



**Victorian and Tasmanian PHN
Alliance feedback to the Draft Report
of the Productivity Commission into
Mental Health
January 2020**



The Victorian and Tasmanian PHN Alliance and the Productivity Commission inquiry into Mental Health

The Victorian and Tasmanian PHN Alliance (Alliance) acknowledge the importance of the Productivity Commission inquiry into Mental Health (Commission), a national inquiry on the social and economic benefits of improving mental health.

This paper provides feedback to the Commission's Draft Report released 31 October 2019 in relation to the role of Primary Health Networks (PHNs) in supporting people's ability to participate and thrive in the community and workplace, highlighting ongoing initiatives in Victoria.

The Commission's inquiry coincides with the Royal Commission into Victoria's Mental Health System (RCVMHS) which represents an opportunity to implement much-needed transformational change in the mental health landscape of Victoria.

The role of PHNs

The role of PHNs was referenced in at least 150 submissions made to the Commission demonstrating the key role PHNs have in supporting, commissioning and locally integrating mental health services.

PHNs work collaboratively with general practices and key mental health service providers in the public and private sectors to promote and provide person centred and holistic care. General Practitioners (GPs) are seen to have a central position acting as 'gatekeepers', guiding people through the health system, monitoring and coordinating progress to maintain and improve quality of care, as well as limiting the use of expensive specialist services

The equity, efficiency and effectiveness of the health system and improvements in health outcomes require a strong primary care system.¹ A strong primary care system needs to withstand the impact from economic pressures, workforce shortages and political influences, as well as keep pace with changing disease patterns.

PHNs, as the key platform of the Australian Government for the implementation of mental health reforms², takes on a more expansive view of mental health to include the social determinants of health through prevention, early intervention and recovery services. It should be noted that the state government in Victoria also currently funds programs for commissioning and local planning into PHNs totalling more than an estimated \$30m. The platform is clearly in place to strengthen existing comprehensive regional planning function through developing strong accountability frameworks to ensure integration across the care continuum and the health, mental health and social domains.

PHNs recognise that they cannot achieve system transformation and mental health system reform on their own and that all stakeholders have a role to play. The development of strong and collaborative

¹ Russell L & Dawda P (2019). *The role of Primary Health Networks in the delivery of primary care reforms*. Retrieved from Analysis and Policy Observatory Website: <https://apo.org.au/node/220956>.

² Australian Government, Department of Health (2018). [*Reform and System Transformation: A Five Year Horizon for PHNs. PHN Advisory Panel on Mental Health.*](#) *PHN Advisory Panel on Mental Health Report, September 2018, Canberra.*





regional partnerships that underpin and facilitate regional needs assessment and planning is an important element in achieving system transformation.

PHNs acknowledge that the Commission’s Draft Report presented a long-term significant reform agenda requiring a staged and adequately resourced implementation. The recommendations in the Draft Report were provided under five reform areas:

1. Prevention and early intervention for mental illness and suicide attempts
2. Close critical gaps in healthcare services
3. Investment in services beyond health
4. Assistance for people with mental illness to get into work and enable early treatment of work-related mental illness
5. Fundamental reform to care coordination, governance and funding arrangements.

The Alliance provides feedback to each of these reform areas.





Feedback to the reform areas

Reform area 1: Prevention and early intervention for mental illness and suicide attempts

Start now	Start later
Incorporate social & emotional wellbeing checks into existing physical development checks for 0 to 3 year olds	Monitor & report on progress toward universal screening
All schools assign a teacher to be their mental health and wellbeing leader	Expand parent information programs on child social & emotional development
COAG-developed strategic policy on social and emotional learning in the education system, including development of national standards for teacher training	Strengthen skills in workforces of early childhood education and care, and schools to support child social and emotional development
Implement a new national stigma reduction strategy	Use data on wellbeing of school students to build evidence base for future interventions
Reduce stigma amongst health professionals	Evaluate best practices for partnerships between traditional healers and mainstream mental healthcare for Aboriginal & Torres Strait Islander people
Follow-up people after a suicide attempt	Apply lessons from suicide prevention trials
Identify local priorities and responsibilities for suicide prevention	
Indigenous organisations empowered as preferred providers of local suicide prevention activities for Aboriginal & Torres Strait Islander people	

PHNs acknowledge the importance of:

- consistent screening of social and emotional development in existing early childhood physical development checks to enable early intervention; and
- provision in all schools of an additional senior teacher dedicated to the mental health and wellbeing of students and maintaining links to mental health support services in the local community.

Screening of social and emotional developmental issues in the 0-12 age group will require support for GPs to properly manage referrals from schools and service providers. Access to specialists in perinatal mental health and child and adolescent psychiatry, currently problematic in rural and regional areas, can assist GPs and other primary health professionals in the early identification and intervention of mental health conditions for this cohort.

At a national level, [Be You](#) was launched in late 2018 to assist educators to nurture the mental health and wellbeing of children and young people through the flexible delivery of evidence-based training programs available free to all 24,000 early learning services, primary and secondary schools in Australia.

