Primary Health Network (PHN) Cooperative Response to Recommendations of the Productivity Commission's Final Report of its Inquiry into Mental Health ('the Final Report').

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Introduction

This submission is made by the PHN Cooperative in response to the Productivity Commissions Final Report of its Inquiry into Mental Health ('the Final Report').

In 2015, the Commonwealth Primary Health Network (PHN) Program established 31 PHNs nationally to strengthen primary care, improve patient-centred service integration and increase the efficiency and effectiveness of primary healthcare services for Australians; particularly those at risk of poor health outcomes. Our focus as a collective, and individually, is ensuring that health systems and adjacent systems (including, but not limited to justice, education and housing) are integrated, patient-centred, and ensure that all individuals, regardless of race, gender, sexual orientation, socio-economic status, geography or age, can access the right care, at the right time.

In 2017, the CEOs of the 31 PHNs formed the PHN Cooperative – a joint initiative to reflect their commitment to collaborating and delivering on a national agenda in primary health priority areas. The PHN Cooperative has coordinated this response to the Productivity Commission's Inquiry to provide the Australian Department of Health with a consistent viewpoint from the PHN program.

The purpose of this paper is to provide a consolidated response by the PHNs to the findings, recommendations and actions made by the Productivity Commission in the Final Report. We have structured this document in response to the questions asked by the Australian Department of Health. The structure is as follows:

- An overview of the PHN Programme
- Response to Question 1: Critical short-term recommendations
- Response to Question 2: Critical long-term recommendations
- Response to Question 3: Implementation considerations
- Response to Question 4: Critical gaps

Executive summary

The Primary Health Network (PHN) Cooperative is pleased to provide our advice to the Australian Department of Health (the Department) as it looks to implement the recommendations made by the Productivity Commission from its Inquiry into Mental Health.

The PHN Cooperative was formed in 2017 by the CEOs of the 31 PHNs. It is a joint initiative of the PHNs and a commitment to collaboration and delivering on the national agenda in primary health priority areas.

The PHN Cooperative has sought input from all PHNs across the country to inform this response to the Productivity Commission's Final Report. As a collective, we are strongly encouraged by many of the findings and recommendations raised by the Productivity Commission, and look forward to supporting the Australian Government, and State and Territory Governments in implementing broad and ambitious reforms to Australia's mental health system.

The structure of this response has been guided by the key questions asked by the Department as they relate to the implementation of the Productivity Commissions recommendations. Below, we provide a summary of the key themes of our position.

Critical recommendations to be addressed short term

As commissioners of primary mental health services, PHNs have a unique perspective on the challenges facing individual communities. In the short-term, the PHN Cooperative strongly supports the implementation of Recommendations 10, 11, 23 and 24. Within these recommendations, we believe the following actions should be implemented as a priority:

- **Action 10.3:** A Medicare item for GPs to get advice from a psychiatrist.
- **Action 10.4:** Establishing a digital mental health platform… including a tool to access clinician-supported online assessment and referral.
- **Action 11.1:** Increase funding to expand online treatment.
- **Action 23.3:** Development of a National Mental Health and Suicide Prevention Agreement.
- **Action 23.5:** Reforming the allocation of PHN funding to support greater regional equity and remove incentives to shift costs.
- **Action 24.8:** AIHW should publish data on mental health services aligned with the National Mental Health Service Planning Framework.

Critical recommendations to be addressed long term

The PHN Cooperative strongly supports addressing the most pressing gaps in the service system – particularly with respect to community mental health services. However, we acknowledge that some reforms will take time, and require sufficient investment, and cross-government coordination. In this context, the PHN Cooperative believes that Recommendations 9, 12, 14, 15 and 16 should be prioritised for implementation in the long-term, and in particular the following actions:

- **Action 9.1:** Governments should offer effective aftercare to anyone following a suicide attempt.
- **Action 12.3:** The Australian Government should commission a rigorous evaluation of MBS-rebated psychological therapy.
- **Action 14.2:** Mental health services should ensure treatment is provided for both AOD and mental health issues where people have co-morbidities.

- **Actions 15.2 and 15.4:** The Government should establish online navigation portals, assess the number of people who require care coordination services, ensure that care coordination programs are available.
- **Action 16.5:** The Australian Government should strengthen the peer workforce.

Significant implementation issues/costs for consideration

Of the recommendations we have identified, we see there are four significant implementation issues/costs:

- **Addressing the missing middle –** this will take time and significant investment to plan, design and implement these services and to create an integrated and fully resourced continuum of care. The PHNs are in the prime position to commission these services on behalf of Government and in doing so establish a more integrated mental health and AOD service system.
- **Ensuring equity of access, especially where there are thin markets –** we know that during the first wave of COVID when demand for counselling increased there were issues in accessing psychologists, especially outside of metropolitan areas. There will need to be a significant investment in virtual services, like those being established by the PHNs, to address supply issues across Australia.
- **Bringing the mental health and AOD service systems even closer together –** historically, the mental health and AOD service systems have been funded and commissioned separately. For example, the Australian Government's priorities for PHNs has mental health and AOD as separate priorities. The last decade has seen these service systems come closer together, acknowledging that many individuals have co-occurring mental health and AOD issues. Whilst planning and commissioning of mental health and AOD services going forward can be better integrated, there will need to be a significant investment in integrating established services and funding streams – something the PHNs are well placed to lead upon for community-based services.
- **Utilising data as a critical asset –** the use of data across the mental health and AOD service systems is poor. It is a hugely valuable asset and one not being leveraged. Significant investment in the better use of data will improve performance and outcomes at a system, service and individual level. Government should leverage emerging data capabilities, such as the Primary Health Insights platform, to achieve a more data-driven service system.

Key barriers and enablers for practical implementation of these recommendations

As highlighted by the Productivity Commission's Final Report, there are many barriers that stand in the way of improving the commissioning and delivery of mental health services. Many of these relate to the current funding and governance structures, and insufficient accountability for system integration. There is an urgent need to address the barriers that stand in the way of effective regional commissioning. Below, we highlight two barriers that will most inhibit genuine and sustained improvement in the planning and commissioning of mental health services.

- **Structural and funding incentives.** The funding and governance structures and delineation of responsibilities between Governments currently magnifies the problem of the 'missing middle' of local community-based services. Consumers bounce between primary care and hospital-based services; when often the most appropriate treatment and support would be community – based treatment and support were sufficient available. Much of this is due to the way services are funded and commissioned by State/Territory Departments, and in turn, delivered by Local Health Networks

(LHNs[1],)and exacerbated by funding models that incentivise directing funding toward hospital-based activity at the expense of ambulatory and community-based services.

Modelling and reviews commissioned at all levels have established the need to shift the balance of the system away from hospital treatment and bed-based services, towards community-based prevention and early intervention services; but the main funding mechanism does not support this. There is an urgent need to reform the policy settings that continue to incentivise the purchasing and delivery of hospital-based services.

- **Structural gaps and funding incentives.** The development of Joint Regional Plans (JRPs) is mandated under the National Health Reform Agreement (NHRA). Over the past 24 months, PHNs have led the way in the development of Foundational JRPs; in line with our accountabilities to the Australian Government under the NHRA. LHNs, as our partners in regional planning, are only required to participate in the development of JRPs. They do not hold accountability for implementing the plans.

