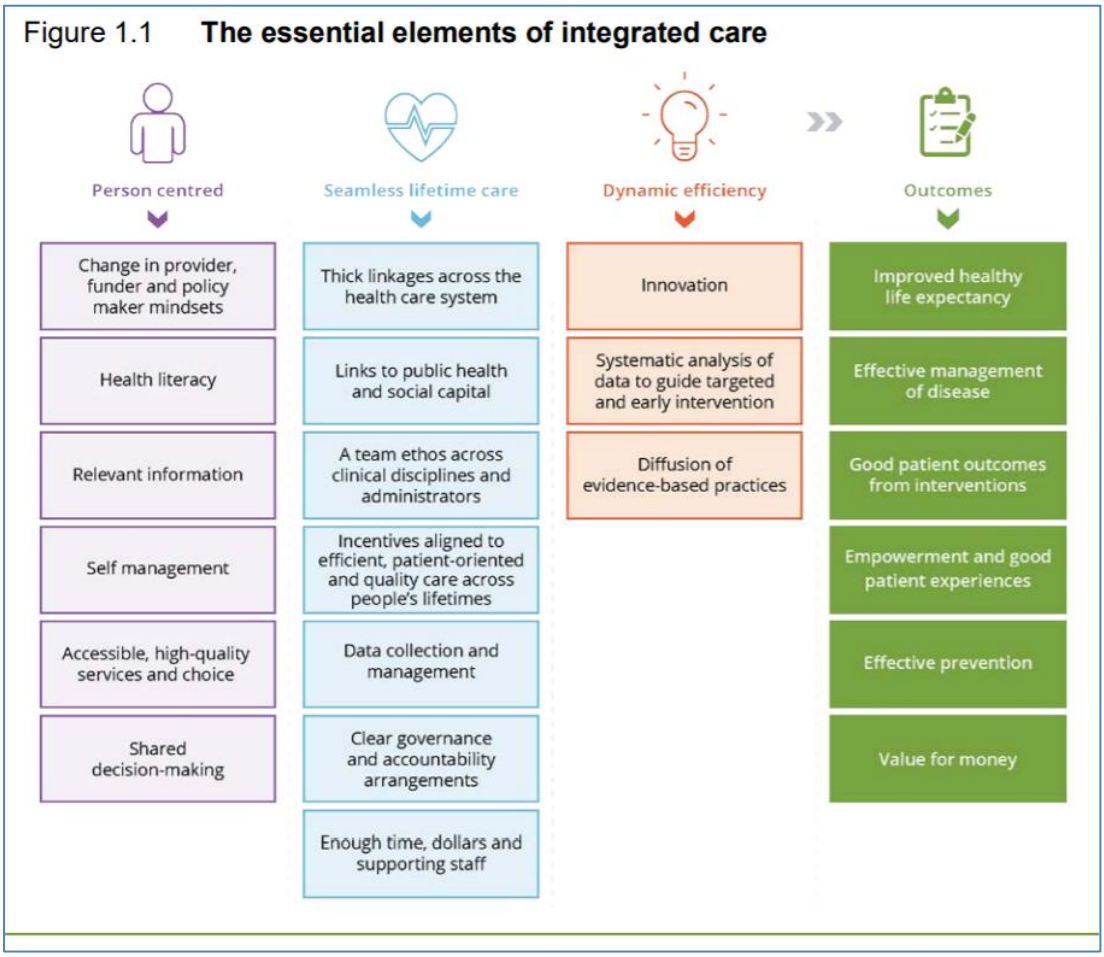
PHNs believe the Productivity Commission should reconsider their draft recommendations in the following areas:

- We do not agree with the conclusion with respect to regional commissioning and favour neither the proposed "rebuild" or "renovate" options.
- We propose and alternate model built on strengthening existing leavers and accountability structures through the development of a local collaborative decision-making function, consisting of representation of PHNs and Local Hospital Networks (LHNs), who would be responsible for the decisions regarding federal and state funding allocations relative to local needs.
- Psychosocial supports funding should not become the sole responsibility of state governments as this would inhibit and disrupt the delivery of collaborative patient-centred integrated care, particularly community based care.
- Service providers should not have funding made conditional on directing a defined proportion of clients to lower intensity services. The intensity of care a consumer is referred to should be determined by their clinical needs.
- The need to reduce unwarranted variation (variation not explained by need or patient preference), individually and collectively. The absence of a formal accountability framework that permits PHN organisations to share and compare information on value - performance and outcomes - is a weakness of the current program structure and should be addressed irrespective of whichever funding model is preferenced.

2 INTEGRATED CARE

PHNs agree with the Productivity Commission finding that mental healthcare services should be characterised by integrated planning and service delivery at the regional level. Guided by the essential elements of integrated care outlined in Figure 1[2], PHNs across Australia are already leading the development of systematic integration through the establishment of cross sector collaborative partnerships, governance arrangements and strategic planning. This is in addition to strengths in the ability to commission services, funding mechanisms designed to implement stepped care and ability to co-design services with people with lived experience.

Figure 1 – From *Shifting the Dial Supporting Paper on Integrated Care*



To achieve social and emotional wellbeing, PHNs understand that the combined social, emotional, cultural and physical wellbeing of a person must be considered in a true integrated care approach. Collaborative partnerships are a vital element of the delivery of this type of patient-centred care, with diverse, cross sector engagement ensuring that services are both culturally appropriate and responsive to local need. PHNs are already demonstrating leadership in these areas as demonstrated in case study 1 below. Additional case studies are provided throughout this submission and in Appendix 2.

[2] Productivity Commission. 2017. Integrated Care, Shifting the Dial: 5 Year Productivity Review, Supporting Paper No. 5. Canberra. Available at https://www.pc.gov.au/inquiries/completed/productivity-review/report. Refer to Figure 1.1, page 5.

Case Study 1

Indigenous Way Back Support Service

The Hunter region has been a trial site for Beyond Blue's Way Back Support Service, with HNECC providing some funding to support this initiative. Through a local Needs Assessment, a gap for Indigenous specific aftercare was identified. HNECC worked with the Way Back lead agency, Hunter Primary Care and the Hunter New England Mental Health Service to design and implement a specific Indigenous program. Similar to the Way Back trial program, the Indigenous program provides non-clinical support and aftercare following a suicide attempt. Referrals are generated exclusively from the LHD.

The relationships established through the pilot project and the Indigenous program will be leveraged for the implementation of the ongoing Way Back Support Service once the bilateral agreement has been signed.

Importantly, PHNs work to support general practice as the cornerstone of primary healthcare. As the draft report has noted, GPs provide both a gateway and gatekeeper function to other mental healthcare services. GPs are an integral component of all PHNs, which includes representation on PHN boards. Moving to a state-funded "rebuild" model would break the link between GPs and commissioning services to address local needs.

Governments and the Productivity Commission have an opportunity to capitalise on the existing capacities of PHNs and Local Hospital Networks (LHNs) working in partnership with local providers and community groups, to implement appropriate supportive funding and accountability structures that enhance the provision of regionally based integrated care.

3 STEPPED CARE AND PERSON-CENTRED CARE

The person-centred stepped care model is designed to provide mental healthcare services in the community and reduce inappropriate hospitalisations.

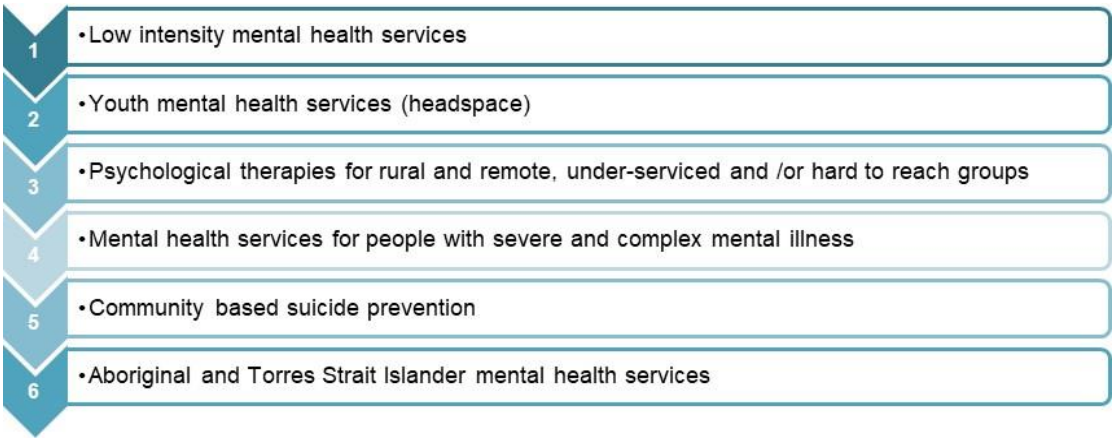
The Productivity Commission's draft report theorises that because PHNs are funded by the Commonwealth Government (rather than the state and territory governments which bear most of the cost of hospital care) PHNs **do not have strong financial incentives** to implement services that lead to reduced hospitalisations.[3]

Funding for PHNs, however, is specifically directed towards a **stepped care approach** to mental healthcare services**.** By its very nature, a stepped care approach is **structurally designed to avoid unnecessary hospitalisations** by enabling an individual to access the right service to meet their needs at the right time, in the right place, to maintain their wellness, or to support their recovery back to wellness, as required. The commissioning approach facilitated by PHNs is designed to enable the purchasing of the complete range of services along the stepped care model, suited to the local community needs outside of the hospital setting.

PHN incentives to reduce hospitalisations go beyond funding models. PHNs have been developed with a **person-centred approach to mental health planning.** We have a commitment to including people with lived experience as part of our planning and decision-making process (co-design), as well as support a peer worker program. Naturally, people with lived experience do not want to be unnecessarily hospitalised, so we have a philosophical or moral incentive to provide appropriate care and reduce hospitalisations which extends beyond financial incentives.