In Victoria, there are two joint initiatives funded by the Department of Education and Training (DET) and implemented by the six PHNs delivering prevention and early intervention services to secondary schools:

- [Doctors in Secondary Schools](#) (DiSS) program to provide school-based health services to 100 Victorian secondary schools most in need; and





- [Enhanced Mental Health Support in Secondary Schools](#) (EMHSS) to assist headspace centres to provide additional mental health clinical capacity to support students in 325 Victorian government secondary schools.

In addition, the DET has funded the [Mental Health Practitioners in Secondary Schools](#) program ensuring every Victorian government secondary school campus will have a suitably qualified mental health practitioner by 2022. This program will employ more than 190 qualified mental health professionals across the state, including psychologists, social workers and mental health nurses, to deliver counselling and early intervention services, as well as coordinating support for students with complex needs, linking in with broader allied community and health services. This is in addition to the investment in government primary schools to provide a positive and nurturing environment for children to develop confidence, social skills and healthy life habits.

PHNs are required to commission primary mental health care services for children and young people including delivery of headspace centres, the latter in line with the existing headspace service model.³ In Victoria, PHNs fund 26 existing and two new headspace centres along with a number of satellite centres, but more importantly integrate these headspace centres with other services in the region including Victorian government funded services (e.g. child and adolescent/youth mental health services, alcohol and other drug services, primary care services) and initiatives (e.g. DiSS and EMHSS). Case study 1 demonstrates the role of PHNs as system integrators.

Case study 1: PHNs as system integrators

In ensuring that youth mental health services are responsive and coordinated in their region, South Eastern Melbourne PHN (SEMPHN) reviewed the current commissioned services in their mental health stepped care model, workforce knowledge gaps and referral pathways.

Anticipating possible duplication and fragmented service delivery due to the concurrent programs implemented in secondary schools (e.g. DiSS, EMHSS, and Mental Health Practitioners in Secondary Schools), SEMPHN initiated discussions with key stakeholders such as the local DET and lead agencies of local headspace centres, to map the services and resources available to secondary schools. Consequently, the lines of communication between stakeholders have improved, referral pathways updated, links with SEMPHN's stepped care strengthened, and finite resources maximised in order to achieve better health outcomes for young people.

PHNs recommend the consolidation and improved alignment of existing initiatives for children and young people particularly at the regional level. This should include Commonwealth, State and PHN funded programs.

In addition, links to primary health need to be better supported to include GP access to mental health specialist advice and treatment services, particularly in the rural areas.

³ Australian Government Department of Health, [PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Child and Youth Mental Health Services](#)





Primary care has a significant role in preventing suicide and GPs are often the first health professional contact for individuals experiencing distress or suicidal thoughts. There is also evidence to suggest that initiatives within the primary care sector, such as psychological therapies targeting suicide prevention are effective.

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 Impact⁴ 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 evaluation⁵ of PBSPT has provided a very strong consensus that the collaborative place-based model was the right approach to 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.

PHNs agree with the Commission's recommendation of delivering universal access to aftercare support for people who have attempted suicide to include discharge planning and follow up support.

PHNs commissioned providers within their stepped care model support people in the community who are at increased risk of suicide or self-harm. Evidence-based one-on-one psychological services are delivered by credentialed mental health clinicians via face-to-face or through telehealth technologies. In addition, PHNs provide professional development activities on risk assessment and suicide prevention to GPs and general practice staff.

The [Hospital Outreach Post-suicidal Engagement \(HOPE\)](#) is a key initiative under the Victorian Government's Suicide Prevention Framework 2016-2025. HOPE provides tailored holistic support to people following a suicide attempt, for individuals, carers and families, to identify and build the protective factors that reduce the risk of suicide attempt/completed suicide. Twelve hospitals currently deliver the HOPE program with service providers delivering assertive outreach service and support within 24 hours of being referred and up to three months support post discharge from hospital. HOPE's

⁴ 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](#).

⁵ PBSPT Establishment Phase Evaluation Report, DHHS (unpublished).





suicide after care service models vary: predominantly clinical, non-clinical using Beyond Blue's The Way Back Support Service (TWBBS), or a combination of both.

Eligibility to the HOPE program in most sites is limited to post-suicide attempt. Individuals with suicidal ideation only (without attempt) are referred to other available programs and services. In addition, only referrals following a presentation to an emergency department are accepted into the HOPE program. This excludes those who survive a suicide attempt but have not interacted with the hospital system (e.g. presents to a GP clinic, seen by ambulance or police).

Unlike the PBSPT, the HOPE program is not supported by a governance structure that fosters regional partnership and do not yet have a community of practice that link the clinical and non-clinical workers involved with the program.

The recently completed Bilateral Agreement between the Australian and Victorian Government as part of the *Prioritising Mental Health: Aftercare following a suicide attempt measure* will have four Victorian PHNs commissioning the implementation of Beyond Blue's TWBSS in four additional hospitals in Warrnambool, Dandenong, Mildura and South East Gippsland.

The RCMHS interim report recommended the statewide rollout of the HOPE program complemented by additional outreach services in sub-regional health services with extended service delivery hours. In addition, the RCMHS recommended the creation, delivery and evaluation of the first phase of a new assertive outreach and follow-up care service for children and young people who have self-harmed or who are at risk of suicide.