  In many regions the PHNs have driven the planning, with the LHNs providing input and contribution in part. Further, following the development of the JRPs, cooperation from LHNs has been limited and there are few indications that the LHNs will prioritise commissioning services set out in the plans. There is also little evidence that the State and Territory Departments of Health are directing their LHNs to do so.

Steps for successful implementation of the priority recommendations made by PHNs

The PHN Cooperative recommends the following actions and considerations for the Australian Government to ensure the successful implementation of the priority recommendations we have identified.

National reforms:

- Establishing a National Mental Health and Suicide Prevention Reform Agreement to bring clearer role clarity and establish the new role of the National Mental Health Commission (NMHC) in providing reporting and accountability over joint regional planning and co-commissioning activities.
- Accelerating the provision of demand and supply modelling at a regional level, as part of the work being undertaken by the NHMC, and the Australian Institute for Health and Welfare, including access to the Mental Health Service Planning Framework.
- Adoption of Vision 2030, including mandatory minimum components of care.
- Development of a patient outcomes-centred approach to co-commissioning, include national and regional-level outcomes indicators.
- Development of a single minimum data set across all providers and service types.
- Development of a joint funding pool, with greater flexibility for how joint funds are used (to include mental health funding from National and State and Territory Departments of Health).
- Identification of other funds to be contributed to funding pool (e.g. other DoH funding, DSS, PM&C etc).
- The development of clear National and State and Territory priorities that inform and govern the use of mental health service funding.

[1] This response uses the term Local Hospital Networks (LHNs) to refer to local entities funded by State and Territory Governments to manage hospital and other community health services. These entities maybe known under different names such as Hospital and Health Services (HHS), Local Hospital Districts (LHDs), or Health Service Providers (HSPs) depending on the jurisdiction in question.

State and Territory reforms:

- Formal obligations included in funding contracts/service level agreements/statements of priorities to mandate joint regional planning and co-commissioning.
- Development of a regional governance agreement between funders and commissioners in each region.
- Development of a Consumer and Carer Engagement Framework.
- Resourcing and funding for the establishment of joint regional planning and co-commissioning functions.
- Addressing GP workforce constraints in regional and remote areas through improving GP training and placements in non-metro areas.

Critical gaps In Productivity Commission recommendations?

In this response, the PHN Cooperative recommends that the Government take a broader view of regional commissioning than recommended by the Productivity Commission. We propose an approach to regional commissioning comprising of two related, but necessarily distinct elements:

- **Joint regional planning** should bring commissioners and providers together with consumers and communities to plan for their future. It should build upon the development of the Foundational Joint Regional Plans; embedding integration of mental health services and driving evidence-based service development to address gaps and regional priorities.
- **Regional co-commissioning** is the implementation of joint regional plans. It should be the collective responsibility of all organisations involved in commissioning and providing mental health, alcohol and other drugs, and psychosocial supports (outside of the NDIS) in each region.

We recognise that PHNs and LHNs should co-lead the development of joint regional plans, but recommend that joint regional planning is broadened beyond just PHNs and LHNs; to include representatives from adjacent, relevant commissioning bodies responsible for Education, Justice, Disabilities and Housing, as well as ACCHOS and other NGOs delivering services locally.

Additionally, we wish to express significant misgivings about two specific actions in the Final Report:

- **Action: 23.2 – State/Territory Governments take sole responsibility for psychosocial supports outside of NDIS**
- **Action: 23.4 – State/Territory Governments establish regional commissioning authorities to administer mental health funding rather than PHN-LHN groupings.**

Each is based upon the notion that a more efficient and integrated system will be achieved through the re-allocation of mental health funding to States and Territories. We disagree with this. Governments at all levels have committed to shifting the balance of services away from inpatient and acute care; towards early intervention and prevention. Recent reviews and inquiries have stressed the need for investment in primary and community mental health services to meet the rapidly increasing demand and reduce mental health-related ED presentations.

Actions 23.2 and 23.4 effectively re-assign responsibility for primary mental health services, and psychosocial support services to State/Territory-based systems that largely overlook and operate independently of the primary care sector. GPs and primary care services are the front-line of Australia's mental health system. Most Australians that experience a mental health or AOD issue will first come into contact with the health system through their GP. Without sufficient investment in, and recognition of the role of GPs and primary care, the gaps identified by the Productivity Commission will not be addressed.

About the PHN Programme

On 1 July 2015, the Australian Government established 31 PHNs with two key objectives in mind:

- To increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- To improve coordination of care to ensure patients receive the right care, in the right place, at the right time.

The establishment of the PHNs was precipitated by the Review of Medicare Locals by former Chief Medical Office, John Horvath (the Horvath Review). The review, found, amongst other things, that organisations focused on commissioning primary health services in response to community needs would reduce the fragmentation of care by integrating and coordinating health services, elevating the role of general practice, and leveraging and administering health program funding[2]. In line with this concept, PHNs were established as regional commissioning bodies in 2015, with a broad autonomy to develop and commission primary health services to meet local community needs in line with Commonwealth priorities; including mental health.

In the five and half years since their inception, the PHNs have grown in capability and maturity, and are well progressed in achieving target outcomes against their primary objectives. An evaluation of the PHN Program in 2018 found that it had clearly demonstrated that it could positively influence the efficiency and effectiveness of medical services. The review found that the PHNs:

- Represented an improved understanding of local health needs, and used innovative ways of commissioning services, including co-commissioning, to respond to those needs; and
- Developed effective partnerships with government agencies, non-government organisations, and the community to foster better service coordination and system integration, particularly with LHNs.

Other reviews of activities undertaken across a range of sectors have revealed the true breadth of PHN contribution and an evolution well beyond the objectives set in 2015. Individually, PHNs are now taking a leadership position within their communities to foster the development and performance of the primary care sector and working strategically towards true integration across sectors. The national PHN Cooperative and state-territory PHN networks have been established to share successful models, learnings and resources across the PHN Program.

Today, PHNs demonstrably improve the health outcomes of the communities they serve. PHNs lead the commissioning of a wide range of primary health services to address local needs across national health priorities, provide practice support for Primary Care providers, and drive towards greater system integration across state and federal jurisdictions, as well as, improving the interface with disability, aged care and community services.

PHNs are well established as regional commissioning bodies with strong partnerships with primary care organisations and local communities

PHNs understand the primary health needs of their region and the central drivers for reform, integration and equitable access across the local health and social care system. As regional commissioners, we aim to reduce fragmentation and address unmet needs through working with LHNs, and other partners, through innovative and consistent service development and delivery. In doing so, the PHNs have five core roles:

[2] Horvath J. Review of Medicare Locals. Report to the Minister for Health and Minister for Sport. Canberra: The Department of Health; 2014

1. **System coordination and integration** – reduce fragmentation and enhance coordinated, integrated care by working collaboratively across services and sectors.
2. **Regional commissioning** – bridge the jurisdictional, hospital- community- primary and cross sector divides through collaborative commissioning with a focus on the primary health care system.
3. **Primary care system stewardship and management** – progressively improve system quality, access and equity.
4. **Primary healthcare education, training and workforce development** – build the general practice / primary care workforce of the future.
5. **Health system transformation and reform** – progress against agreed system reform objectives.

PHNs receive and distribute both quarantined funding for specific mental health services and a flexible funding pool for planning, integrating and commissioning other mental health services in each PHN's local community in accordance with the needs of that community.