Importantly, PHNs are directed by the Australian Government to commission mental health services for each region based on the stepped care model in **guidance documents** which mandate how the mental health flexible funding pool must be spent.[4] In particular, PHNs are funded to deliver mental

Figure 2. Six priority areas for PHNs set by Australian Government under a stepped care approach



[3] Productivity Commission 2019, Draft Report. Section 23.2, pg 941.

[4] Department of Health 2019, PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance: Stepped Care. Australian Government: Canberra. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools.

health services via **6 priority areas or buckets of funding** which range from low-intensity services to services for people with severe and complex mental health issues (see Figure 2). Three additional sources of funding have since been provided to PHNs: drought/fire assistance; psychosocial support services; and psychological services for those in residential aged care facilities. As noted in the draft report, PHN mental healthcare services are routinely monitored and evaluated for their effectiveness and PHNs are held to account if the outcomes of these initiatives are not met.[5]

The Australian Government has subsequently provided additional funding initiatives for drought-related mental health services and psychosocial services for people living in residential aged care facilities. An example of successful commissioning of services in our region for people with severe and complex mental health issues; the so-called "**missing middle**" is provided in the text box below. Importantly, programs to address the "missing middle" are best delivered by PHNs, due to the unique ability to link services back to general practice and therefore keep mental healthcare truly primary-care focused.

In summary, due to the person-centred, stepped care approach to service planning and implementation, reducing inappropriate hospitalisations is a **core objective** of PHN mental health programs.

Case Study 2

Complex Mental Health Integrated Recovery Services Program

The Complex Mental Health Integrated Recovery Service, commissioned by COORDINARE (the South Eastern PHN), is a medium-term clinical service for adults who are experiencing serious or complex mental health issues and who are at-risk of hospital admission or readmission. The Service uses individual and group therapies under the stepped care model of mental healthcare, provided by mental health workers and peer support workers.

This commissioned Service is for people whose needs are too acute or complex for primary mental healthcare, but not sufficiently acute to receive the specialised mental healthcare offered in the public hospital system and who cannot access private psychiatric treatment, the so-called "missing middle."

The service provides coordination of primary care, specialist mental healthcare and other clinical service providers. Mental health nurses are a critical part of the current mental health workforce, being the largest clinical occupational group dedicated to mental health, and one of the most geographically dispersed and cost-effective sources of expertise for combined management of mental and physical health and care coordination. Mental health peer workers utilise learnings from their own recovery experiences to support other people to navigate their recovery journeys. The blended delivery model, including peer support workers, is critical to generating trust and engagement with services and supports and well suited to the creation and maintenance of care coordination. Reducing unnecessary hospital admissions is a key goal of the Service.

[5] For example, see Productivity Commission Mental Health Draft Report, 2019, Figure 25.2, pg 1004.

Governance and Evaluation

The Service was commissioned on a 3-year contract (with local provider Grand Pacific Health); the longer timeframe has helped ensure continuity of access for the community and improved outcomes and measurement. Lived experience was represented in the co-design, delivery and governance of the service. The service model increases the proportion of consumers receiving appropriately targeted recovery-orientated interventions, aligns session numbers to consumers' individual needs, targets consumers most at risk in the region and facilitates seamless referrals between providers and services. The service is provided across the entire PHN region, at no cost to consumers, and reports into the National Primary Mental Health Care Minimum Data Set (MDS). It partners with two Local Health Networks and local Aboriginal Community Controlled Health Organisations. All service staff have completed cultural competency training.

Regular service monitoring and evaluation activities such as data accuracy checks and auditing provided by PHN, uploads to MDS, verification of consent and privacy requirements – all contribute to ensuring the service is monitored, measured and evaluated. Person-led and co-facilitated outcomes measurements provide better service accountability and assist consumers to access the least intense care they require, contributing to reduced hospital admissions or readmissions.

The PHN also encourages service participants to register and use My Health Record, ensures there are up-to-date referral templates in HealthPathways, promotes and links the service to general practice to build awareness and referrals, and monitors such services to ensure they are safe, compliant and of a high standard. The governance model includes incident and complaint reporting, risk management processes, regular activity and budget reporting, service evaluation, measurement and monitoring.

4 LOCAL COMMISSIONING AND GOVERNANCE STRUCTURES

PHNs do not favour the "rebuild" option.

We do not agree with the proposed "rebuild" approach involving the creation of "Regional Commissioning Authorities" as a new tier of bureaucracy which would also likely exacerbate the mental healthcare silo. We partly agree with the "renovate" approach, however with the major caveat that the "renovate" approach must include further changes to intergovernmental roles and responsibilities. We instead propose a third "repurpose" model discussed in more detail below.

We believe that governments have an opportunity to capitalise on the existing capacities of PHNs and Local Hospital Networks (LHNs) working in partnership with local providers and community groups, to implement appropriate supportive funding and accountability structures that enhance the provision of regionally based integrated care

The introduction of levers that enhance and strengthen this approach would build on existing organisational structures already embedded within communities and delivers on the intention of Commonwealth, state and territory governments for joint planning and funding of the health system at a local level. This intention is articulated within:

- The National Health Agreement[6] outlined in the February 2018 Heads of Agreement between the Commonwealth, state and territory governments (COAG Health Council);
- The Fifth National Mental Health and Suicide Prevention Plan[7] which is premised on PHNs and Local Hospital Networks implementing integrated planning and service delivery at the regional level; and
- The Australian Government Response to the 2015 *Contributing Lives, Thriving Communities-Review of Mental Health Programs and Services*.[8]

The Productivity Commission itself has also recently identified the need for regional alliances between Local Hospital Networks, Primary Health Networks and others in their *Shifting the Dial* report, which outlines where Australia's priorities should lie in enhancing national welfare. While this recognition was in the context of the health system more broadly, to single out mental health services further positions mental health as a separate silo within the health system.

The risk with the "rebuild model" is that the proposed regional commissioning agency would build in an extra layer of bureaucracy and cost, and that mental health could become increasingly "siloed"

---

[6] Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform, initially proposed by the Commonwealth Government on 9 February 2018. As at November 2019, all state and territory governments have signed on to this funding and reform agreement. Available at https://www.coag.gov.au/about-coag/agreements/heads-agreement-between-commonwealth-and-states-and-territories-public-0.

[7] The Department of Health 2017. 'The Fifth Mental Health and Suicide Prevention Plan', available https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-fifth-national-mental-health-plan.

[8] Department of Health, 'Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services', p.8. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/0DBEF2D78F7CB9E7CA257F07001ACC6D/$File/response.pdf.

and distanced from the broader health system within which it functions. It also signals the delinking of mental health and physical health which would be the antithesis of the principles of integrated care, to which the government has publicly committed,[9] and moves away from meeting the full healthcare needs of individuals and communities.

Mental health services, and the health system more generally, are part of a diverse ecosystem of funders, providers and consumers. A additional layer of bureaucracy would not mitigate the challenges being faced.

Policy and decision makers recognise that mental healthcare exists in a highly complex amorphous ecosystem to which there is no one easy solution to the numerous and complex issues identified in the draft report. As a sector, mental health has traditionally not received the same level of scrutiny or systematic intervention as other areas of health, resulting in the creation of a highly disjointed and mismatched system.

A core aim of PHNs is to implement integrated care initiatives across the physical health and mental health sector as demonstrated in the case studies throughout the document. However, additional funding is required to further improve the provision of integrated mental healthcare services across a wider range of providers.

To effect better planning for service delivery at the local level, the existing structures of Primary Health Networks and Local Hospital Networks should be utilised. This draws upon existing organisational structures already embedded within communities, and builds on the intention of Commonwealth, state and territory governments for joint planning and funding of the health system at a local level.[10]

PHNs and LHNs already demonstrate significant leadership in this space, with many examples of the development of cross sector partnerships and governance relationships designed to promote integrated service delivery at a local level. The case studies throughout this document provides practical examples of how this can work, and how it is currently working, highlighting an opportunity to leverage these existing capabilities in a renovation approach.

[9] Heads of Agreement between the Commonwealth and the States and Territories on public hospital funding and health reform, initially proposed by the Commonwealth Government on 9 February 2018. As at November 2019, all state and territory governments have signed on to this funding and reform agreement. Available at https://www.coag.gov.au/about-coag/agreements/heads-agreement-between-commonwealth-and-states-and-territories-public-0.

[10] ibid.

Case Study 3

Improving regional service consistency by rationalising funding models

The different funding sources being used by various stakeholders, can be a major barrier to achieving service integration. It can be confusing to service providers, consumer and carers when a regional service provider has multiple funders resulting in inconsistency of service delivery. Organisationally, adopting a co-funding model demonstrates significant commitment and trust between the organisations and is focused on improving consumer and carer experience over organisational benefits.

The Active Life Enhancing Intervention (ALIVE) program is a service for people aged 17 years and older who are at medium to high risk of suicide. ALIVE aims to decrease the incidence of suicide and self-harm behaviour in the community by providing a safe, non-judgmental support service for those at risk, offering up to three months of intensive therapeutic support as needed, with the aim to link people into ongoing counselling services and programs, where necessary. Prior to the 2018/19 financial year, the program received separate funding from the Western Australian Primary Health Alliance and the Western Australian Mental Health Commission for separate arms of the service. During 2018/19 the Western Australian Primary Health Alliance and the Western Australian Mental Health Commission agreed to jointly fund and contract manage the ALIVE service.

The decision to align service schedules was based on reducing confusion around accessibility and improving the operational performance of the service, by providing a consistent pathway to receive the service across the Perth-metro area. The changes to the model of co-commissioning of ALIVE has led to a well-connected and integrated system that services the most vulnerable people and ensures that individuals at risk receive the care and support required.