The Victorian PHNs appreciate the Victorian Government's investment in suicide prevention including the RCMHS' recommended expansion of the HOPE program. However, additional resources will be required to coordinate these multiple suicide prevention initiatives from different funding streams to ensure consistent and systematic implementation, as well as avoid duplication.

The well-meaning patchwork of initiatives as illustrated in Figure 1 highlights the importance of a whole-of-Australian Government systems approach to suicide prevention, under the leadership of the health sector, with support from other government portfolios operating within their direct scope of influence.

National leadership with bipartisan support is required to assist in the regional implementation of a systems approach to suicide prevention involving evidence-based interventions, from a population level to an individual level. Multiple strategies implemented at the same time are likely to create synergy, and avoid duplication and gaps.

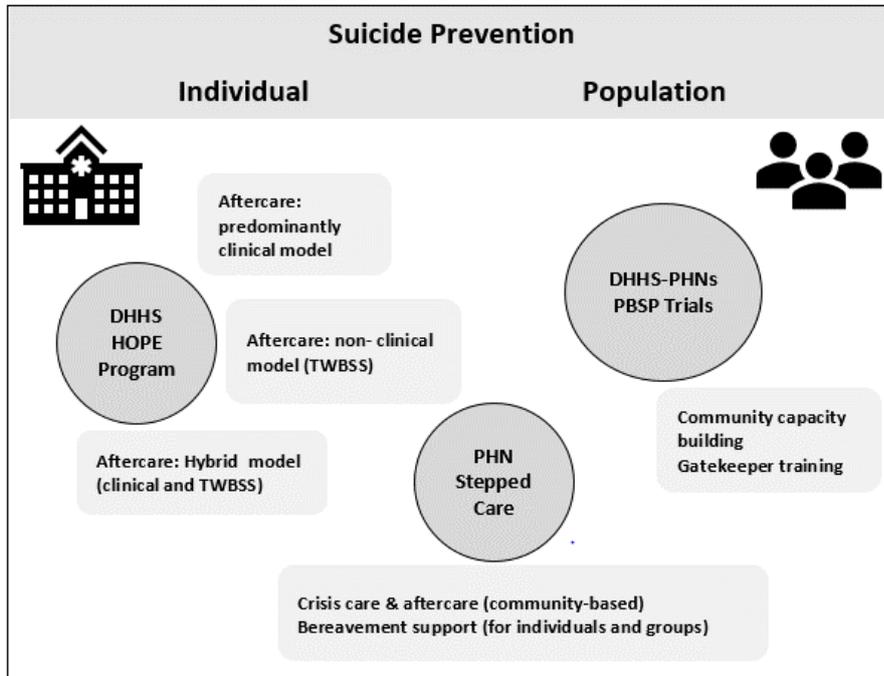
Integral at the regional level is the collaboration between local healthcare, community services, and people with lived experience to encourage local ownership of activities and build capacity for community members to have an active role in the planning, development, implementation, and maintenance of these activities. Regional suicide prevention activities to include: an audit of current workforce capacity and training, a survey of local service providers and their use of evidence-based





therapies, a stocktake of diversity strategies and level of implementation, and the development of shared practice guides and care protocols⁶ (including postvention).

Figure 1. Suicide prevention activities in Victoria



The DHHS Mental Health Branch currently has a memorandum of understanding with Victoria’s Coroners Prevention Unit to access regular and timely suicide data and both parties work closely with the Victorian Injury Surveillance Unit and Ambulance Victoria to improve timely access to information, such as suicide and self-harm audit reports, shared with Local Hospital Networks (LHNs), HOPE program coordinators, and PHN staff involved with the PBSPT.

The RCMHS interim report highlighted that although Victoria’s approach to suicide data collection through the Victorian Suicide Register is considered nation-leading, the data are not linked, nor consistently reported or disseminated to suicide prevention services. Data on suicide along with risk factors for suicidal behaviour will assist suicide prevention services at a regional level to intervene quickly and effectively to support people, contain suicide contagion, and prevent further suicides.

PHNs recommend support for a regional approach to suicide prevention, where multiple suicide prevention initiatives from different funding streams are coordinated resulting in consistent and systematic implementation, as well as achieving allocative efficiency.

Improved processes in suicide data linkage and dissemination is required to assist the regional approach to suicide prevention.

⁶ Australian Government Department of Health (2016). [An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring: Document for Primary Health Networks](#), Canberra.





Reform area 2: Close critical gaps in healthcare services

Start now	Start later
Expand clinician-supported online treatment options	Expanded online portal for consumers, with timely & linked-up referral processes
Provision of acute & non-acute beds & ambulatory services that reflect regionally assessed needs	Access to face-to-face psychological therapy at a level commensurate with treatment needs
Improve the ED experience & provide alternatives	Strengthen the peer workforce
Provision of child & adolescent mental health beds separate to adults	Incentivise family-focused & carer-inclusive care
Mental health expertise as support to police & paramedics	Incentivise psychiatric advice to GPs
Navigation platform for mental health referral pathways	Single care plan with electronic sharing of information
Care coordinators for consumers with the most complex care needs	
Expand mental health nurse workforce	
Widen access to psychological therapy & psychiatric assessment by video	
Rigorous evaluation of Better Access	

Critical gaps in the stepped care model

PHNs welcome the Commission’s recommendation for mental health system reforms to use a stepped care model, a spectrum of evidence-based service interventions where the intensity of services provided for individuals vary according to their level of need.