The PHNs have spent five years building their commissioning capabilities from scratch; which has seen the adoption of a national best practice commissioning approach; an approach based upon global best practice in commissioning. It has taken time to establish this capability, but the outcomes of a world class commissioning approach are starting to pay dividends.

Case Study: Western Sydney Collaborative Commissioning

Western Sydney Collaborative Commissioning is a whole of system approach designed to enable and support delivery of value-based healthcare in the community. It aims to incentivise integration across the entire care continuum, and embed local accountability for delivering value-driven, outcome-focused and patient-centred healthcare. The Collaborative Commissioning model currently being implemented in Western Sydney includes three transformative models of care.

1. Value-based Urgent Care (VBUC) – aims to reduce the number of low acuity conditions requiring "urgent" treatment presenting to Western Sydney Emergency Departments, through provision of sustainable alternative local patient centred urgent care services in the primary care setting.
2. Cardiology in the Community (CIC) – strengthen participation and screening to improve identification of people at risk of cardiovascular disease, in turn supporting ongoing management of Heart Failure, Chest Pain and Atrial Fibrillation in the primary care setting.
3. Rapid Expansion of Care in the Community – aimed at preventing the need for hospital admissions, by providing rapid access to care in the community, including the management of COVID-19 positive patients in the community with low or medium risk.

The LHD CEO and the PHN CEO co-chair the Patient Centred Collaborative Commissioning Executive Steering Committee and each of the three models is co-led by a WSLHD clinician and a GP. Models take into account primary, community and acute care options to design optimal integrated and patient-centred services which adapt to meet diverse patient needs.

Resources are pooled and jointly deployed to deliver the vision of 'one Western Sydney Health System'. Services gaps are collaboratively commissioned through the PHN's strategic commissioning function and LHD resources are realigned to support the models of care. Through integrated governance, delegations, shared culture, information sharing, community/consumer engagement and communications, WSLHD and WSPHN are able to overcome organisational and professional barriers to integration and focus care on the individual, family and carers.

The PHNs approach to commissioning aligns with the stepped care model of mental health service delivery. The stepped care model is based on the premise that a person presenting to the mental health care system is matched to the intervention level that most suits their current need. An individual does not generally have to start at the lowest, least intensive level of intervention to progress to the next 'step'. Rather, they enter the system and have the intervention aligned to their requirements.

Our commissioning approach is guided by a holistic view of mental health, which acknowledges that there are varying physical, social, cultural and economic determinants of mental illness, which may require different interventions and supportive approaches at different times. As such, best practice commissioning is undertaken through co-design with consumers and carers, communities, clinicians and service providers; including LHNs. Commissioned activities are planned, delivered, evaluated and evolved based on evidence and the feedback of our local communities. PHNs monitor and evaluate the efficacy and effectiveness of commissioned mental health programmes by managing the performance of the many non-government service providers that provide services across Australia. This performance is assessed against a specified mental health outcomes framework, demonstrating value for money and supporting continuous improvement.

PHNs acknowledge that it is important for consumers and carers to control, lead and participate directly in the decisions that affect them. People with lived experience inform and support PHN commissioned activities and evaluate the quality and efficacy of care provided and drive best outcomes.

Significant progress is being made across the PHN network on the use of data driven commissioning and working with local partners to ensure care is value based, person centred and co-designed with communities.

Case Study: WAPHA PORTS

PHNs are required to improve targeting of psychological interventions to most appropriately support people with or at risk of mild mental illness through the development and/or commissioning of low intensity mental health services.

PORTS was co-designed with WA GPs and the MindSpot Clinic of MQ Health, who operate the program across all three PHNs in WA from their base at Macquarie University, Sydney.

It is a virtual psychology clinic offering clinical assessment and psychological treatment for adults (16yrs +) with anxiety, depression and substance use disorders. Referrals are by GP, with the PORTS initial assessment considered equivalent to a GP Mental Health Treatment Plan (MHTP).

PORTS commenced operation in 2017 and offers two treatment options following assessment (i) telephone delivered CBT (tele-CBT): sessions of structured psychological therapy (ii) clinician supported CBT-course (online or via workbooks), with supplementary weekly brief therapy follow up by telephone/secure messaging. In both programs the patients have the same therapist throughout their treatment course, who can also be contacted by the referring GP to ensure continuity of care.

The outcomes of this initiative are that GPs are provided with structured feedback on patients progress and can access a secure online dashboard for all their referred patients.

As the PORTS initial assessment is deemed equivalent to a GP MHTP (under PHN guidance), PORTS can on-refer individuals to traditional in-person MBS-rebated psychological therapy, as indicated. Around 20 per cent of PORTS referrals utilise this option. It also has established triage, escalation and rapid-referral pathways into crisis and urgent response services.

Critical short-term recommendations

Implementing the recommendations of the Productivity Commission represents a demanding, yet worthwhile reform agenda for the Australian Government. Getting this reform right, will require significant investment and genuine partnerships between government at a Commonwealth, State and Territory-level. The PHNs, with now more than five years of unique local knowledge, commissioning capability, and service development maturity, are well positioned to support the Australian Government through this once-in-a-generation reform.

The PHN Cooperative recognises and concurs with the findings and recommendations made by the Productivity Commission in relation to whole-of-system governance, funding and commissioning arrangements, and accountability. Our role as commissioners of primary mental health, AOD, suicide prevention services, chronic disease programs and community-based services, provides us with a unique perspective on the challenges facing individual communities, and the broader mental health and AOD service systems. We agree with the Productivity Commission's finding that the gaps in the mental health system, while often unique to each region and locality, are underpinned by systemic issues, including those relating to funding, governance, and system design.

We are encouraged by the broad set of recommendations and actions proposed by the Productivity Commission around improving system governance, accountability and regional commissioning of mental health services. The PHN Cooperative strongly supports the concept of regional commissioning as the mechanism for improving service development and integration in local communities.

Specifically, we support the implementation of the following recommendations in the short-term:

- **Recommendation 23:** Funding arrangements to support efficient and equitable service provision.
- **Recommendation 24:** Drive continuous improvement and promote accountability.

The recommendations have significant bearing on the future of the PHN Program, both in terms of its ability to fulfil the expectations placed upon it as a planner and system integrator, and as an independent commissioning partner for the Australian Government.

Specifically, in Recommendation 23, we support the recommendation that Governments should strengthen cooperation between PHNs and LHNs through comprehensive joint regional planning and formalised consumer and carer involvement. Effective PHN-LHN cooperation is essential to each organisation fulfilling its mandate, and also a fundamental bedrock of improved system integration, namely better outcomes for consumers. PHNs and LHNs individually have a unique perspective of their local mental health system and the needs of the community they serve. Combining these perspectives brings an understanding into local needs that is comprehensive and nuanced. In turn, there is a more complete understanding of the services currently delivered across the continuum of mental health, and adjacent service systems within their community. Where PHN-LHN cooperation has worked well – it has worked very well, with leaders in PHN-LHN groupings working in partnership, with a genuine commitment to improving outcomes for consumers and the community. However, as detailed by the Productivity Commission, the partnership between PHN-LHN groupings is patchy, and policy settings governing PHN-LHN cooperation is insufficient. The PHN Cooperative supports the Productivity Commission's view that in the short to medium-term, the priority for the Australian, State and Territory Governments should be directed toward strengthening PHN-LHN cooperation. This should be enabled through addressing the structures and incentives that stand in the way of genuine cooperation, as identified by the Productivity Commission. The successful implementation of this recommendation will be foundational to a more integrated mental health system.