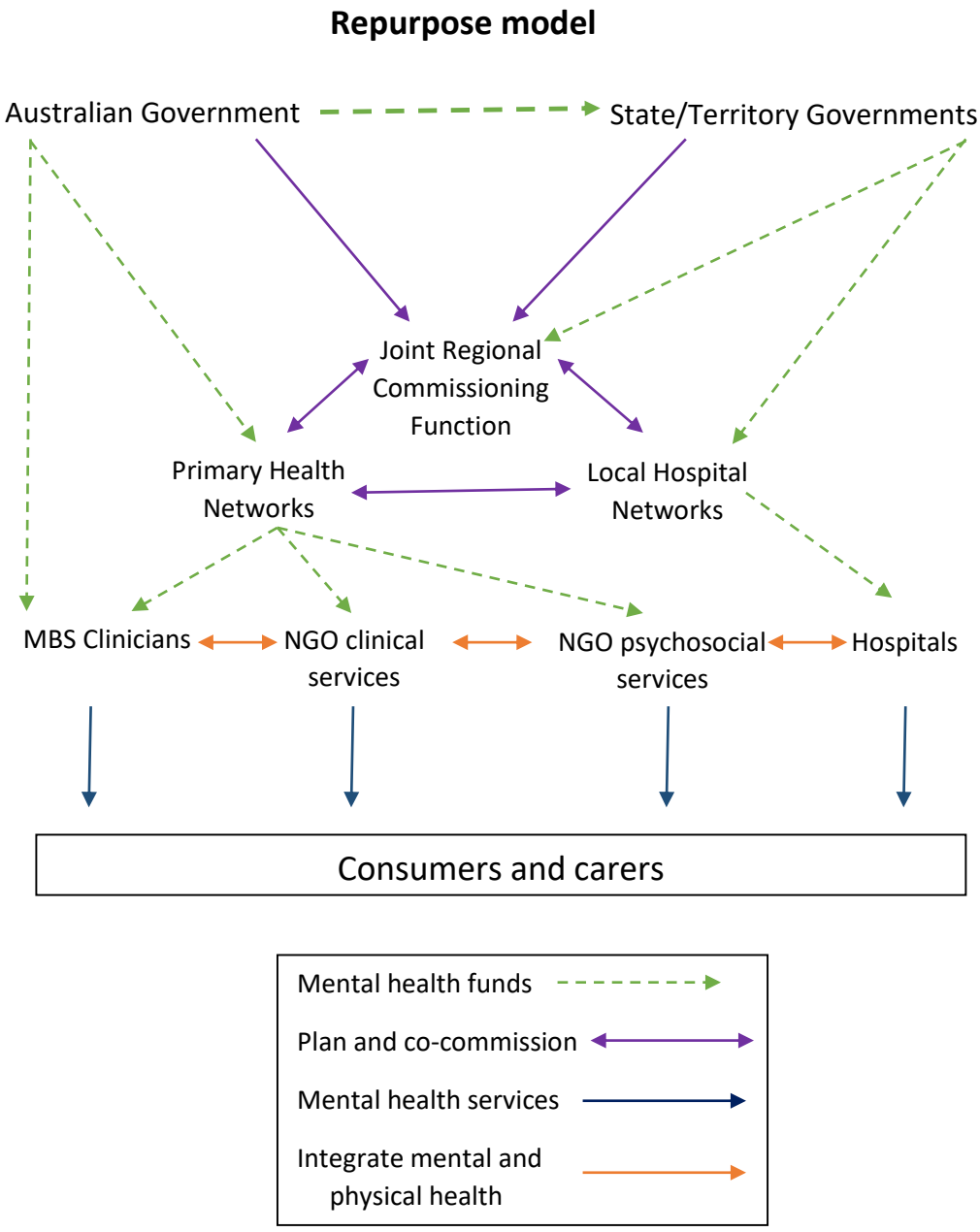
Another contemporary example of the role that PHNs fulfil in facilitating the coordination of services at the local level is around local responses to the recent bushfire disasters. The government recently announced $6.9 million in community wellbeing grants that will allow PHNs to commission mental health, wellbeing and recovery activities tailored to the local needs of a bushfire affected communities.[11] Due to their existing networks and stakeholder relationships, as well as experience in commissioning services, PHNs will be able to rapidly deploy this funding to implement the necessary services in fire-affected local areas.

In light of our reservations of both the 'rebuild' and 'renovate' models outlined in the draft report, we propose a third option, outlined in Figure 2, that instead leverages and builds on existing infrastructure, relationships and processes in place at a local level to strengthen integrated mental healthcare services. Incentives and levers must become embedded within the mental health system that require PHNs and LHNs to work collaboratively and be held accountable for the delivery of patient-centred integrated care.

While briefly outlined below, more details on this proposed approached, that we have called a "repurpose" model, are provided in Appendix 1.

[11] The Hon Greg Hunt MP, 'Immediate mental health services deployed into fire affected communities,' *Media Release,* 12 January 2020.

Figure 2



At the regional level PHNs and LHNs would work together to create a Regional Commissioning Function (RCF) in each region. In some regions this may also involve the state or territory government or other regional entities (e.g. community mental health, children's health). Over time, local RCFs may also include other commissioning bodies such as the NDIA, housing, employment and so on. There will be regional flexibility in forming the RCFs to take account of the federated structure in Australia, the significant differences across states and territories, and taking into account more granular regional differences.

Figure 3 – The Quadruple Aim

Source: Australian Government Department of Health and PricewaterhouseCoopers (PwC), PHN Planning in a commissioning environment - Resources.[12]

Compared to the 'rebuild' model, the implementation of this option will avoid losing momentum around better planning and coordination at the local level through further disruption and delays, and is consistent with broader whole of health system reform directions that are underway. It also protects against the potential unintended consequence of change fatigue that would invariably result from the 'rebuild model' approach.

The Productivity Commission draft report also notes that cross-jurisdiction coordination on a broad range of mental health policies under the auspices of the Fifth National Mental Health and Suicide Prevention Plan is a work in progress and states that results so far have been mixed (Volume 1, page 131)[13].This is not surprising as over the past four years the mental health system has experienced the introduction of PHNs, procurement of new mental health services, development of regional plans and the introduction of the NDIS. In addition, responsibility for commonwealth mental health services was transferred to PHNs in July 2016, however the first year was a year of 'service continuation.' Essentially, PHNs have only had two years to implement many reforms since the transfer of federal funding and then the release of the Fifth Plan in August 2017. This is not enough time to successfully implement the range of reforms envisaged under the reform agenda. These reforms must be allowed sufficient time to consolidate and become embedded before another major reform is embarked upon such as the proposed 'rebuild.' If we do not, we risk the creation of an

[12] Australian Government Department of Health and PricewaterhouseCoopers (PwC) 2016, PHN Planning in a commissioning environment – Resources. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN+Planning+in+a+commissioning+environment.

[13] Productivity Commission Mental Health Draft Report, 2019, p.131.

apathetic mental health environment frustrated by constant disruption that impedes the creation of long-lasting health promoting structures that improve mental health.

Broader PHN and LHN commissioning responsibilities within mental health should also not be merely viewed as a 'bolt-on' activity. It is essential that funding mechanisms (including private provider MBS funding) should be linked and coordinated to ensure the system for mental health is effective, efficient and responsive; and to ensure that existing and commissioned services for other health conditions are also planned and held to account for outcomes in a range of health domains including mental ill health. For example, commissioning services should be appropriately funded to fill service gaps and facilitate cross-sector local planning and accountability structures that incorporates consumer perspectives. A practical example of how PHNs are already working to identify service gaps is exemplified in the case study on Mother- Infant Dialectical Behavioural Therapy Groups below.

Case Study 4

Mother-Infant Dialectical Behaviour Therapy Groups

In South Australia, an evidence-based group therapy program for Mothers with Borderline Personality Disorder (BPD) in the perinatal period is occurring through partnerships between the Adelaide PHN, the specialist perinatal mental health unit within the Women's and Children's Hospital Network, Department of Human Services and Commissioned service providers.

The partnership ensures that women have access to these specialised groups within the community geographically closer to where there is demonstrated need and a gap in services targeting people with BPD. Women can access a specialised service within a primary setting with Helen Mayo House providing clinical support and supervision to the primary clinicians undertaking the project. Groups are run at no-cost through Children's Centres to ensure appropriate venues and appropriate trauma-informed child-care arrangements are in place for this vulnerable group.

The agreement between the Women's and Children's Hospital Network, Department of Human Services and the Adelaide PHN has resulted in four, 26-week groups being provided throughout 2019-2020 in both the Northern and Southern Regions of Adelaide.

The project is supported by a Steering Committee made up of all the partners which will guide the coordinated implementation of the Mi-DBT Projects within both the Southern Adelaide and Northern Adelaide regions, with Memorandums of Understanding which set out the terms and conditions of this Project. The project has resulted in a knowledge transfer and an upskilling of clinicians as tertiary and primary clinicians work in partnership with each other resulting in better outcomes for the community.

Preliminary feedback indicates that the groups have been well received by participants with good attendance and outcomes. The collaborative delivery of the project has had positive outcomes in relation to clinician skill development and redirected women who would have previously needed to be seen by a specialised outpatient tertiary service to a coordinated service within the community.

The length of the funding cycle for psychosocial and clinical supports should also be extended from one year to a minimum of five years (Draft Recommendation 12.1)[14] to enhance planning, service delivery, evaluation and data collection. These five-year cycles should then be aligned to ensure that relevant work streams commence and end at the same time. Currently the delivery of a stepped

[14] Productivity Commission Mental Health Draft Report, 2019.

care model of service procurement is impeded by the disjointed nature of funding cycles.

Furthermore, there should be a mapping process undertaken that identifies other government policy reforms where the opportunity for a more cohesive and "joined up" approach can be achieved in the delivery of mental health services. This is particularly relevant in the current aged care reform agenda. Greater regional control of mental health funding is required in conjunction with clarification and transparency around the roles and responsibilities of Commonwealth, state and territory governments.

Accordingly, while PHNs support headspace as the best practice model for low to moderate youth mental healthcare, PHNs require greater flexibility over the use of youth mental health funds to best meet the needs of local communities (Draft Recommendation 24.2). Positive mental health outcomes will be better served if PHNs have regional autonomy over service provider funding.

National Mental Health Treatment and Recovery Framework

PHNs also strongly recommend the development of a National Mental Health Treatment and Recovery Framework. This would establish minimum expectations of service availability in each region across the acute, primary and community sectors (based on the architecture of the National Mental Health Services Planning Framework). Regional commissioning bodies could use this framework to plan and implement local services.