The Commission received more than 120 submissions from both individuals and organisations that mentioned the stepped care model as a framework for service delivery.

The [Victorian Government](#) submission to the RCMHS acknowledged the stepped care model as a nationally agreed framework that can provide a basis to redesign Victoria’s mental health system that would reposition it as leader in mental health promotion and care.

The stepped care model require collaboration with State funded LHN-area mental health services to deliver interventions in the complex to severe end, and PHNs to deliver interventions for the low to moderate end of the spectrum.

In Victoria, PHN commissioned stepped care services are addressing the increased number of referrals from GPs who are struggling to manage people presenting with mental illness and complexity which in turn results in a higher demand for interventions in the moderate to severe end of the PHN stepped care spectrum. A significant contributory factor to the demand is the increased threshold of entry into publicly funded mental health services due to years of underinvestment in mental health not commensurate with population growth and changing needs.





The RCVMHS interim report called for additional acute inpatient beds and specialised community mental health bed-based care particularly in regional areas to alleviate some of the pressures from hospitals and emergency departments.

However, more upstream approaches will be required not only to reduce the constant demand for more beds, but also to address existing treatment gaps in the community particularly for children and young people. These upstream approaches include:

- Investment in community based mental health services with more capacity to deliver outreach and supported referral pathways to non-clinical services;
- Support for GPs to increase their capacity (e.g. utilising a stepped model in delivering mental health MBS items) and capability (e.g. mental health training and clinical support including community consultation-liaison psychiatric services);
- Regional satellites for specialist mental health services for people with complex needs e.g. Borderline Personality Disorders, Eating Disorders, and Alcohol Acquired Brain Injury;
- Increased access to service delivery using telehealth and online platforms;
- Care coordinators or navigators to assist consumers with complex needs, building on the learnings from the Partners in Recovery (PIR) program;
- Innovative and accessible bundled care models for people with mental illness and complexity delivered at a regional level.

Service navigation: Navigation platform for mental health referral pathways

The PHNs agree with the Commission that clear and seamless care pathways are required by people accessing the mental health system particularly those receiving services from multiple providers.

The Commission proposed the creation of navigation platforms at a regional level to act as centralised online and phone portals to facilitate and coordinate referrals, to be used by clinicians and care coordinators across the clinical and non-clinical sectors (e.g. psychosocial service providers, schools). The Commission suggested that the HealthPathways portal model, already used by most PHNs, be considered as the basis for the proposed navigation platforms.

The HealthPathways is a clinical navigation portal for GPs and other health practitioners containing primarily clinical information/advice and localised clinical referral pathways. There is scope to include Social Prescribing⁷ in HealthPathways with corresponding information on local community supports, thereby linking health care with social care. HealthPathways is already regionalised but expansion of this portal to allow access to non-health providers to facilitate and coordinate mental health referrals, is a complex undertaking that may be difficult to achieve in the short term.

Service navigation: Online portals for consumers

The Commission acknowledged the importance of using the point of view of people needing care in addressing significant service gaps including navigation platforms, and for these platforms to be created

⁷ Non-medical prescribing or community referral, an innovative way to address the wider social determinants of health





at a regional level.

A model for regional service navigation portal for consumers is [HealthInfo](#), a health information website for the general public developed by the Canterbury District Health Board of New Zealand. HealthInfo is written and approved by local doctors, practice nurses, hospital clinicians, and other healthcare professionals.

An expanded National Health Service Directory is another option but will need to include non-health service information and options to regionalise the portal.

Improved configuration of these two aforementioned options require collaboration across sectors (health and non-health) and more importantly, involvement of people with lived experience in the co-design.

Service navigation by both consumers and service providers, and referral pathways will be significantly improved if the core structural elements of a system at each regional level are available and aligned across the care continuum.

In Victoria, 26 out of the total 85 LHNs have significant mental health service delivery functions but are not evenly distributed across the six PHNs. Clinical mental health services are provided in geographic catchment areas established in the 1990s and are not aligned with aged-based service groupings.⁸

The recent VAGO report on Child and Youth Mental Health⁹ cited the complex catchment arrangements across the system because DHHS has not adequately considered the geographic distribution of services relative to the population thereby resulting in inequities in service provision.

Improving service access and navigation requires a major reform, redesign and re-alignment of the DHHS Area Mental Health Service catchment boundaries across ages (infant, children, youth, adult, and aged) and across services. As it stands, the design of Victoria's publicly funded mental health system not only creates access barriers but also limits its performance.

There is an expectation that the final report of the RCVMHS will fulfil its mandate of designing the central components of a future mental health system that is responsible, accessible and equitable.¹⁰

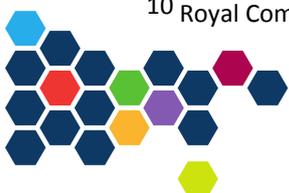
PHNs recommend addressing critical gaps in the stepped care model with a focus on upstream approaches delivered across the lifespan.