Case Study: Joint regional planning and co-commissioning in Brisbane North

Under the fifth National Mental Health and Suicide Prevention Plan, PHNs and LHNs were tasked with developing a joint regional plan. Brisbane North PHN and Metro North HHS have a strong history of working together, including the formation of The Health Alliance, to progress joint strategic priorities. *Planning for Wellbeing*, the joint regional plan for mental health, suicide prevention and alcohol and other drug treatment, was launched in October 2018.

Overseen by a strategic coordination group and informed by a number of partnership groups, the plan sets out the shared objectives and actions of the local community. It is not a plan about what the PHN or HHS will do, but rather a plan about what the local mental health system will do together to improve quality, coordination and integration, leading to improved health and wellbeing outcomes by the community.

A dedicated website www.planningforwellbeing.org.au has been established to provide information on the joint plan, and to report progress on the over 200 actions in the plan. It also highlights a number of actions that have been completed or significantly progressed. A refresh of the plan is nearing completion, including an initial regional resourcing plan identifying local investment, gaps and priorities for future resourcing.

Planning for Wellbeing has led to increased collaboration across stakeholders to jointly identify needs, develop plans and implement actions to improve quality, coordination and integration. A first year implementation report is available from www.planningforwellbeing.org.au. The PHN and HHS are exploring how to take things to the next level with joint regional planning and co-commissioning, in line with the recommendations of the Productivity Commission.

In this context, there are specific actions the PHN Cooperative sees as critical to the success of the how funding is used as a critical level for reform:

- **Action 23.3: That all Governments should develop a National Mental Health and Suicide Prevention Agreement to clarify responsibilities and the new role of the NMHC**. The PHN Cooperative supports the prospect of a new intergovernmental agreement between the Australian, State and Territory Governments for mental health and suicide prevention. There is an urgent need to clarify government responsibilities for mental health and suicide prevention services, psychosocial supports, and carer supports. While we do not necessarily agree with some proposed elements of the proposed National Mental Health and Suicide Prevention Agreement, particularly the transfer of responsibility of psychosocial supports to State and Territory Governments, we nonetheless support the clarity that the proposed agreement will bring to governance arrangements for the sector, particularly in providing transparency and accountability for PHNs, LHNs, State and Territory Departments of Health, and consumers, carers and the community. PHNs should be an active and involved participant in the development of the agreement.
- **Action 23.5: The Australian Government Department of Health should reform the way it allocates funding to PHNs to support greater regional equity and remove incentives to engage in cost shifting**. The PHN Cooperative strongly supports the Productivity Commission's recommended reforms to the process of determining the PHN Mental Health Care Flexible Funding Pool. We concur with the Productivity Commission's finding funding mechanisms available to PHNs are constrained, and insufficient to address the gap for those unable to access MBS-rebated mental health services. Ensuring the mental health funding pool is equitable and commensurate with service demand in each region is critical to driving the Productivity Commission's proposed reforms to joint planning and regional commissioning.

The PHNs are well positioned to support the broad implementation of Recommendation 24 through utilising Primary Health Insights, a data storage and analysis solution for primary health care data that commenced in January 2021. Currently, GP data is being integrated into this platform with many PHNs bringing in primary mental health and alcohol and drugs service data in the coming months. The PHNs are currently in the process of establishing protocols for national data sharing through Primary Health Insights (PHI). The data infrastructure behind PHI can be used to develop transparent public reporting, including developing publicly accessible dashboards at the sub-regional level, where variation is preserved rather

averaged out and represented accordingly so differences can be seen not just within regions but between. Of critical importance is:

- **Action 24.8: The Australian Institute of Health and Welfare should publish data on mental health services at a national, State and Territory, and regional level, that is aligned with the National Mental Health Service Planning Framework (NMHSPF); and gap analyses against NMHSPF benchmarks. Each regional commissioning body should report a regional-level gap analysis in their joint regional plan**. Conducting regional needs assessments and gap analysis is a core business of the PHNs. As such, it is appropriate that PHNs should continue to co-lead this gap analysis, and use this data to inform the mix of mental health and suicide prevention services that are commissioned over the next three years. Gap analyses would be greatly assisted if the AIHW data could be timelier and cover a broader spectrum of services (including LHD services), and have consistency regarding timeframes and geographical locations. To supplement this action, the PHNs can leverage their investments in data management and analytics to develop standardised and outcome-focused reporting for service providers, and report all data relating to the performance of services at a regional level, with a particular focus on consumer and carer outcomes and experiences, and the experience of clinicians and other staff working in these service (three of the four elements of the Quadruple Aim) . This process should be aligned with joint regional planning processes, and publicly reported in a manner that is standardised, open to scrutiny, and enables funding allocations to be linked to activity, performance and outcomes at a local level, as well as NMHSPF benchmarks (essentially measuring cost efficiency for that funding – the fourth element of the Quadruple Aim).

While the bulk of mental health funding is funnelled into State services, the majority of people experiencing mental illness do not come into contact with this intensive level of care. In 2017-18, 435,000 Australians received State-based community mental health care services, yet 2.5 million people received Medicare-subsidised mental health-specific services during this period, with GPs providing the greatest proportion of these MBS services. Indeed, GPs consistently report psychological issues to be the most common health presentations they manage, and they are the most frequently contacted health professional by those engaging in suicidal behaviour. It is imperative that the role of Primary Mental Health is enhanced into the future; in many ways Australia's GPs and Primary Mental Health services are the nations front-line for dealing with the increasing awareness and prevalence of mental health.

In this context, the PHN Cooperative also support the implementation of the following recommendations in the short-term:

- **Recommendation 10:** Increase informed access to mental healthcare services.
- **Recommendation 11:** Expand supported online treatment.

In 2019, the Department of Health issued guidelines to provide advice to PHNs on establishing effective systems for the initial assessment and referral (IAR) of individuals presenting with mental health conditions in primary health care settings. The PHNs have been investing in the establishment of Initial Assessment and Referral (IAR) capabilities across the country; supporting GPs and patients to be able to access standardised assessments and referrals into the appropriate services that meet the specific needs of individuals. When fully implemented these IAR capabilities will see a significant improvement in the early identification and intervention of those with emerging mental health issues; enabling the individual to be assessed and referred to most appropriate treatment and support to meet their individual needs.

In this context there are three critical actions that we fully support as they will significantly enhance the emerging IAR capabilities:

- **Action 10.3: The Australian Government should introduce a Medicare item for GPs and paediatricians to get advice from a psychiatrist about a patient under their care**. Not every individual will need to be referred into the IAR service. In many instances, the GP can manage the patient with the input and advice from a psychiatrist. However, current MBS funding does not

compensate GPs for the time and expense it takes to consult a psychiatrist. This action, alongside the introduction of the IAR will significantly improve the capability of GPs across Australia to effectively manage patients within a primary care setting. However, the PHN Cooperative cautions that the availability of the MBS item will itself be insufficient to enable access for GPs to obtain advice from psychiatrists in most cases. Currently, most psychiatrists have very long waiting lists, so alternative models of service provision for GPs, such as the free *GP Psychiatry Support Line*, commissioned by PHNs, have been implemented to overcome this issue.