To enhance planning and facilitate transparency PHNs also support the recommendation of the Productivity Commission to expand the role of the National Mental Health Commission to incorporate accountability measures and become the national evaluation body of government and non-government mental health programs and services.

Case Study 5

Health Alliance
December 2019

The Health Alliance

The Health Alliance has been created by the Boards of Metro North Hospital and Health Service (MNHHS) and Brisbane North Primary Health Network (PHN) to support a "neutral space" in the region where parts of the health sector and other sectors related to health can come together to work on health challenges in the region that cannot be addressed by the organisations operating in isolation. This process will in future become an element of regional commissioning, where planning is better connected to purchasing and implementation, taking account of the local context.

The Joint Board Committee

The Joint Board Committee is a governance mechanism for Brisbane North PHN and MNHHS to progress their strategic intent through partnership between the organisations. It provides governance of the activities of the Health Alliance and the Joint Operations Group (described below). The Joint Board Committee is made up of the two Board Chairs, two other members from each Board, and the two Chief Executives. The Chair of the Committee rotates annually between the organisations.

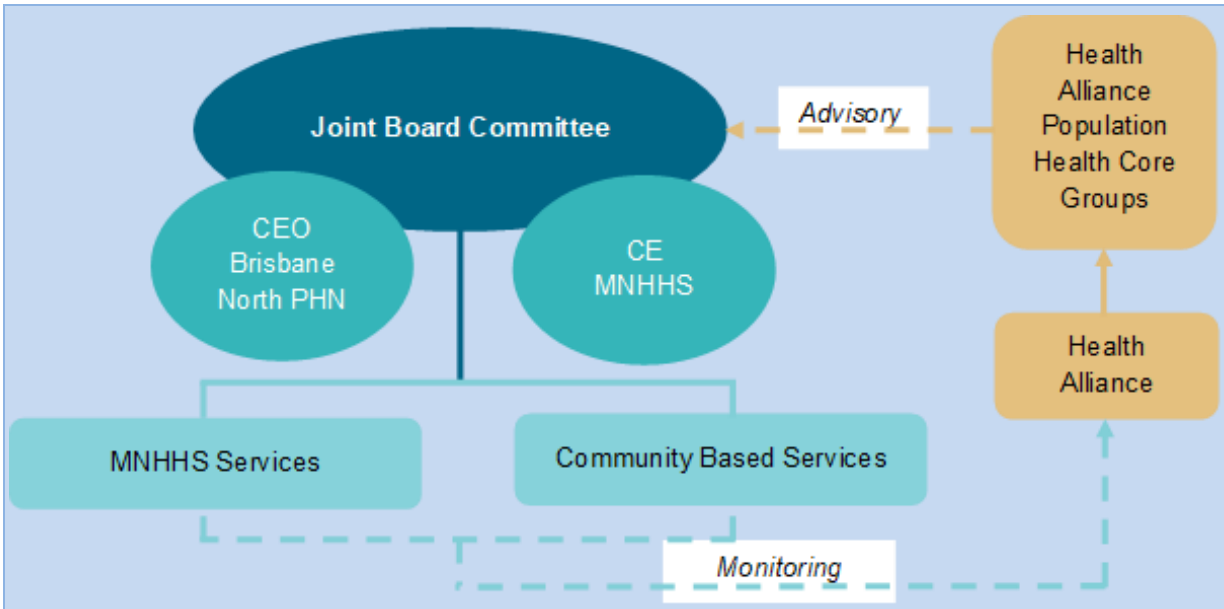


Figure 1. Health Alliance governance

Population Health Core Groups

The Health Alliance activities currently focus on three population groups: older people, children in the Caboolture area, and people with complex health and social needs who frequently attend emergency departments (ED). For each of these populations a 'Core Group' has been formed, consisting of the relevant stakeholders in the region. For example, the Core Group focused on older people includes non-government service providers, GPs, Residential Aged Care Facilities (RACFs), consumers and carer representatives, Indigenous service providers, Brisbane North PHN, MNHHS, Geriatricians, and the Queensland Ambulance Service.

The Core Groups empower people and the sector to design a system response not limited by existing program or institutional boundaries. The Alliance holds an objective and open-minded view, with a focus on solutions that benefit both consumers and the health system.

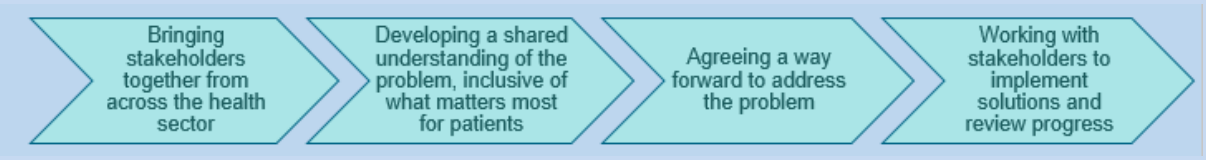


Figure 2. The Health Alliance process

Core groups also play a monitoring role, reviewing system performance and designing quality improvements. They have each developed an outcome statement and outcome indicators to focus their activities and provide advice to the Joint Board Committee.

Joint planning and funding at the local level: Regional commissioning

In addition to the governance structures described above, the two organisations are developing mechanisms in preparation for a regional commissioning role; a regional commissioning strategy which describes how outcome-focused prioritisation and purchasing decisions would be made at the regional level, and a North Brisbane Population Health Advancement Fund. This fund would be governed by the Joint Board Committee, but would remain virtual in nature with specific resources identified within each of the two organisations.

PHNs do not agree with the proposal that psychosocial supports should be the sole responsibility of state governments. From an integrated perspective we believe that clinical and psychosocial supports should not be treated separately under any proposed funding model. In response to consumer feedback PHNs have been effectively combining mental health nursing, psychosocial and other funding streams to develop integrated one-stop-shop patient-centred services.

If psychosocial support funding was to become the responsibility of the states delivering patient-centred integrated care in this way would become more difficult for PHNs and it may act to disrupt patient care. If the draft report identifies making the 'least disruptive change possible'[15], then channelling psychosocial funding through the states would not be an effective strategy.

The draft report outlines the important role that GPs must play in the stepped model of care, however it is recommending reforms that would give commissioning responsibility to a state-based system. With 90 percent of Australians seeing a GP at least once a year[16], and GPs increasingly reporting that psychological issues are their most common presentations,[17] we contend that primary care should play a predominant role in decision making regarding the commissioning and strategic direction of mental health care. Ultimate commissioning responsibility should not sit with the states and territories. PHNs have successfully negotiated partnerships with their local stakeholders, such as the LHNs or government departments. An example of the benefits of collaborative partnership is the Victorian Place Based Suicide Prevention Trials (PBSPT) explored in further detail in the case study below.

We also recommend the Productivity Commission consider funnelling the allocation of carer support funding through Regional Delivery Partners outlined under the new Integrated Carer Support Services (ICSS) program.[18] A specific proportion of the funding allocated to Regional Delivery Services should be earmarked for mental health support. Funding mental health carer support separate from all other carer supports risks siloing mental health carers and making it more difficult for carers to access "mainstream" carer supports.

Chronic underfunding of mental health

It must also be acknowledged that whilst we support the many recommendations outlined in the draft report to address the lack of coordination and clarity within the sector, mental health nonetheless remains chronically underfunded. The legacy of a system designed to promote and treat episodic physical illness has created an environment in which mental health investment has not been sufficiently prioritised. Additional funding is essential to generate long-term reform of the mental health system.[19]

---

[15] Productivity Commission Mental Health Draft Report, 2019, p.949.

[16] Department of Health 2018. Annual Medicare statistics – Financial year 1984–85 to 2017–18. Canberra. 2018.

[17] RACGP 2019. General Practice: Health of the Nation 2019. East Melbourne, Victoria.

[18] Department of Human Services 2019, 'Integrated Carer Support Services', *Disability and Carers,* available at https://www.dss.gov.au/disability-and-carers-carers/integrated-carer-support-service-implementation-updates-and-information.

[19] Productivity Commission Mental Health Draft Report, 2019, p.6.

Case Study 6

Placed Based Suicide Prevention trials (PBSPT)

In Victoria, progress in suicide prevention has been achieved through a partnership between the Victorian Government and PHNs to realise the goal of halving the suicide rate in Victoria by 2025.

The agreement between the Department of Health and Human Services (DHHS) and the six Victorian PHNs resulted in an aligned funding model that implemented the Placed Based Suicide Prevention trials (PBSPT) in 12 metropolitan, regional, and rural locations of need over a four-year period (2017-2020).

This unique funding model is supported by a statewide Project Steering Committee with senior representatives from the DHHS and from each PHN providing high-level oversight and accountability of work across all 12 place-based trial sites. A community of practice has also been convened to bring together the local coordinators and the DHHS divisions.

PBSPT aim to improve local responses to suicide and lay the groundwork for future suicide prevention efforts across Victoria through the use of a Collective Impact[20] approach, actively engaging communities in bringing together the skills, expertise and resources needed to develop a systemic plan for reducing suicide, based on local needs and priorities, and focussing on the interventions likely to have the greatest impact.

Preliminary evaluation[21] of PBSPT has provided a very strong consensus that the collaborative place-based model was the right approach suicide prevention and confirmed the improvement of suicide prevention capacity in those local communities. There was also a recognition of the time required to build trust and genuine partnerships that will empower communities and sustain efforts.

While access to primary health care services through the MBS is largely uncapped, and all Australians have access to basic hospital emergency medical care in times of mental and physical health crisis, at many other points along the stepped mental healthcare spectrum insufficient funding ensures that services effectively remain capped and are rationed. This prevents consumers from being able to access the care they need, when they need it.

This issue of underfunding needs to be addressed by Commonwealth, state and territory governments independently of the reform proposals identified in the draft report.

Reducing unwarranted variation

PHNs are held collectively responsible for efficiency and effectiveness at a program level but there is little transparent accountability built into the program and guidance material provided by the Department of Health to PHNs to enable the examination of performance and outcomes to collectively address unwarranted variation (variation not explained by need or patient preference).