Two important enablers to any proposed service navigation platforms for consumers and providers include: the availability of the core structural elements of a system at each regional level, and having these elements aligned across the care continuum. A redesign and realignment of Victoria's Area Mental Health Service catchment boundaries across all ages is therefore warranted.

⁸ Victorian Auditor-General's Report (2019). Access to Mental Health Services Report. Victorian Auditor-General's Office, Victorian Government Printer, March 2019.

⁹ Victorian Auditor-General's Report (2019). Child and Youth Mental Health. Victorian Auditor-General's Office, Victorian Government Printer, June 2019.

¹⁰ Royal Commission into Victoria's Mental Health System - Interim Report Summary, November 2019, p. 14.





Reform area 3: Investment in services beyond health

Start now	Start later
Govts to commit to no discharges from care into homelessness	Mental health training and expanded tenancy support services for frontline housing tenancy workers
Additional supported housing places for people needing care on a regular basis	Develop disability justice strategies to ensure rights of people with psychosocial disabilities are protected during their interactions with justice system
Work toward meeting the gap in long term housing for people with mental illness who are persistently homeless	Improve rigor of mental health screening in correctional facilities and actively plan for care continuity post-release
Standards of care in correctional facilities to be equivalent to care in community	Ensure legal representation & non-legal advocacy services for those subject to involuntary mental healthcare
Ensure culturally capable mental healthcare for Aboriginal and Torres Strait Islanders in correctional facilities	
Funding cycles for all psychosocial services to be at least 5 years	
Improve eligibility requirements, availability & suitability of psychosocial supports	

PHNs wholeheartedly agree with the Commission’s recommendation for investing long-term housing solutions for people with severe mental illness who are homeless or at risk of homelessness.

Housing instability, along with interrelated factors such as poverty, unemployment, social isolation and family violence are significant barriers to people’s recovery from severe mental illness.

Investment in specialist mental health services, such as additional acute beds, should be complemented by investment in housing supports to ensure that people will not be discharged from care to homelessness.

The NMHC funded research on housing and homelessness issues in relation to mental health by the Australian Housing and Urban Research Institute (AHURI) noted the need for the following:¹¹

- better policy integration between housing, homelessness and mental health sectors, with the two sectors operating in silos;
- scaling up of effective existing programs that integrate housing and mental health instead of more pilots and one-off projects;
- prevention and early intervention strategies, instead of crisis management, to include supported transitions from hospital care and prisons and tenancies sustainment programs;
- improved hospital discharge planning to avoid discharging people into homelessness; and
- encourage private sector involvement via tax incentives and rebates, given this sector’s access to an immediate and greater supply of established homes.

¹¹ Brackertz, N, Wilkinson, A & Davison, J (2018) [Housing, homelessness and mental health: towards systems change](#), AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne.





The AHURI research also acknowledged that PHNs can play an important role in early intervention and system integration.

PHNs work closely with their regional partners to address homelessness, in recognition of its impact to an individual's mental health and wellbeing. An example is a project facilitated by North Western Melbourne Primary Health Network (NWMPHN) as illustrated in Case study 2.

Case study 2: PHNs as innovators

Homelessness is a major issue in several Local Government Areas (LGAs) in NWMPHN's catchment including the City of Melbourne which has a relatively large concentration of community services that draw people to the city in search of support, including health, education and housing. Key areas of need for this cohort include services targeting mental health, alcohol and drugs, sexual health, and immunisation rates.

In 2015, NWMPHN, Northern and Western Alcohol and Other Drugs (AOD) and Mental Health Catchment-Based Planners and Homelessness Networkers in Victoria established a joint project to improve coordination across the three sectors in Melbourne's north and west. Practitioners in each sector, conducted consultation forums and set out to design responses to identified priorities. A major priority is access to clear information about each sector which resulted in the development of a manual, [A Guide to Making Links](#), a resource for workers in AOD, mental health and homelessness sectors in Melbourne's north and west.

In 2019, NWMPHN commenced the Psychosocial Support Services Homelessness (PSS-H) pilot delivering a specialised support to people who are experiencing homelessness in the Cities of Yarra and Melbourne, a component of the commissioned region-wide psychosocial support services.

PHNs previously funded the PIR programs which have since transitioned to psychosocial support services. PIR previously had capacity building funding that allowed them to deliver innovative pilot projects to facilitate access to housing. An example is the [Inner East PIR Access to private rental project](#) that involved partnerships with local real estate agents to improve access to private rental options including the development of a private rental guide to provide PIR consumers and their care team with information and resources to help navigate the private rental market.

PHNs are now responsible for delivering psychosocial support services in the community for people with mental illness and complex needs. These supports include social interventions such as life skills training, supported education/employment/housing and links to the local community.

PHNs advocate for more funded programs that promote social participation and inclusion and not just limiting these services to people with severe mental illness. Majority of people with high prevalence mental health disorders such as anxiety and depression, are seen in the primary health sector with trauma and social isolation as significant contributing factors to their mental illness.

People who feel socially isolated are more likely to have mental, emotional, and financial issues. They are also less likely to receive timely, good-quality care. Groups vulnerable to social isolation include lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) and culturally and linguistically diverse (CALD) and refugee communities, Aboriginal and Torres Strait Islander peoples, older persons and those isolated due to rurality.