- **Action 10.4: The development and ongoing provision of a digital mental health platform, to be co-designed with consumers and clinicians, and include a tool to be used by GPs and individuals to access clinician-supported online assessment and referral**. As the front-line of the Australian health system, GPs are under increasing pressure to manage the significant increases in individuals with mental health needs; and the IAR will be a critical tool to mitigate the inevitable variability of assessments that happen in General Practice across Australia; and also for helping patients to be referred to the treatment and support they need, where they need it, when they need it. Some PHNs have already implemented localised information and navigation portals. Informed by their experience, we recommend that the proposed platform should provide consumers with localised information about online, and face-to-face mental health care services in their area, and be able to integrate with common patient management tools used by GPs.
- **Action 11.1: The Australian Government should increase funding to expand supported online treatment.** The IAR service will help GPs to develop specific and targeted treatment plans for individuals. However, for many Australians, especially those living in remote and regional communities, the type of treatment they need is not available locally. In some regions, these individuals are being supported in their treatment through virtual mental health services that they can access from home. However, most online treatment services are modest in scale and will inevitably be put under increasing pressure as IAR services are implemented. Additionally, there remains resistance to online interventions amongst the national GP workforce. An expansion of supported online treatment should be enabled by investments in training and development to support GPs to effectively integrate online treatment with face-to-face treatment, where appropriate. The PHN Cooperative strongly supports an increase in funding to expand online treatment services across the country.

Critical long-term recommendations

The PHN Cooperative is encouraged by the Productivity Commission's focus on access and equity in the mental health system – that is, ensuring all Australians are informed of, and can easily access the mental health services they need, when they need them. Additionally, we are strongly supportive of the Productivity Commission's focus on addressing the most pressing gaps in the mental health service system – particularly with respect to community mental health services, and services for consumers with co-morbidities. Sufficient investment across the continuum of mental health and suicide prevention services will be critical to ensuring that problems like the 'missing middle' are addressed.

The PHN Cooperative recommends that the Australian Government prioritise the following recommendations in the long-term:

- **Recommendation 9:** Take action to prevent suicide
- **Recommendation 12:** Address the Health Gaps: Community Mental Health
- **Recommendation 14:** Improve outcomes for people with comorbidities
- **Recommendation 15:** Link consumers with the services they need
- **Recommendation 16:** Increase the efficacy of Australia's mental health workforce

Within these recommendations, the PHN Cooperative recommends the following actions as a priority:

- **Action 9.1: Australian, State and Territory Governments should offer effective aftercare to anyone who presents to a hospital, GP or community mental health service following a suicide attempt, including culturally capable support before people are discharged or leave a service, and proactive follow-up support within the first day, week and three months of discharge**. This support should be tailored to each individual and should be implemented as part of a whole-of-family, and include support to families, carers and in some cases, communities. The PHNs are well-placed to support this action through the commissioning effective community-based suicide postvention services, and through the expansion of the Way Back Support Service.
- **Action 12.3: The Australian Government should commission a rigorous evaluation of MBS-rebated psychological therapy, including trials to test whether consumers would benefit from more sessions in a year, and to test the value to consumers of feedback-informed practice.** The report notes that PHNs commission a large volume of psychological therapy services, targeted at underserviced populations across the country. It also notes that these services are substantially more expensive per session that MBS-rebated therapy. We support a rigorous evaluation into the efficacy of all psychological therapy services, including PHN commissioned services and headspace services. It is important that Government understands what it is funding and the impact this significant expense is having on our population.
- **Action 14.2: Mental health services, including hospitals and clinical community health services should ensure treatment is provided for both alcohol and other drug issues, and mental health issues, for people with co-morbidities**. This is a critical initiative, which requires a number of enabling actions, including:
    - Address the stigma around AOD with health professionals
    - Improving data capture to support multiple episodes of care to enable holistic treatment for participants, and more appropriate measures patient outcomes
    - Address the MBS item disparity for GPs supporting people with mental health concerns

- Enable GPs to claim for each of the items covered in a session so that holistic care can be provided – a significant proportion of GPs time is unpaid and often mental health items are not claimed per the current rules
- Improve alignment of AOD and MH data sets
- Including consumer and carer voice in redesign of any future emergency departments.

- **Action 15.2: Regional commissioning bodies should develop and maintain online navigation portals that include detailed clinical and non-clinical referral pathways, which can be accessed by clinical and non-clinical service providers. PHN should be resourced to develop and maintain these portals**. HealthPathways is an online platform that increases the links between GPs and hospitals, and results in a decrease of inappropriate referrals by providing up-to-date relevant local referral information. The PHN Cooperative consider that while HealthPathways is suitable for clinical management and decision support (usually by GPs), a broader, publicly accessible portal is needed. A number of PHNs have developed regional service navigation portals, assessment decision support tools and electronic referral system. Lessons can be learnt from this initiative or built on and expanded. PHNs should be resourced to develop these portals.

Case Study: PHNs initiatives to improve service navigation, Brisbane North PHN

Consumers and carers report great difficulty in navigating the complex and fragmented mental health system. Service providers find it difficult to keep track of other services outside of their area of specialisation (e.g. regularly changing scope of NGOs due to funding changes). The development of the national Initial Assessment and Referral (IAR) guidance introduced a standardised and evidence-based approach to assessing level of need and matching people to the most suitable service.

To guide and support service navigation, PHNs have led on the following initiatives:

- Establishment of the www.mymentalhealth.org.au website to provide access to information on local mental health services for consumers, carers and service providers. Also includes news, events, consumer and carer forums and resources for consumers, carers and providers.
- Development of rediCASE, an integrated electronic assessment and referral tool for use by GPs, providers and in the future consumers and carers. Based on the IAR guidance, rediCASE integrates with GP software and on the basis of need and demographics of consumers, suggest services that are best suited. An electronic referral can then be generated which is sent to the provider, who makes contact with the consumer to initiate service.
- Availability of My Mental Health service navigators, employed by the PHN, who provide information, assessment and referral via phone and email to consumers, carers and providers. The navigators also curate www.mymentalheath.org.au and manage the rediCASE system.
- HealthPathways provides evidence based clinical management guidance for GPs across a number of mental health and suicide prevention conditions. It includes information on other services available locally and includes a link to rediCASE for referrals to community services.

Consumers, carers and service providers now have access to information about local mental health services, via websites, phone and a decision support tool (rediCASE).

People are more able to get to the right service, in the right place at the right time. Information on local services across the region (state, NGO and private) is brought together, made available to all and kept up to date by the My Mental Health navigation team.

- **Action 15.4: Governments and regional commissioning bodies should assess the number of people who require care coordination services and ensure that care coordination programs are available to match local needs.** The PHNs regularly and routinely engage, and formally consult with consumers and communities across the country. The most common frustration for Australians is the complexity they experience in navigating our mental health system. We fully support this action and propose that

PHNs across the country take the lead on this action. All consumers and carers who access mental health services will interact with a GP and with primary care services. The PHNs are uniquely placed to assess the needs for care coordination and establish and commission care coordination services at a local level. PHNs already receive an element of care coordination funding via the Primary Mental Health Care schedule. Existing care coordination services funded by PHNs should be expanded for people receiving both clinical and psychosocial care via PHN funded providers.