Unwarranted variation in access, quality, investment, and outcome has significant consequences (i) overuse of low or no-value interventions, which wastes scare resources and harms patients, albeit

[20] Collective Impact is a collaboration framework that engages across sectors and groups who share a common interest to address a complex social issue in a given community, from Kania and Kramer (2011) Collective Impact, Stanford Social Innovation Review.

[21] PBSPT Establishment Phase Evaluation Report, DHHS (unpublished).

unintentionally (ii) underuse of high-value interventions, which always leads to poor or deleterious outcomes and amplifies rather than attenuates inequity.

These command our attention, individually and collectively, and need to be managed centrally as a responsibility of the Department in the current structure.

At a minimum, what is needed are program-level processes to enable PHNs to share and compare information on performance and outcomes, with each other and commissioned providers, which are scalable to context and location.

The absence of, or lack of access to, such information on the variation in the performance of PHNs in terms of delivering value (allocative, technical and personal) is a significant limitation on the programs capacity to meets its objectives notwithstanding the efforts of the 28 separate PHN commissioning organisations to achieve these common goals.

To address this issue is fundamental to any reform process irrespective of the funding model.

Finally, we support the Productivity Commission recommendation to establish a Mental Health Innovation Fund that would allow PHNs to trial new models of care based on local population needs (Draft Recommendation 24.4). Independent evaluations of these programs will increase the national mental health research evidence base with national structures that support findings to be shared nationally enabling innovative evidence driven programs to be transferred and scaled up.

This alternative model of regional planning would provide both short- and long-term value if used to strengthen collaboration and further resource the existing structures. This will also enable the creation a nationally unified, regionally controlled health system that puts consumers at the centre.

5 WORKFORCE

The workforce required to deliver mental healthcare services must be diverse to address the varying needs of people in need of mental healthcare. The existing health workforce must be supported to allow continued improvements in understanding and responses to the mental health issues associated with other health conditions. This is consistent with the stepped care approach to mental healthcare outlined in the Productivity Commission draft report.

The Mental Health Workforce strategy currently being developed should align with the many other national health focussed strategies that have been agreed to, or are under development such as the Primary Health Care 10-year Plan, the 10-year National Prevention Health Strategy, the National Women's Health Strategy, National Men's Health Strategy, the National Action Plan for the Health of Children and Young People, and the Stronger Rural Health Strategy.

We agree that there is a need for greater quantity and wider mix of skills in the health workforce including the more efficient allocation of skills to specific services. This should also recognise the importance of peer support, navigation services, therapy coaches and lower-intensity psychological treatments.

PHNs have the capacity to provide significant leadership to initiate and facilitate the development of a diverse, widely skilled workforce as demonstrated in the case study shown in Case Study 7.

Case Study 7

Family Referral Service

As a pilot project, Hunter New England Central Coast PHN along with Central Coast LHD, the NSW Department of Education and the Benevolent Society co-commissioned the Family Referral Service. The service provided a family-based assessment and engagement service for families who are known to be vulnerable. The project provided an upstream early intervention for vulnerable children and families by placing a family engagement worker within disadvantaged school communities.

This project was initiated by Central Coast LHD after a large cohort of families were identified by the tertiary system as not having a General Practitioner or other primary care support. A steering committee was convened that included representation from the four commissioning bodies and the school executive to provide oversight and governance of the project.

Workforce integration, collaboration and information sharing should be encouraged across health services, both within the mental health sector and across the health and social services sectors more broadly. This facilitates the provision of care that is person-centred, integrated and encompasses the broader social context in which mental health needs to be addressed.

Local workforce integration and identification of service gaps should also be coordinated and administered through existing health and community structures. This should again involve formalised cooperation between Primary Health Networks and Local Hospital Networks. This is most effective when collaborative relationships are formalised through memoranda of understanding, collaborative governance structures and joint planning and obligations for accountability.

It is essential that regional commissioning bodies are adequately resourced to facilitate local implementation of the National Mental Health Workforce Strategy. While sustainability of a local mental health workforce is a current top risk reduction priority for PHNs, the majority do not receive specific funding to facilitate mental health workforce promotion and development.

An indigenous mental health workforce must be funded and supported to address the specific needs of local indigenous communities. This recognises the distinct needs of, and obstacles faced by these sub-groups of the population as well as their holistic cultural approach to matters of social and emotional wellbeing.

We support the need for more mental health nurses in the health care system. This will help support the provision of mental health care through a flexible and responsive workforce with an increased level of specific mental health knowledge, skills and capabilities.

We believe careful consideration must be given to how specialisation is introduced to ensure that it does not create an over use of specialisation and a de-skilling of generalist workforce. Workforce development, integration and coordination, through education, registration and funding models must be introduced to generate the greatest net benefit for the community.

Rural workforce development should be a priority for governments. Allowing PHN access to the Commission's recommended Mental Health Innovation Fund to look at long term workforce projects in rural areas would aid the provision of an appropriate workforce reflective of rural needs.

We also support the need to strengthen the peer workforce. PHNs recognise the vital role that peer workers play in the delivery of services that promote better health outcomes. Integrated care will be enhanced through a stronger, increasingly educated and engaged peer workforce.

PHNs support initiatives that lead to placements and internships being more representative of healthcare settings, including in the private sector and settings other than inpatient units. We also support initiatives that improve access to mental healthcare services in rural locations through a mix of workforce attraction strategies and ehealth programs.

We also agree that funding should be allocated to improve the availability of community and after-hours mental health services as an alternative to emergency departments for people in need of mental healthcare.

6 MEDICARE BENEFITS SCHEDULE

The Productivity Commission draft report identifies two types of funding for mental healthcare services. These are primary care by general practitioners or psychologists funded through the Medicare Benefits Schedule (MBS) and acute care at public hospitals where funding is shared between the Commonwealth, state and territory governments. However, this does not appropriately support the continuum of care envisaged within the stepped care approach to mental healthcare need.

The MBS should be adapted to be more flexible in meeting an individual's need for mental healthcare services.

A recent example of how flexible MBS funding mechanism can be applied to mental health is the implementation of the new MBS items for eating disorders. These changes enabled an MBS rebate to be received when an Eating Disorder treatment or management plan was implemented or reviewed. Consumers were then eligible for up to 40 psychological services, and up to 20 dietetic service in a 12-month period, that could be flexibly moulded to meet an individual patient's need.[22]

We support the amendment of MBS regulations to require all referral providers to advise, and provide an easy to understand statement, informing patients that they have flexibility to choose a specialist or allied health provider as an alternate to the professional stipulated on the referral document (Draft Recommendation 5.8).

We support matching consumers with the right level of care and recognise that overall currently consumers may not have easy access to low-intensity mental health services. However, this should not be addressed by requiring a targeted proportion of people in need of mental healthcare being referred to low-intensity services, as suggested in Draft Recommendation 5.3. The provision of mental healthcare services should instead be on the basis of clinical need and ensuring that a local community is appropriately resourced to provide this care. PHNs should continue to inform and encourage GPs to refer patients to lower intensity services (eg on-line services, health coaching etc) where this is clinically appropriate.

We acknowledge that this potentially creates the potential for over servicing or other types of inappropriate care. This risk can be mitigated by appropriate monitoring of service providers. As noted in the draft report, PHNs could contribute by promoting best practice in initial assessment and referral, including the establishment of processes to monitor the use and outcomes of services in accordance with the stepped care approach (Draft Recommendation 5.2).

Joint commissioning agencies (PHNs or RCAs) should establish mechanisms for monitoring the use of services that they fund to ensure that consumers are receiving the right level of care. If service use is not consistent with estimated service demand, commissioning agencies may need to make changes to initial assessment and referral systems (or work with providers to do so). This would enhance public accountability in the commissioning process.

[22] Department of Health, 'Upcoming changes to MBS items-Eating Disorders', *MBS Online,* Available http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-EatingDisorders.

A strength of PHNs is that they have established mechanisms for collecting data and monitoring the use of services that they fund to ensure that consumers are receiving the right level of care. If services are not provided at the correct level of the stepped care continuum, the PHN can work with the service provider to make changes to initial assessment and referral systems. This enables public accountability in the commissioning process. Similar monitoring and evaluation processes should be extended to other government-funded healthcare services.

There should be flexibility in how video conferencing in healthcare consultations are funded in rural and remote areas (Draft Recommendation 5.7). Rural and remoteness is not the only reason that someone might not access a mental health professional face to face. There are many other reasons such as disability, transport cost, time and family, work pressures (eg farming) and stigma. Requiring that at least 3 out of the 10 sessions in metropolitan areas, regional centres and large rural towns must be face to face could limit access for the most vulnerable populations.

We support changes to the MBS to allow an increase in the number of MBS rebated mental health individual and group sessions, along with the proposal to change the time period for receiving MBS sessions to a 12-month period as opposed to a calendar year. We also support the increased flexibility measures of MBS funded mental health sessions e.g. use sessions for group therapy, or couples and family counselling.

We agree that funding for mental health service providers should be conditional on and in alignment with taking a stepped care approach to the provision of mental healthcare. Improved links between providers and state child and youth and adolescent mental health services should also be prioritised as part of joint LHN and PHN planning.

However, we do not see the merit of funding for service providers being made conditional on directing a defined proportion of clients to lower intensity services. The intensity of care a consumer is referred to should be determined by their clinical needs.

We also support an independent evaluation of the effectiveness of MBS-rebated psychological therapy. While mindful of the financial risk of open-ended entitlements to MBS-funded services, we believe there should be flexibility in the number of mental health psychological treatment sessions provided by a registered MBS professional an individual may access over a set period of time. The number of MBS services should be determined on the basis of clinical need.