[NWMPHN](#) has engaged Carers Victoria to develop and deliver an innovative approach to improve social connectedness for people experiencing poor health outcomes in the Hume and Wyndham regions. This project, informed by a co-design process with carers, recognises the role that social connectedness can have on health and wellbeing and will focus on carers of family members/friends with a disability, mental illness, chronic health issue or age-related condition.

GPs witness first-hand the bi-directional impact of loneliness with depression and social anxiety, and acknowledge that non-clinical interventions offered by community-based organisations need to be considered in the care of individuals. Social prescribing programs reinforce the link between social connection and a person's physical and mental health.

PHNs are well-positioned to create and maintain a network between primary care and the community sector and have considered commissioning social prescribing programs.

Case study 3: PHNs as advocates for social prescribing

NWMPHN, in partnership with the Brimbank Collaboration (Brimbank City Council and Australian Health Policy Collaboration at Victoria University), IPC Health (a community health service) will jointly plan, adapt, deliver and test [a model of social prescribing](#). This model aims to improve the psychosocial wellbeing of residents, prevent escalation of complex health risk, and reduce avoidable emergency department presentations. It will also provide community-based organisations with appropriate resources and tools to manage and respond to people's individual needs.

Other PHNs are also interested to develop and test social prescribing models in their region. Husk et al. (2019)¹² highlighted that the implementation of social prescribing programs and activities need to be responsive to context and capacity, particularly when dealing with complex interventions and behaviour change approaches. The researchers described social prescribing as a pathway with many interacting elements and series of relationships that combine and interact with both the consumer and local context. Consumers with complexity will require appropriately trained and knowledgeable link workers (similar to PIR support facilitators) to assist in developing knowledge banks of local activities, and then accessing and assisting transitions between services.

The evidence base for social prescribing currently lags behind practice; hence, it is important for high-quality research to be funded alongside practice.

PHNs recommend a regional partnership approach in delivering service models that link health with non-health services such as housing, education and social participation, and to use the learnings from previously funded programs. Funding allocation for PHNs to trial social prescribing models responsive to regional context and capacity is also suggested.

¹² Husk, K, Blockley, K, Lovell, R, et al. (2019). [What approaches to social prescribing work, for whom, and in what circumstances? A realist review](#). Health Soc Care Community. pp. 1– 16.





Reform area 4: Assistance for people with mental illness to get into work and enable early treatment of work-related mental illness

Start now	Start later
<p>Effective outreach for disengaged school students</p> <p>Tertiary education institution registration linked to having effective student mental health & wellbeing strategy</p> <p>Improve employment support program assessment tools for people with mental illness</p> <p>Increase the appropriateness of job plans for those people with mental illness who are using employment services</p> <p>Amend model WHS laws to elevate the importance of psychological health & safety</p> <p>Develop codes of practice to assist employers to better manage psychological risks in their workplace</p> <p>Provision of no-liability clinical treatment for mental health related workers compensation claims</p> <p>Review insurance industry practices for people with mental illness</p>	<p>Staged rollout of Individual Placement & Support programs to job seekers with mental illness</p> <p>Eligibility criteria for Carer Payment and Carer Allowance that account for the differences between mental and physical illness</p> <p>WHS agencies to work with employers to collect & disseminate information on effectiveness of workplace programs & interventions</p>

The Commission highlighted the strong links between employment and mental health, and provided multiple recommendations targeting young people, workplaces, people with mental illness and existing laws, practices and national policies.

In addition to the proposed reforms in these areas, PHNs recommend a review of previous innovative but small-scale projects delivered in partnership with local community agencies.

Case study 4: PHNs facilitating local partnerships and social inclusion

The *Volunteering to employment project* was an 18-month initiative of the Inner East PIR consortium led by Eastern Melbourne PHN. This project delivered a 10-week volunteer program, based at a community health service, to people with severe mental illness using a strength-based approach that developed their skills and confidence. Positive outcomes for 16 consumers who graduated from the program include:

- five securing interviews for paid and volunteer employment;
- four obtaining paid employment;
- five returning to the community health service for mainstream volunteer work; and
- two working as volunteers in other agencies.

The success of the project was due to the partnership approach involving the PHN as lead agency, non-government organisation providers, and local employment agencies. More importantly, the primary aim of the project was to link people to the local community as part of social inclusion and stigma reduction, rather than just obtaining employment.





This example highlights the Commission’s report acknowledging volunteering as an important source of social capital and its interconnection with social participation/inclusion and mental health.¹³

PHNs recommend a regional partnership approach in delivering service models that promote mental health recovery through volunteering as gateway for social participation and employment.

¹³ Productivity Commission into Mental Health: Draft Report, volume 2, p. 824.