- **Action 16.5: The Australian Government should strengthen the peer workforce by providing once off, seed funding to create a professional association for peer workers, and in collaboration with State and Territory Governments, develop a program to educate health professionals about the role and value of peer workers in improving outcomes.** A consistent theme we hear from consumers and clinicians across the country is the significant value that those with lived experience can bring to complement the treatment and support that an individual receives. Yet the use of peer workers is sporadic and inconsistent. We support any action that will advance the role of peer workers within the mental health service system; especially in primary care and community-based services where the individual can engage with individual not receiving acute care. Within this context we recommend that PHNs are funded to design and commission peer support services, either as stand-alone and/or integrated into existing services.

Case Study: WAPHA Choices

In 2017-18 it was estimated that of the one million presentations to emergency departments in WA, around 19 per cent could have been avoided with treatment in primary care or community settings.

Choices, the first service of its kind in Australia, connects vulnerable people at risk of poor health outcomes with social and mental health support upon discharge from hospital emergency departments or exiting justice services. The WA Primary Health Alliance worked with the East Metropolitan Health Service (Local Hospital Network - LHN) and RUAH Community Services (NGO) to co-design a service model that is centred around RUAH's peer workers who draw on their lived experience in similar situations to provide supportive intervention.

The pilot saw peer and case workers based in emergency departments and the justice system to connect with over 3,000 people. Many clients did not have a regular general practitioner (GP) or were presenting to hospital emergency departments with health conditions that could be potentially managed through primary care. Choices connected them to a GP who can offer ongoing health care, as well helping them to access crucial support with things like emergency accommodation and treatment for mental health, alcohol and other drug issues

Overall, emergency department presentations fell by 35 per cent among the target client group in the twelve months following support. The pilot also showed that addressing the client's housing situation is crucial in order to overcome other issues such as alcohol and other drug use and mental health issues.

An additional $7 million in funding from the Australian Government's Community Health and Hospitals Program will allow Choices to be expanded to four more hospitals in the Perth metropolitan area.

Implementation considerations

National and State and Territory reforms

The PHN Cooperative emphasises that without meaningful reforms at a national, State and Territory-level, it will be difficult to realise the Productivity Commission's vision for improved mental health outcomes for all Australians. Driving enduring, system-wide reform in the way proposed by the Productivity Commission will be resource-intensive, and require investment in genuine partnerships at a national, State and Territory and regional level.

In this context, the PHN Cooperative recommends the following actions and considerations for the Australian Government to ensure the successful implementation of the priority recommendations we have identified.

National reforms:

- Establishing a National Mental Health and Suicide Prevention Reform Agreement to bring clearer role clarity and establish the new role of the NMHC in providing reporting and accountability over joint regional planning and co-commissioning activities.
- Accelerating the provision of demand and supply modelling at a regional level, as part of the work being undertaken by the NHMC, and the Australian Institute for Health and Welfare, including access to the Mental Health Service Planning Framework.
- Adoption of Vision 2030, including mandatory minimum components of care.
- Development of a patient outcomes-centred approach to co-commissioning, include national and regional-level outcomes indicators.
- Development of a single minimum data set across all providers and service types.
- Development of a joint funding pool, with greater flexibility for how joint funds are used (to include mental health funding from National and State and Territory Departments of Health).
- Identification of other funds to be contributed to the funding pool (e.g. other DoH funding, DSS, PM&C etc).
- The development of clear National and State and Territory priorities that inform and govern the use of mental health service funding.

State and Territory reforms:

- Formal obligations included in funding contracts/service level agreements/statements of priorities to mandate joint regional planning and co-commissioning.
- Development of a regional governance agreement between funders and commissioners in each region.
- Development of a Consumer and Carer Engagement Framework.
- Resourcing and funding for the establishment of joint regional planning and co-commissioning functions.
- Addressing GP workforce constraints in regional and remote areas through improving GP training and placements in non-metro areas.

Key barriers and enablers

As highlighted in part in the Final Report, there are several structural and institutional barriers to stand in the way of improving the commissioning and delivery of mental health services. Many of these barriers

relate to the current funding and governance structures of the mental health system, and insufficient oversight and accountability for cooperation and integration. Regardless of the direction pursued by the Australian Government in reforming the funding and commissioning landscape for mental health services, there is an urgent need to address the structural and institutional barriers that stand in the way of effective partnerships and regional commissioning.

The PHN Cooperative wishes to highlight two of these barriers, in particular.

Structural and funding incentives exacerbate the problem of the 'missing middle'

Despite some State and Territory variability, the funding and governance structures and delineation of roles and responsibilities between the Australian, and State and Territory Governments currently magnifies the problem of the 'missing middle' of local community-based services. Consumers predominantly bounce between primary health treatment and support and hospital-based treatment; when often the most appropriate treatment and support would be community based services and supports – were there sufficient available.

Much of the problem of this 'missing middle' is owed to the way mental health services are funded and commissioned by State and Territory Departments of Health, and in turn, delivered by LHNs. This is exacerbated by the lack of standardised data recording and reporting across the continuum of care. At a State and Territory-level, commissioners and providers are focused largely on hospital-based mental health services, with a relatively small proportion of funding dedicated toward ambulatory and community-based services. At an LHN-level, the level of funding dedicated toward non-hospital services is marginal at best. Much of this imbalance is owed to the way mental health services are funded through an activity-based funding (ABF) model; as discussed at length in the Final Report, which highlighted several examples of funding being directed toward hospital-based services at the expense of ambulatory and community-based services.

In recent years, modelling and reviews commissioned at a national, State and Territory-level have firmly established the need to shift the balance of the mental health service system away from hospital treatment and bed-based services, and toward community-based prevention and early intervention services; but the primary funding mechanism does not support this. There is an urgent need to reform the policy settings that continue to incentivise the purchasing and delivery of hospital-based services. PHNs – as the commissioners of primary and community mental health services – will play a major role in shifting the balance of services. However, PHNs only have responsibility for, on average, five per cent of all mental health funds. It is in this context that alternative approaches, such as the establishment of funding pools administered as part of joint regional plans, should be explored as a mechanism for achieving the priorities of government.

Structure gaps and funding incentives limit genuine LHN participation in joint regional planning

The development of joint regional plans is mandated under the National Health Reform Agreement. Over the past 24 months, PHNs across all States and Territories have led the way in the development of Foundational Joint Regional Plans (JRPs). As PHNs, we have responsibility and accountability to the Australian Government for the establishment and implementation of these plans.

LHNs, as our partners in the regional planning process, only have a requirement to participate in the development of the joint plans. They do not hold any accountability for the implementation of the plans themselves. In many regions the development of the JRPs has been driven by the PHNs, with the LHNs providing input and contribution in part, throughout the process. Further, following the development of the JRPs, cooperation from LHNs has been limited and there are few indications that the LHNs will prioritise the commissioning of services as set out in the plans. There is also little evidence that the State and Territory Departments of Health are directing their LHNs to do so.

Much of this practice is due to current policy settings. LHNs have no accountability to their respective State or Territory Government, nor the Australian Government for the implementation of commitments contained within the plans. Once JRPs are developed, LHNs have, implicitly, 'no skin in the game'. LHNs are by their nature, providers of secondary and tertiary health services, not commissioners of mental health services. The consequence is that any initiative or priority geared towards improving service coordination or integration falls to the PHN as they are seen as the commissioners in the LHN-PHN grouping, responsible for the co-design and commissioning of new services.

Case Study: Establishing governance and senior executive buy-in

A (deidentified) PHN gained CEO level commitment for three organisations (one PHN, two LHNs) to work together on developing a regional plan, as one of two joint priorities for the region. To do so, a working group was established which included representatives of all three organisations as well as people with lived experience. We convened the working group regularly to guide development of the plan, support consultation and recommend the final version to the CEOs and Boards for approval.