Although in principle we agree that the MBS should be amended to include an item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP (Draft Recommendation 5.1), this option is in reality impractical. As the draft report and the RACGP have noted, psychiatrists waiting lists are at least 6 weeks long, and many psychiatrists will not provide consultation/liaison services to GPs and patients together under the existing MBS item (291) which is designed for that purpose. There is no reason to suppose that a new MBS item would enable a timely consultation with a GP (without the patient present). We strongly recommend that the GP Psychiatry Support Line service, established by PHNs in eight regions across NSW, which facilitates *immediate advice* for GPs from psychiatrists, and provides them with the skills and knowledge needed to deliver care to their community, continues to be supported and expanded. We suggest this should be further expanded to allow GPs to also access

compensation for these consultation with the effectiveness of these new items to be evaluated after two years rather than the undefined several years.

Overall, we agree that a rigorous evaluation of MBS-rebated psychological therapies is appropriate, including the collection of outcome data from clinicians and consumers. While this evaluation to be conducted in the short term may only rely on a sample of clinicians, in the medium to longer term, we support the mandatory requirement for every provider that receives public funds for the provision of healthcare services to provide a minimum level of patient and outcome data as a supplement to the service data they already provide to effect payment for their services.

FLEXIBLE AND POOLED MBS FUNDING RECOMMENDATIONS (Draft Recommendation 24.1)

While we have proposed an alternative "repurpose" funding model in the section on Local Commissioning and Governance Structures, the following points are made on the implications of the Productivity Commission's recommendations on flexible and pooled MBS and other funding.

The Productivity Commission suggests that the "renovate" model could give more flexibility to PHNs by relaxing centrally imposed restrictions on their funding pools and enabling them to contract with Medicare-funded clinicians to better meet the needs of consumers in their region (Draft Recommendation 24.1).

PHNs are interested in alternatives to the fee-for-service funding models, such as capitation or bundled payment models trialled in New Zealand and the UK, or a partial capitation model, as suggested in the draft report (pg 969). PHNs are also interested in being able to provide incentives to attract MBS-funded clinicians to under-serviced areas, as suggested in the draft report. As mentioned above, we support Draft Recommendation 24.4 regarding the establishment of a Mental Health Innovation Fund that would be used to trial innovative system organisation and payment models.

Under the proposal, to prevent cost-shifting, the size of a PHN's mental health funding pool would be linked to the volume of Medicare rebates for allied mental healthcare in their region. Draft Recommendation 24.1 proposes that "MBS-rebated and regionally commissioned allied mental healthcare should be funded from a single pool, and commissioning agencies should be permitted to co-fund MBS-rebated after-hours GP services where this will reduce mental health-related emergency department presentations." Under this recommendation, the risk of an increase in the volume of services billed to the MBS would be transferred to PHNs who would bear the cost of MBS rebates in their region above the estimated level.[23]

Some concerns regarding the draft report proposal to integrate MBS and PHN funding are outlined below:

1. A significant issue regarding integrating Better Access/MBS funding with traditional core PHN funding is the fundamental difference in the rationale for the service delivery, along with the monitoring and evaluation of both outputs and outcomes of the funding.

   PHNs are expected to undertake detailed assessment of the needs and service gaps in their respective catchments using both quantitative analysis as well as stakeholder and community based qualitative evidence. The programs and services funded by PHNs are a result of the findings, conclusions and recommendations from this analysis through a structured process of

[23] Productivity Commission Mental Health Draft Report, 2019, pg.969, paragraph 4.

prioritisation, procurement, establishment and service delivery. As described previously, PHN funded programs have dedicated program monitoring and key performance indicators which are monitored by the Department of Health.

On the other hand, Better Access/MBS funding is granted through benefits payment that are claimed by private providers who chose to deliver services from a location and to a population cohort that is likely not based on community need. As MBS practitioners work as private businesses, their remit is self-determined by the service deliverer. Additionally, none of the MBS funding has any monitoring and evaluation in place, and has no obligation in relation to population health outcomes. While private practitioners may deliver services aimed at outcome improvements for their clients, there is no nationally mandated monitoring mechanism of service outcomes. There is also no collection, transfer and analysis of MBS service data from an outcome and KPIs perspective.

Matching the existing PHN obligations of funding services based on a needs and service gaps analysis, performance monitoring and management of services against set KPIs, and mandatory flow of data to a minimum data set held by the funding agency is vital for the adoption of the "renovate" model. Otherwise, this approach would result in PHNs funding unmonitored services for which there is no transparency or control over activities or progress.

2. Another consideration with integrating PHN and MBS funding is that MBS funding and MBS benefit payments are driven by practitioners themselves.

   In a market that is largely supply-driven it will always be difficult to estimate expected expenditure, particularly at the regional level. While the use of historical MBS expenditure to establish the size of the total pool of funding may work over a very short timeframe, say a year, any significant change in a region's private workforce or changes in their claiming behavior or service delivery model, will impact the total MBS expenditure for the period. This could have substantial implications to the funding made available to PHNs in subsequent periods. In areas of workforce shortage, the extent of population need for mental healthcare services will also not be reflected in the MBS billings.

   Therefore, using provider-driven expenditure of MBS funds to determine PHNs' funding can have serious implications for the sustainability of the PHN. Furthermore, it alters the prospective planning cycles and risk mitigation strategies that PHNs work on, and can be significantly disruptive to the progressive quality improvement work that PHNs undertake for all commissioned services.

   The proposed method of pooling and allocating mental health funds to PHNs relies on a unreliable proxy that is too insensitive to local circumstances and transfers a likely unsustainable level of risk to PHNs.

3. For the proposed model to be considered by PHNs, there would need to be full transparency around how the PHN funding pool is calculated, including the variables and variable weights used.

PHNs recommend that for such an approach to be adopted, the concerns identified above must first be addressed. A well-designed proof-of-concept pilot implementation must then be undertaken before any widespread implementation. A trial phase would be useful in identifying practical issues that may not be initially apparent. A thorough evaluation and transparency around the findings from the pilot would then be a good basis for detailed discussions with PHNs prior to a change in national policy.

7 DATA

All PHN funded programs have dedicated program monitoring and evaluation key performance indicators (including health outcomes) with an unbiased scrutiny on the progress of the service by regular data flow through to PHNs as the commissioning agency. The Department of Health examines most of these KPIs through regular progress reporting by PHNs that are aligned with nationally established performance framework.

As noted in the draft report, PHNs have more complete data sets compared to services funded by the MBS and private health insurers.[24] The draft report noted that a national minimum data set exists for *activity and outcomes data* of primary mental healthcare services commissioned by PHNs (Section 25, pg. 995). Most PHNs are moving to commissioning for *outcomes*, (most are already doing so); therefore tax-payer money is being spent towards attaining detailed and well-monitored key outcomes.

On the other hand, none of the Better Access/ MBS funding has any outcomes monitoring and evaluation in place and has no obligation of achieving any clinical or population health outcomes. There exists no nationally mandated monitoring mechanism of service outcomes and no collection, transfer and analysis of MBS service data regarding outcomes and KPIs for private practitioners. However, private healthcare providers do already produce service data to effect payment for the services they provide. They should also be required to provide a defined minimum set of patient and outcomes data for services that receive public funding.

Apart from the PHN sector, availability of centrally reported patient and outcomes data in the healthcare sector is poor. This inhibits understanding of population health, can make it difficult to monitor appropriate provision of care and creates an excessively cautious environment for innovative policy development due to concerns over inappropriate use of programs and excessive claiming of payments.

Data collection and evaluation must be enhanced across the sector. A common Minimum Data Set (MDS) should be introduced for all health services. The current mix of different MDSs that don't collect the same data in the same way leads to additional costs for service providers and poorer data for planners.

We agree that expanding the use of digital records in the mental healthcare system would facilitate greater information sharing and improve consumer experience (Draft Recommendation 10.1). The My Health Record system could provide an adequate platform for information sharing between providers of mental healthcare services and healthcare more generally.

We note that all Australians, as consumers, have recently been through an opt-out process with the creation of My Health Records. The Government should develop a strategy aimed at enabling all healthcare providers to also be able to upload patient data onto My Health Record and to eventually require this to be done as a condition of receiving public funding.

[24] Productivity Commission Mental Health Draft Report, 2019, Figure 25.2, pg 1004.

Mental health treatment and service provision must be driven by an effective and up to date evidence base. Governments must prioritise and incentivise mental health research, evaluation and data collection from patients, carers and health services. My Health Record should be more effectively utilised to enhance mental health data collection, with health services incentivised and encouraged to opt in to My Health Record and upload data. Currently services operate under an opt in method.

We support Draft Recommendation 6.1 that on-line treatment outcomes data should be forwarded to a patient's nominated GP or other health professional along with the consumer's consent. This would enhance integration and person-centred care.

Collaborative regional data sharing arrangements have the potential to significantly enhance strategic planning and commissioning services as exemplified by the 'Dynamic Simulation Modelling for Suicide prevention project' outlined in the case study below. In order to encourage and strengthen these collaborative relationships the Department of Health should develop protocols for sharing information between health services. A degree of flexibility should be retained within these protocols allowing for regional variation.

Monitoring and reporting should be consistent, outcome driven, patient-centred and fit for purpose.

Case Study 8

Dynamic Simulation Modelling for Suicide Prevention

In a new initiative, Hunter New England Central Coast (HNECC) PHN partnered with Sax Institute and Hunter New England and Central Coast Local Health Districts to apply dynamic simulation modelling to suicide prevention across the region.

The process of simulation modelling is an emerging field in healthcare and provides a robust, evidence-based approach to suicide prevention. The development of the model draws on a wide range of evidence and data sources, including population survey data, systematic reviews, administrative data, lived experience and expert knowledge.

Multiple workshops that were held as part of the process bringing together a range of diverse opinions and perspectives.

The results of the modelling will outline what interventions were shown to have the most significant effect on suicide rates and demonstrating how various interventions interacted with each other to either amplify or diminish the overall impact. These results will inform future commissioning of suicide prevention services for the region.

HNECC funded the project and HNE LHD contributed a 0.8 project officer to run the project.

8 CONCLUSION

Primary Health Networks are an integral element of the Australian Government's reform agenda aimed at delivering an efficient and effective primary health care system.

The federal, state and territory governments are all publicly committed to joint planning and funding at a local level.