Reform area 5: Fundamental reform to care coordination, governance and funding arrangements

Start now	Start later
<p>Include consumers and carers in all mental health program development</p> <p>COAG to develop a new National Mental Health & Suicide Prevention Agreement that</p> <ul style="list-style-type: none"> establishes clear funding, data sharing and service delivery responsibilities creates RCA governance arrangements (if adopted) <p>Expedite National Strategic Framework for Aboriginal & Torres Strait Islander Peoples' Mental Health & Social & Emotional Wellbeing</p> <p>Determine targets for key outcomes, & set data collection, monitoring & evaluation arrangements consistent with targets</p> <p>COAG to develop new whole-of-govt strategy to align health and non-health sectors on improving mental health outcomes</p> <p>Review regulations preventing insurers from funding community mental health care</p> <p>Review proposed activity-based funding classification for mental healthcare</p>	<p>Link regional mental health funding to volume of regional MBS rebates for allied mental healthcare</p> <p>NMHC to be given statutory authority</p> <p>Strengthen national leadership, guidance and the coordination of mental health program evaluations and research</p> <p>Use data collections to evaluate what works well, encourage continuous improvement and inform funding decisions and consumer choices</p> <p>Responsibility for all (non-NDIS) psychosocial & carer supports to be with states and territories</p>

The Commission advocates reforming the governance arrangements that underpin Australia's mental health system in order to have genuine accountability, clearly demarcated responsibilities, and with mechanisms to ensure consumers and carers participate fully in the design of policies and programs that affect their lives.

PHNs appreciate the Commission's request for stakeholders to provide feedback on their proposed conceptual models to reform the architecture of the mental health system: Renovate and Rebuild.

The Renovate model, similar to the current arrangements, would see more responsibility for funding allocation sit with the PHNs.

The Rebuild model, under which State and Territory Governments establish Regional Commissioning Authorities (RCAs) that take on the mental health responsibilities of PHNs, commission mental healthcare from LHNs including psychosocial and carer supports outside of the National Disability Insurance Scheme.

The Alliance proposes a variation of the Renovate model (Renovate version 2/v2) where:

- PHNs have flexibility via more relaxed centrally imposed restrictions on their funding pools, this includes giving PHNs the option to either continue funding headspace services or redirect this funding to better meet the needs of their local areas as they see fit.
- State and Territory Governments:
 - continue responsibility for public hospital and community mental health services;





- for community mental health services (currently block funded) to be activity-funded, which should improve their productivity and negate incentives for LHNs to preference hospital-based over community-based care;
- have major responsibility for psychosocial supports (outside of the NDIS) and individual placement and support employment services, with the Australian Government providing additional funding, through PHNs to support case finding and service consumers with no direct link with LHNs.
- PHNs and LHNs are Regional Commissioning Bodies (RCBs), using pooled funding to deliver integrated models of care.

In this model, an agreed regional accountability framework will be used by the state government to hold LHNs accountable for services they are funded for, and for the Commonwealth Government to do the same with PHNs. A limited set of indicators for mental health and social priorities evident in mental health care such as in relation to social participation, education/employment and homelessness, will be useful nationally and regionally, allowing for improved monitoring and benchmarking.¹⁴

Renovate version 2

The Renovate v2 model supports the first priority area of the Fifth National Mental Health and Suicide Prevention Plan (Plan) that of pursuing regional integration between PHNs and LHNs, with the PHN catchment as the basis for the regional focus. The Plan's intention was for the joint regional mental health and suicide prevention plans developed by PHNs and LHNs, to inform the coordinated commissioning of services across the stepped care spectrum of need for services and across the lifespan¹⁵.

There is merit in devolving mental health decision-making and purchasing activities to the regional level delivering tailored and place-based services that are more responsive to the needs of local communities.

PHNs have demonstrated and can continue to demonstrate leadership in a regional approach. To date, majority of PHNs have been the leaders and facilitators of regional planning for mental health and suicide prevention even though the expectation of governments is for PHNs and LHNs to be equally involved.

PHNs already have strong links and partnerships into all parts of the healthcare system such as LHNs, residential aged care facilities, Aboriginal Community Controlled Health Organisations, pharmacy, and mental health and substance abuse providers.

PHNs already work across the Commonwealth and State/Territory divide but given their limited funding and funding restrictions, they have very few available levers to incentivise change.

PHNs have the capability to translate and implement national policy given their role as commissioner and system integrator.

¹⁴ Rosenberg, SP et al. (2015). [Using accountability for mental health to drive reform](#). Med J, 203 (8): pp.328-330.

¹⁵ Department of Health (2018). [Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Guide for Local Health Networks \(LHNs\) and Primary Health Networks \(PHNs\)](#),





PHNs can harness the RCB infrastructure and better target mental health resources to meet population needs on a regional basis.

PHNs and LHNs working together as co-commissioners of services, can design and develop alliance/consortium contracting arrangements with service providers, in response to service gaps and workforce shortages.

The Alliance has already developed a framework for co-commissioning primary care in Victoria¹⁶ and is currently in the process of applying this operating model in pharmacotherapy as a test case to further refine the model across the commissioning cycle. In this framework, co-commissioning is defined as a process where two or more parties work together to commission services to achieve greater alignment, improved consumer outcomes and leverage value from joint investment. Co-commissioning requires a collaborative approach across the three phases of the commissioning cycle from strategic planning, procurement, and monitoring and evaluation. Critical enablers include people, systems, tools, technology, and analytics underpinned by a robust governance structure.