The planning process was a standing item on the agenda of our Strategic Alliance meetings (at CEO level, and with each LHN). We achieved:

- Sustained attendance and participation at working group meetings, which continued through staff changes
- Regional plan delivered and endorsed by all three Boards
- Resources allocated to employment of a Project Coordinator to support implementation
- Ongoing interest from all three CEOs
- Strong commitment by all working group members

The challenges faced in this initiative were:

- Getting the governance arrangements right for making the transition from planning to implementation. Implementation is crunch time and involves change, so we need to work hard at maintaining buy in.
- Maintaining momentum. It would be easy to get distracted by the next priority, but we need to maintain our focus on implementation.

Critical gaps

The PHN Cooperative supports an approach to regional co-commissioning that addresses the inherent strengths and limitations of both PHNs and LHNs

The PHN Cooperative recommends that the Australian Government take a broader view of regional commissioning than that recommended by the Productivity Commission. This approach would recognise that regional commissioning comprises of two related, but necessarily distinct elements: **joint regional planning**, and **regional co-commissioning**. The PHN Cooperative proposes that this approach informs the development of the National Mental Health and Suicide Prevention Agreement.

Joint regional planning should bring commissioners and providers together with consumers and communities to plan for their future

The process of joint regional planning should broadly mirror the current process guiding the development of the Foundational Joint Regional Plans. Joint regional planning broadly has two objectives:

- It should embed integration of mental health and suicide prevention services and pathways for people with or at risk of mental illness or suicide through a whole of system approach; and
- It should drive and inform evidence-based service development to address identified gaps and deliver on regional priorities.

Joint regional mental health and suicide prevention plans should inform the coordinated commissioning of services across the stepped care spectrum of need. They will also create the opportunity for coordinated regional implementation of national priority areas as agreed through the Fifth Plan.

The PHN Cooperative recognises that PHNs and LHNs should co-lead the development of joint regional plans. However, mental health and suicide prevention should not be viewed and planned in isolation from the determinants of poor mental health, including physical health and social determinants of health. In line with this, the PHN Cooperative recommends that broadening joint regional mental health planning activities to include not only PHNs and LHNs, but representatives from adjacent, relevant commissioning bodies (i.e. State and Territory agencies responsible for Education, Justice, Disabilities and Housing), ACCHS, and other non-government organisations delivering community services in any given catchment area.

Regional co-commissioning is how commitments made in joint regional plans should be implemented

Regional co-commissioning is the implementation of joint regional planning activities. Co-commissioning should be the collective responsibility of all organisations involved in commissioning and providing mental health, alcohol and other drugs, and psychosocial supports (outside of the NDIS) in each region. Co-commissioning activities should be informed by joint regional planning but, it is a necessarily separate process.

LHNs, by virtue of their composition and role in the mental health system, have limited expertise in commissioning. The responsibility for mental health, suicide prevention, and alcohol and drug service commissioning should be 'devolved' to a joint commissioning function. That way services can be co-commissioned by those agencies' expert in commissioning, taking into account a truly holistic view of the region.

Case Study: Governance arrangements for PHN-LHN Cooperation

One PHN-LHN grouping has established a high-level steering group as the principle governance structure to guide/lead the development of a regional plan. The Group consists of representatives from Department of Health (including the Office of the Chief Psychiatrist), LHN, Mental Health Council, Consumer and carer peak bodies and representatives, and NDIA.

The group has met on three occasions, including a full-day workshop to consider the Commonwealth Guidance material and progress the development of the regional plan. All key stakeholders present acknowledged the need and their willingness to be part of the project. The Steering Group is co-chaired by PHN and the Department of Health and all associated papers and resources are co-branded.

The outputs of this arrangement have seen:

- Development and agreement of a Terms of Reference
- Agreement on the type of plan to be delivered
- Inclusion of carer and consumer peaks and representatives on the Steering Group
- Clear direction from the Steering Group around how the regional plan will intersect with and draw from existing local policies and strategies
- Co-branding agreement with the Department of Health, demonstrating a clear partnership approach to this activity
- Joint commissioning (PHN and Department of Health) to undertake service mapping, using the NMHSPF Taxonomy
- Identification of potential working groups to develop and deliver components of the regional plan

The successes and learnings of this approach have been:

- Single PHN, DoH and LHN in the region with existing positive relationships and a willingness to work in partnership to achieve outcomes
- Guidance material that identifies the role of the LHN in the process
- The one-day workshop where time was spent with the Steering Group to ensure that all members had a clear and consistent understanding of the requirements and the guidance material
- There is a necessary chronology in progressing this work – some steps need to occur prior to others
- This is a complex task, it requires a dedicated resource to manage and progress
- Everyone needs to be on the same page – with a shared understating of the aim, outcomes and intentions
- It would be a relatively easy exercise to produce a plan that meets the basic requirements of the Guidance material. But – producing a plan that will affect and impact on the current system in a positive and meaningful manner is a complex task that takes time.

How do you get from joint regional planning to co-commissioning?

The PHN Cooperative acknowledges that the process of moving from joint regional planning to co-commissioning will not be seamless. While the foundations are in place, much work will need to be done in defining the form and function of co-commissioning and addressing the barriers and enablers of good co-commissioning.

For most PHN-LHN groupings, the Foundational Joint Regional Plans have laid the groundwork for effective cooperation between PHNs, LHNs and the broader mental health service system. The next step, as required under the Fifth Plan, should be a comprehensive service development plan. These plans should be owned not just by the PHN and LHNs, but all organisations involved in joint regional planning – including State or Territory Departments of Health, ACCHS, and other non-government organisations.

A comprehensive service development plan should be underpinned by rigorous demand and supply modelling, and systematic service and workforce planning. However, its focus should be on the process and outcomes of co-commissioning. That is, it should articulate both the process of co-commissioning in each region – who is involved, and to what extent they are involved, and the outcomes of co-commissioning – what the collective of organisations aim to achieve from the services they co-commission.

The 'functions' of joint regional planning and co-commissioning could take many forms