While Primary Health Networks broadly agree with most of the recommendations put forward in the Commission's draft report, a key area of difference is the approach to regional commissioning. We recommend that the Productivity Commission reconsider its view in relation to regional commissioning. We suggest that the draft proposal to support a "rebuild" option is out of place with the current direction of reform within the health system and with other Productivity Commission recommendations in 'Shifting the Dial'[25]

Instead, we propose a model of reform that builds on the existing capacities embedded in the system. We believe that this is the most cost-effective method of creating a more effective, better integrated system that promotes long-term, outcomes-driven mental health care.

[25] Productivity Commission. 2017. Shifting the Dial: 5 Year Productivity Review, Report No. 84, Canberra. Available at https://www.pc.gov.au/inquiries/completed/productivity-review/report.

APPENDIX 1 – 'REPURPOSE' FUNDING MODEL

Under our proposed repurpose model, the Australian, state and territory governments would jointly set the national strategic, service and funding direction for mental health, suicide prevention and alcohol and other drug treatment.

At the regional level PHNs and LHNs would work together to create a Regional Commissioning Function (RCF) in each region. In some regions this may also involve the state or territory government or other regional entities (e.g. community mental health, children's health). Over time, local RCFs may also include other commissioning bodies such as the NDIA, housing, employment and so on. There will be regional flexibility in forming the RCFs to take account of the federated structure in Australia, the significant differences across states and territories, and taking into account more granular regional differences.

In the first instance, an RCF would not be an independent legal entity, but would be an identifiable shared governance function of the PHNs, LHNs and potentially other partners. If over time the partners choose to progress to the formation of a legal entity, further discussion would need to occur as to the best legal form (statuary body, trust, company limited by guarantee, etc).

The initial operations of an RCF would be governed by Terms of Reference, MOUs between the partners, and operational policies and procedures. This would include careful management of conflicts of interest. There will be flexibility in how an RCF is operationalised at the regional level. For example, a small team of staff may be put together under the direction of the RCF, but hosted by the PHN or LHN. Or roles and responsibilities could be shared across the PHN, LHN and other partners, as governed by their RCF's MoU.

The RCF would utilise the capacity of its partners (PHN, LHNs and others) to undertake the following activities:

- identification of needs of the local community
- mapping of current service capacity and quality
- identification of gaps in service or other responses (using the projections from the National Mental Health Services Planning Framework)
- developing a regional plan, setting out actions to deliver outcomes in quality, coordination and integration of services
- developing an investment strategy, making best use of available resources to provide care as close to the patient's home as possible
- monitoring the uptake of services, patient rated experience and outcomes measures and evaluations of service

The regional plan, including the investment strategy, would then guide the procurement and delivery of services. A total population-based budget for the region would be agreed by the Australian and State/Territory Governments, based on local need and taking into account the National Mental Health Services Planning Framework. MBS services would continue to be funded by the Commonwealth and public hospital services would continue to be funded through the state or territory government. There would be local flexibility in the procurement of non-government

services, for example the PHN may take the lead in running the procurement and contract management of NGO services. Or this could be shared across the PHN, LHN and other partners.

The RCF, through the regional plan, will take a whole of population, system view to drive coordination and integration, and to ensure that the system responds to the needs of the consumer. This may include developing care pathways, shared-care plans, single digital record, workforce planning and development and integration of mental health and physical health.

People with a lived experience, including consumers and carers, will be involved in all aspects of the RCF, including as partners in the RCF, engagement and consultation activities, sitting on procurement panels and providing feedback on services.

Features Underpinning Regional Commissioning

The following features underpin our approach to the Regional Commissioning Function:

- **Regional population based budgets** - using the National Mental Health Services Planning Framework, governments will set a total budget for each region, including hospital and MBS costs. Expenditure against this budget would be monitored and publicly reported.
- **Joint Regional Commissioning Function** – The Regional Commissioning Function (RCFs) will initially be underpinned by Terms of Reference, an MOU and operating procedures, including managing conflicts of interest. This would include joint accountability at the board, CEO and operational levels. Regional flexibility will be allowed to accommodate differences across states and territories and individual regions.
- **Equality in decision making** – while the PHNs, LHNs and other partners may be of considerable size difference (based on annual budget), the sectors they represent are of similar magnitude. Decision making by the RCF will give equal voice to each partner.
- **Lived experience engagement** – people with lived experience (including consumers and carers) will be actively involved in regional commissioning, including development and oversight of the Joint Regional Plan, commissioning and procurement, and as members of the RCFs.
- **Regional planning** – there will be development, publication and public reporting against a Joint Regional Plan that sets out actions to deliver outcomes in quality, coordination and integration of services.
- **Integration** – there will be integration of services and supports for people across mental health services (e.g. clinical and psychosocial), across health services (e.g. mental health and physical health) and across wider services and support (e.g. social inclusion, housing, education).
- **Local commissioning** – commissioning directions will be set out in the regional plan and procurement process and contract management will be run by the most appropriate organisation (i.e. PHN or LHN).
- **Shared accountability** – The LHN, PHN and other commissioners will share responsibility for the development, implementation and reporting on the regional plan and commissioning and for managing the pooled budget.
- **Life-course approach** –appropriate services and supports will be in place from pregnancy and early years, through childhood and young people, to working and older age.
- **Stepped care approach** –appropriate services will be in place across the spectrum of need, including health promotion and prevention, early intervention, mild to moderate mental illness,

high and complex need and crisis care. This recognises that most people with a mental illness will ideally receive most of their care in primary and community care settings.

RCF Accountability Framework

The Regional Commissioning Function sits within a wider set of existing and proposed national structures which will provide levers to guide the work of the RCFs, ensuring a level of consistency across the country while allowing for appropriate regional variability, and provide accountability to governments and the public. These include:

- **New National Mental Health Vision and Strategy** – integrating health and non-health sectors across all levels of government.
- **National Mental Health and Suicide Prevention Agreement** – between the Australian, State and Territory Governments setting out jurisdictional responsibilities.
- **National Mental Health Treatment and Recovery Framework (proposed)** – setting minimum population level service availability expectations (based on the National Mental Health Services Planning Framework).
- **National Standards for Mental Health Services** – ensuring appropriate services and continuous quality improvement.
- **Joint Regional Mental Health and Suicide Prevention Plans** – developed through the Joint Regional Commissioning Function.
- **Reporting and performance framework** – A nationally consistent Minimum Data Set and performance framework, with public release of data.
- **Rolling evaluations** – of mental health and suicide prevention programs, coordinated by the National Mental Health Commission.

PHN Value

Under the Commission's preferred 'Rebuild' model, responsibility for mental health commissioning would be removed from PHNs and a new, separate entity created, by the states/territories. We do not support this model. We see PHNs as being naturally placed to not only be one of the joint 'owners' of the Regional Commissioning Function, but also jointly responsible for its implementation.

- PHNs **already fulfil** most of the functions of the proposed Regional Commissioning Authority, including needs assessment, regional planning, procurement, contract management and system integration. The establishment of new entities would take time and delay the implementation of other recommendations from the Commission. Enhancing the role and flexibilities of existing PHNs, in partnership with LHNs though the Regional Commissioning Function, would mean we could 'hit the ground running' with better, faster implementation of the Commission's recommendations.
- PHNs already use a **commissioning approach** to funding local services, going far beyond a simple procurement approach. Current PHN commissioning approaches include understanding the needs of communities, working with communities to prioritise needs and co-design solutions, implementing a range of solutions (e.g. procurement of services, development of clinical pathways, workforce development) and monitoring and evaluation of solutions that feed into continuous quality improvement. Mental health and suicide prevention is already incorporated into PHN commissioning approaches.

- PHNs already undertake comprehensive community **needs assessments**, utilising access to data sources from funded providers, LHNs and national data sets. These needs assessments already include mental health, suicide prevention and alcohol and other drug treatment.
- PHNs already undertake extensive and ongoing **engagemen**t with a range of stakeholders and with the wider community, both through formal mechanisms (e.g. Clinical Council, Community Advisory Committee) and through mechanisms such as forums, partnership groups, online and relationship management and shared projects and programs. Engagement occurs specifically on mental health and suicide prevention, but these and related issues can also arise in wider, general engagement activities.
- PHNs already nurture local **relationships** to achieve local outcomes. While the investment in PHNs is relatively small, our impact is much larger through the cultivation of meaningful relationships with a wide range of stakeholders. Through these relationships we can:
  - better understand the needs of communities and providers;
  - bring various stakeholders together;
  - address local issues before they become problems; and
  - negotiate challenging system reforms on the basis of trust, open communication and a safe environment.
- PHNs facilitate quality improvements within **general practice**, (and to a lesser extent in allied health) through the analysis of practice data, practice visits, and provision of HealthPathways, resources and training. Mental health and suicide prevention issues are integrated into this overall approach to general practice development. PHNs have extensive experience in this area, including through our previous iterations as Medicare Locals and Divisions of General Practice. States, territories and LHNs do not have the same level or depth of experience and day-to-day connection with the broader primary care sector.
- PHNs already drive **integration** of the health and wider sectors. We often act as partnership brokers, bringing together a range of stakeholders from across various parts of the health and wider systems, along with consumers and carers, to agree on shared outcomes and strategies to achieve these outcomes. PHNs can also play a practical role in supporting integration, including developing clinical care pathways, negotiating MOUs and other partnerships, developing shared-care arrangements and using data.
- PHNs use **data** to drive improvement. PHNs have collaborated, through WA Primary Health Alliance as the lead, in the development of Primary Health Insights, a single data storage and analysis solution aligned with best practice security and data governance standards. Data will be sourced from participating general practices, funded service providers and others. This will reduce duplication of effort, simply processes and reduce IT costs. Data related to mental health, suicide prevention and drug and alcohol will be included in Primary Health Insights.
- Regionally based planning and procurement already allows PHNs to identify and respond to the **diversity of needs** of individual local communities for example, local CALD communities, that may not otherwise be prioritised in national processes. Regional needs assessments and regional plans for mental health and suicide prevention identify the specific needs of local communities and agree responses to these needs. Regional plans set out actions to improve the response of all mental health services, for example through training or the use of the Framework for Mental Health in Multicultural Australia.