The framework¹⁷ viewed co-commissioning as existing across a continuum, varying in the level of alignment and integration, from coordinated commissioning, to secondary, aligned and pooled commissioning.

A co-commissioning approach provides an opportunity to develop and implement a set of shared consistent outcome-based performance measures, with service providers incentivised to work as partners in achieving those outcomes.¹⁸

PHNs and LHNs need to be sufficiently resourced to fulfil the role of RCBs to include:

- structures to facilitate co-design and co-production, including a Lived Experience Advisory Group (consolidating and then integrating PHNs-LHNs lived experience initiatives);
- funding to incentivise integrated primary health care models (not just mental health) and support the implementation of single care plans and ‘wrap-around care’;
- supports to address critical gaps in the stepped care model (e.g. secondary consultation, care coordination/navigation models).

PHNs and LHNs as RCBs will require sufficient autonomy and time to develop relationships and capability in achieving the delicate balance between competition associated with contracting, and the collaboration required for service development and participatory design.¹⁹

¹⁶ Co-commissioning for Primary Care in Victoria, a report funded by DHHS & VTPHNA (unpublished).

¹⁷ Ibid.

¹⁸ Consumers Health Forum of Australia, George Institute & University of Queensland (2018). [*Snakes & ladders: the journey to primary care integration.*](#)

¹⁹ Gardner, K (2019) *Primary Health Networks caught between a rock and a hard place*, 8 March 2019, The Mandarin, available at <https://www.themandarin.com.au/105124-primary-health-networks-caught-between-a-rock-and-a-hard-place/>.





RCBs will have strong governance arrangements that mandate consumer and carer participation in decision-making. In Victoria, PHNs and DHHS have begun mapping lived experience engagement initiatives and acknowledge the value of having consistent representation in each region.

A Consumers Health Forum of Australia white paper²⁰ highlighted ‘siloes funding’ as a major barrier in achieving integrated localised services and identified pooled funding arrangements supported by formal agreements between governments, PHNs and LHNs, as enablers to improve local and regional system performance and deliver integrated, consumer centred services.

The final report of RCMHS will likely recommend the Victorian Government to review its LHN boundaries with a view to increasing compatibility with the Victorian PHNs, thereby further strengthening the proposed regional partnership model.

As part of the reform to the architecture of the mental health system, PHNs propose a revision of the Renovate model (version 2) in support of the Fifth National and Mental Health and Suicide Prevention Plan’s intent of supporting regional integration and partnership between PHNs and LHNs. Regional integration through joint planning will inform coordinated commissioning and provide opportunities such as fund pooling and co-commissioning to make better use of workforce and other resources.

Need to take an expansive view of health care

Reforms in mental health care need to take a more expansive view of health care that includes the social determinants of health and preventive activities to deliver health and wellbeing across the lifespan.

The Alliance supports the recommendation from Eastern Melbourne PHN²¹ for the future system to focus on: inclusion and wellness using a population health approach, early intervention that includes identification of high-risk groups, and a purposeful and calibrated response to individual and community needs.

PHNs are key players in the proposed reforms of both the Commission and RCMHS and are well-positioned, but currently not adequately resourced to link health care with social care.

PHNs are innovators and have delivered upstream initiatives that connect health with the social determinants of health in response to local needs, which have the potential to be scaled up at a regional level, and shared across regions, states and territories. Examples from a Victorian PHN context have been provided in this paper, such as a population approach to suicide prevention, innovate projects that address homelessness and unemployment, and initiatives that promote social participation and build social capital.

The PHNs echo the recurrent theme in the Commission’s Draft Report - that of having a regional partnership approach in the delivery of health care including mental health care.

²⁰ Consumers Health Forum of Australia (2018). [*Shifting Gears — Consumers Transforming Health*](#) - A White Paper.

²¹ Eastern Melbourne PHN, *A future system for inclusion and wellness*, a submission to the Productivity Commission into Mental Health, January 2020 (unpublished).





About the Victorian and Tasmanian PHN Alliance

The Victorian and Tasmanian PHN Alliance (Alliance) provides a platform for the Tasmanian and six Victorian Primary Health Networks (PHNs) to work together. The Alliance enables the PHNs to collectively achieve the best possible outcomes for local communities and organisations through leadership, collaboration, coordination and synergy across the jurisdictions.

The Alliance has a significant interest in mental health reform and system transformation given the dual role of Primary Health Networks (PHNs):

- **as commissioners**, PHNs have a role in developing and shaping primary healthcare services to deliver evidence-based models of care across a geographical area; and
- **as improvement partners**, PHNs have an active role in supporting the clinical and non-clinical workforce to build individual skills and expertise, and to implement systems of care.

This dual role offers a unique contribution to system capacity that strives to advance safety and quality within primary healthcare.

The Alliance has made a [submission to the RCMHS](#) that included a description of the current state of the Victorian mental health system (where we are now), the desired state (where we want to be) and a proposal on how to get there through a set of recommendations.

The Alliance proudly acknowledges Australia's Aboriginal and Torres Strait Islander community and their rich culture and pays respect to their Elders past and present. We acknowledge Aboriginal and Torres Strait Islander peoples as Australia's first peoples and as 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 Victorian and Tasmanian PHN Alliance also acknowledge all people who 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.

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