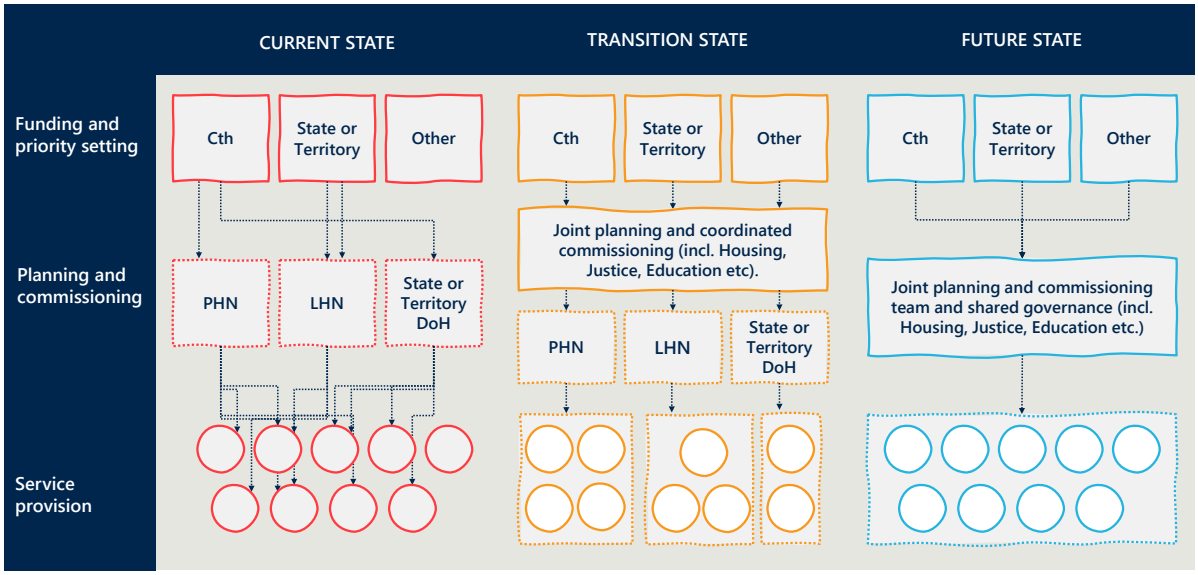
The PHN Cooperative suggests that the terms joint regional planning and co-commissioning should be used to describe a set of functions that should be performed by organisations in each region. In our experience, the process of joint regional planning and co-commissioning includes, but is not limited to the following functions:

- Understanding the needs of consumers, carers and the community
- Understanding the local service systems – what services are provided, and by whom?
- Undertaking a detailed gap analysis of service demand (and likely growth in demand) versus supply of services
- Collaboratively identifying, prioritising, and developing potential solutions
- Drafting and publishing a joint regional plan
- Developing a formalised approach to consumer and carer engagement
- Co-designing solutions in partnership with carers and communities (and in co-leadership with Aboriginal and Torres Strait Islander leaders and service providers for Aboriginal and Torres Strait Islander specific services)
- Procurement and contract management
- Co-developing service navigation infrastructure, including formal and informal care pathways
- Service monitoring and evaluation
- Outcomes monitoring and reporting
- Reporting to the public, and the NMHC on progress against commitments
- Shared clinical governance arrangements

The PHN Cooperative acknowledges that a 'one size fits all' model for regional commissioning is inappropriate. While the 'functions' of joint regional planning and co-commissioning should broadly be consistent across each jurisdiction, their form will necessarily be different. There is broad variation in funding and governance structures in each State and Territory, and varying levels of maturity and capability in cooperation and integration across PHN-LHN groupings. As such, it is necessary to apply a degree of flexibility for how joint regional planning and co-commissioning would look.

The evolution of co-commissioning will take some time, but done right will achieve a genuine holistic approach to commissioning services in a collaborative and holistic way (Figure 1).

Figure 1 | The expected evolution of the co-commissioning model



Implementing the co-commissioning model will require formalised governance arrangements, appropriate resources, and incentives and disincentives for involved bodies (i.e. through target setting). Effective joint regional planning and co-commissioning requires more formalised governance arrangements, and appropriate resources. The transition state in the above diagram reflects the fact that it is likely to be complex to get to an environment where funds are pooled, but that this should not be a limiting factor to greater integration in planning and commissioning.

The form of the co-commissioning body in any one jurisdiction or region will need to align with the prevailing governance models in the jurisdiction, and there are different structures and forms that joint regional planning and co-commissioning could take. Just two examples of these could be:

- **A joint PHN-LHN-State Department team**. A joint team could be formed in each PHN-LHN grouping and possibly co-located in one location. The joint team would be responsible for the development of joint regional plans under and the commissioning of services under the direction of a cross-sector governance group which should comprise of representatives from the PHN, LHNs, State or Territory Department of Health, State and Territory Departments of Justice, Education, Communities and Local Government (among others), Aboriginal Community Controlled Health Services, other non-government organisations, and consumer and carer representatives. This team would ultimately be accountable to the leadership of the PHN and LHN; and be subject to monitoring by the NMHC under its new role.
- **Allocated responsibility**. A joint governance group (as above) comprising of cross-sector representatives, consumers and carers could oversee the process of joint regional planning and co-commissioning. However, specific roles could be allocated to the PHN or LHN(s) (i.e. the PHN and LHN may co-lead a co-design process, while the PHN could be responsible for procurement and contract management).

The ideal is that in due course whatever body is in place would be responsible for the planning and commissioning services using a joint pool of mental health, suicide prevention, alcohol and other drug, and psychosocial support funding. This would enable all funding and services to be directed toward the effective implementation of commitments set out in joint regional plans.

While there will always be regional and jurisdictional variation – the one constant in each State and Territory is the PHNs. Each is funded, governed and responsible in the same way, regardless of the State or Territory; and each is required to understand and reflect local needs in the service they commission. This balance of national consistency and local knowledge means the PHNs have a critical and unique

perspective and capability that can ensure there is both national consistency and local nuance in how regional planning and co-commissioning is taken forward.

The PHN Cooperative cautions against progressing the notion of Regional Commissioning Authorities

The PHN Cooperative wishes to express significant misgivings about two specific actions made by the Productivity Commission in the Final Report:

- **Action 23.2, that State and Territory Governments should take on sole responsibility for psychosocial supports outside of the National Disability Insurance Scheme; and**
- **Action 23.4, which would enable State and Territory Governments to establish regional commissioning authorities (RCAs) to administer mental health funding as an alternative to PHN-LHN groupings.**

Each of these recommendations are underpinned by the notion that a more efficient and integrated mental health system will be achieved through the re-allocation of mental health funding to the States and Territories. The PHN Cooperative disagrees with this notion. Each recommendation is incongruous with both the current funding and governance of the mental health system, and how most consumers access and experience mental health services.

Most Australians receive mental health care in the primary care setting – not in an acute care setting. The focus of future funding and commissioning models should be designed to support, rather than weaken the primary care sector. For example, in 2017-18 435,000 Australian's accessed State or Territory-funded community mental health care services, as compared with the 2.5 million people who access Medicare-subsidised mental health-specific services. Despite this, disparity, the overwhelming majority of mental health funding is allocated to State and Territory mental health services that are delivered in a secondary or tertiary care setting. Actions 23.2 and 23.4 purport to effectively re-assign responsibility for primary mental health services, and psychosocial support services to State and Territory-based systems that largely overlook and operate independently of the primary care sector.

The risks of this approach are significant. At a national, State and Territory-level, Government has committed to shifting the balance of the mental service system away from inpatient and acute care, and toward early intervention and prevention. This priority has been reinforced by recent reviews and inquiries, including the Interim Report from the Royal Commission into Victoria's Mental Health System; and the WA Auditor General's review of Access to State-Managed Adult Mental Health Services. Each have stressed the need for investment in primary and community mental health services to meet the rapidly increasing demand for these services, and reduce mental health-related emergency department presentations.

Progressing these recommendations of the Productivity Commission would continue to put pressure on the primary mental health sector, whilst providing funding to State- and Territory-based systems that are incentivised to continue directing funding toward acute-care beds.

Throughout its Final Report, the Productivity Commission emphasised the importance of creating a person-centred mental health system, one that address the gaps and barriers to improved outcomes for Australians. GPs and primary care services are the front-line of Australia's mental health system. Most Australians that experience a mental health or alcohol and other drug issue will first come into contact with the health system through one of these avenues. Without sufficient investment in, and recognition of the role of each in our mental health system, the gaps identified by the Productivity Commission will not be addressed.