Through procurement and contract management, RCFs will be able to select providers that are culturally competent, enforce requirements through inclusion in the contract and monitor progress. Where need directs and resources allow, RCFs may decide to procure CALD specific mental health services.

Many PHNs already have experience in procuring psychological providers who specialise in working with CALD communities generally, or with specific language and cultural groups in their local areas.

Case Study 9

Psychological Therapies for People from Chinese Cultural Background

The Northern Sydney Primary Health Network Needs Assessment identified a service gap for people from culturally and linguistically diverse backgrounds, in particular for those from a Chinese cultural background experiencing mild to moderate mental illness.

In 2017, New Vision Psychology was commissioned to deliver culturally appropriate individual and group psychological services for people from a Chinese cultural background. New Vision Psychology facilitates the provision of culturally safe services through experienced bilingual psychologists and appropriately trained and qualified mental health clinicians which deliver services in Mandarin, Cantonese, Shanghainese and English. Utilising a stepped care approach, staff ensure integration with other services through care-coordination with other health service providers. New Vision Psychology provides support and advice to all GPs and other relevant practitioners in the Northern Sydney PHN region as well as delivering outreach services and advocacy as required.

Uptake of this service has been strong since establishment and consumers accessing New Vision Psychology have reported positive outcomes, as illustrated in the following consumer stories:

- New Vision Psychology actively engaged with an elderly Mandarin speaking consumer unable to speak English who was at high risk of homelessness. The consumer was unable to apply for appropriate housing due to a significant language barrier. Advocacy provided by New Vision Psychology staff assisted the consumer acquire appropriate housing. Having this need met allowed the consumer to more effectively engage in clinical treatment for his mental health condition.

- After initial contact with a consumer experiencing domestic violence, New Vision Psychology staff recognised the immediate need to link the consumer to services that could assist with broader psychosocial needs. A New Vision Psychology clinician supported the consumer to access the Early Childhood Centre and Family Referral Service. The New Vision clinician liaised with the other support providers to ensure that the consumer's comprehensive service needs were met during the period of removing herself from the abusive relationship and ongoing.

APPENDIX 2 – ADDITIONAL CASE STUDIES

Mental Health Co-Commissioning Examples

Transitional Care Packages

Since 2018, Hunter New England and Central Coats (HNECC) PHN have commissioned three providers to deliver Transitional Care Packages in collaboration with both Central Coast and Hunter New England Local Health Districts. The Transitional Care program co-locates with and receives referrals from three LHD inpatient units across the HNECC region. Clients who are identified by inpatient staff as having complex psychosocial needs are referred to the program upon discharge for assertive outreach and linkage to appropriate primary care supports. The aim of the program is to reduce inpatient readmission rates.

The concept was introduced to the service providers and was developed in partnership with the LHDs to meet local needs. Each location has contextualised the program and offer slightly different models with varying eligibility criteria based on demographics, identified service gaps and demand. The program has the support of the Executive in both LHDs through the two PHN/LHD Alliances with work undertaken by senior LHD staff, the commissioned providers and HNECC to enable the program to be embedded in the inpatient setting across the three locations.

Regional Mental Health and Suicide Prevention Plan

Central and Eastern Sydney PHN (CESPHN), Sydney Local Health District (SLHD), South Eastern Sydney Local Health District (SESLHD), St Vincent Health Network (SVHN) and Sydney Children's Hospitals Network (SCHN) have jointly developed a 3 year mental health and suicide prevention plan. This plan sets in place agreed shared action between the PHN, LHD/LHNs on key local health and service needs including the pursuit of joint commissioning and investment opportunities.

Implementation has progressed prioritising joint review of data and assessment of needs with a focus on the current investment in suicide prevention and ensuring regional planning is in place to address gaps and avoid duplication.

Mental Health Shared Care

CESPHN jointly funds GP Shared Care programs across the 3 LHD/LHNs in the region. This program provides a clinical workforce including Peer Support to work proactively to engage with General Practitioners and People experiencing Severe mental illness who are supported in secondary care. There is a high focus on addressing the physical health needs of clients and ensuring joint monitoring, review and care of the mental and physical health needs of patients. This program also supports clients to transition from secondary mental health services into primary care support.

Suicide Prevention Aftercare Services

CESPHN, SLHD, SESLD, and SVHN are working jointly together on a collaborative commissioning approach for suicide prevention aftercare services. Leveraging off the current SP Connect Program which offers one to one care coordination for people who have attempted suicide or who may have experienced a suicidal crisis and who have been discharged from one of the three large hospitals in our northern region. The success of this model includes the incorporation of a Hospital Project Officer in each of the 3 hospitals whose role is to support the referral process and provide awareness and education across the relevant hospital staff. Our joint approach will include The Way Back Support Service and 5 hospitals (3 LHD/Ns) across the CESPHN region.

Youth Severe Mental Health

CESPHN has worked with SLHD, SESLHD and headspace Lead Agencies to integrate services for young people across the continuum of mental health needs through the 5 headspace Centres in the region. Two programs, CASPAR (Comprehensive Assessment Service for Psychosis and At Risk - SESLHD – headspace Bondi Junction, Hurstville and Miranda) and hEIT (headspace Early Intervention Team – SLHD – headspace Ashfield and Camperdown) support young people identified through the headspace Centres who are experiencing or at risk of severe mental illness. A package of care is offered to these young people including access to psychiatric care and psychosocial support for their recovery journeys. This approach uses clinical staging to ensure that each young person receives the level of services needed to address their mental health needs - a Stepped Care Approach.

GPs in Schools Program

Northern Sydney PHN's GPs in Schools provides 3-hour workshops for year 11 students in Northern Sydney high schools. The program was initiated by Hornsby Ku-Ring-Gai Division of General Practice in 1996 and has had numerous iterations over the past 24 years. The program currently offered has been externally evaluated and updated to align with the NSW Department of Education's Life Ready course, part of the PDHPE syllabus.

The evidence-based program brings General Practitioners and Nurses into their local schools to build student confidence and health literacy in areas such as access to free healthcare services, mental health, sexual health, drugs and alcohol, confidentiality, Medicare, and their healthcare rights.

GPs in Schools empowers students to ask questions that matter to them in a safe environment, in their school with their self-selected friendship groups of approximately 12-15 students per GP or Nurse. Utilising a peer-centred health promotion approach that allows students to ask questions anonymously, the program supports young peoples' ability to take an active and informed role in their healthcare as they transition to adulthood.

In the 2019-20 financial year, the program will be delivered in 35 high schools across the Northern Sydney region. In the 4.5 years that the program has been operated by Northern Sydney PHN, GPs in Schools has delivered to over 1,100 small group education sessions to more than 17,400 students.

NSW/ACT PHN Commissioning Network and National Commissioning Showcase

The National PHN Commissioning Showcase has taken place annually since 2017. Originally arising as an initiative of the NSW/ACT PHN Commissioning Network, the Showcase provides an opportunity for PHN staff to come together to learn from one another's commissioning experiences, build their capacity, networks, and to understand the commissioning landscape across Australia and internationally.

The Showcase is run by PHNs for PHNs. For the last two years, the organising committee have surveyed commissioning staff at PHNs across Australia about:

- What they would like to gain from the Commissioning Showcase
- Topics they would be interested in learning more about
- Areas that would assist in improving their commissioning capabilities; and
- Cases they can present that would provide learnings to other PHNs.

This information is then used to shape the Showcase agenda and inform the speaker lists.

In 2019, the Commissioning Showcase took place over two days in Newcastle. Staff from 22 out of 31 PHNs attended, with 100 participants in total (increasing from 60 the previous year). International and national keynote speakers were able to provide insight into commissioning activities on a global scale. Presentations from keynote speakers and from PHN staff were tied to the themes developed from the pre-survey.

Following each Showcase, attendees are surveyed about the benefits of attending. In 2019, 86% of attendees rated the event as 'excellent' or 'very good', and people felt the variety of content, the keynote speakers and the sharing of experiences were all highlights.

The Commissioning Showcase is one example of collaboration and co-commissioning that occurs across the PHN Network. The NSW/ACT PHN Commissioning Network, which meets on a quarterly basis and draws its membership from the commissioning and contracting managers across the PHNs, has also collaborated to jointly develop and commission the GP Psychiatry Support Line. More than 500 NSW GPs have registered to use the free telephone-based service which links them to psychiatrists who can provide information and advice to assist with diagnosis, investigation, medication and development of patient safety plans.

NSW GP Data Linkage Project

The NSW GP Data Linkage Pilot Project was developed to provide a more complete picture of the provision of health care in NSW to enable a better-informed design of the system; and support general practice and local health district (LHD) services to improve care for patients.

Delivered in partnership by NSW Ministry of Health and NSW Primary Health Networks, the Project links data sets of GP practices and hospitals to produce a data asset that:

- Provides a comprehensive patient journey across primary, acute and other healthcare settings
- Allows early identification of current and emerging population health issues
- Improves patient care and potentially constrains or reduces system costs
- Informs data-driven quality improvement and system re-design responses

To date, the four-year pilot project has linked general practice data of approximately 400,000 patients across 40 NSW practices to hospital admission, Emergency Department admission and mortality data held by NSW Ministry of Health. It has demonstrated that patient information can be securely extracted from general practices and linked with hospital and other data collections to generate new insights while safeguarding patient confidentiality.

Over the next three years, the Data Linkage Project, now called Lumos, will expand state-wide, linking data from up to 500 general practices across all 10 PHNs in NSW. This is the largest collaboration the NSW Ministry of Health has ever undertaken with the NSW PHN network, in terms of the nature of the collaboration, the number of PHNs involved and the scale of practices engaged.

It is anticipated that Lumos will generate insights on up to 4 million patient journeys across the NSW health system. This information will assist in:

- demonstrating the impact of primary care in preventing hospitalisations (comparing patients journeys between those who have visited a GP and those who have not)
- identifying priority areas/areas of collaborative commissioning between PHNs and LHDs.