



***Victorian and Tasmanian PHN
Alliance submission attachment***

**Royal Commission into
Victoria's Mental Health System**

July 2019



The **Victorian and Tasmanian PHN Alliance** (Alliance) welcomes the opportunity to provide this submission to the Royal Commission into Victoria’s Mental Health System.

The 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. Information about the role of PHNs and associated enablers in health system reform are provided in Appendix 1.

The Victorian and Tasmanian PHN 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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Introduction

The Royal Commission into Victoria's Mental Health System is a once in a generation opportunity to investigate and deliver a comprehensive set of recommendations on how to best support Victorians with mental illness, including Victorians at risk of suicide.

The Royal Commission into Victoria's Mental Health System has the potential to advocate for a reform of the health system in addition to raising public awareness about mental health and illness as an important issue. System reform is required in order to:

- simplify access and navigation;
- better integrate mental health services with primary healthcare and other health services;
- ensure comprehensive, appropriate and consistent support to individuals, families and carers; and
- build a sustainable workforce.

An important objective of reform should be the provision of an integrated system that provides effective and efficient mental health services for individuals and families. Promoting mental health and addressing mental-ill health requires a holistic view of health. This includes examination of the physical, social, cultural and economic determinants of health.

The Victorian and Tasmanian PHN Alliance (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.

This submission briefly describes the current state of the Victorian mental health system (*where we are now*), the desired state (*where we want to be*) and proposes how to get there through a set of recommendations.

Mental health and primary healthcare

Achieving better mental health outcomes for consumers through access to the right care, at the right time and in the right place, is fundamental to mental health reform and system transformation.

Mental illness is associated with a higher prevalence of chronic conditions such as diabetes and cardiovascular disease, alcohol and other drugs (AOD) use, homelessness, family violence and unemployment, reinforcing the need for broad-based interventions and systems thinking. The 'whole-of-health approach' needs to include strategies and approaches that increase community assets and social cohesion, in addition to effectively contributing to a consumer's recovery and ability to lead a healthy, meaningful and fulfilling life.





Adopting a holistic view of health including the physical, social, cultural and economic determinants of health acknowledges that mental illness may require a range of different interventions and supportive approaches at different times throughout the life of the consumer. An important objective of reform should therefore be the provision of an integrated system that provides effective and efficient mental health services for individuals and families.

Holistic care will never be achieved until mental health is integrated with primary care.

- World Health Organization 2018

The provision of more effective and efficient mental health care requires two levels of integration:

1. **Horizontal integration** within primary healthcare that brings together physical and mental health care along with sectors outside of health such as community services, housing, employment, and education; and
2. **Vertical integration** of primary, secondary and tertiary services through collaborative partnerships, system redesign and resource reallocation.

PHNs have a role in driving mental health reforms in Australia to achieve both horizontal and vertical integration. This is achieved through the following:

- Considerations of the broader needs of mental health consumers, recognising that a range of different interventions and supportive approaches may be required at different times for any consumer.
- Procurement of services across the spectrum of illness severity to meet the needs of consumers when and where needed, using a stepped care approach.
- Working collaboratively with general practitioners (GPs), general practices and key mental health service providers in the public and private sectors to promote and provide person-centred and holistic care.¹ General practitioners have a central position in the health system as 'gatekeepers', guiding people through the health system, monitoring and coordinating progress to maintain and improve quality of care, and limiting the use of expensive specialist services.

The Commonwealth Government has positioned PHNs to enhance the regional planning and integration of mental health services, with progress reported to the Council of Australian Governments and the National Mental Health Commission (NMHC). The Fifth National Mental Health and Suicide Prevention Plan commits all governments to work together towards integrated service planning and delivery at a regional level, achieved through collaboration between PHNs and Local Hospital Networks (LHNs) (also referred to as Victorian public hospitals and health services).

As mental health change agents, the six Victorian PHNs leverage knowledge of the mental health needs of regional populations and the local service provider context to achieve both horizontal and vertical integration.

¹ Australian Government, Department of Health, '[Reform and System Transformation: A Five-Year Horizon for PHNs](#)', PHN Advisory Panel on Mental Health Report, September 2018, Canberra.





The current state of the Victorian mental health system

Reviews of roles and responsibilities in the Australian health system, including mental health, have reported the following:

“There is in fact no such thing as a mental health ‘system’; instead, this ‘system’ is shorthand for the many systems and services consumers and carers may encounter. For the most part, these services and systems are poorly integrated, overseen by different parts of government, based on widely differing organising principles, and not working towards a common goal. The Commonwealth and the States and Territories both have roles in policy, funding, and regulation in mental health. These roles have evolved in piecemeal fashion and have usually not been defined with respect to an overarching vision shared across governments and portfolios. It is therefore no surprise that consumers find the system enormously difficult to navigate.”

Source: Australia. Department of the Prime Minister and Cabinet, issuing body. 2014, <https://apo.org.au/sites/default/files/resource-files/2014/12/apo-nid56123-1158991.pdf>

The Victorian mental health system is highly fragmented. An inefficient patchwork of programs and services resulting from siloed funding arrangements between Commonwealth, State and private services.

Key issues are as follows:

- Diversity in funding agreements, accountability frameworks, reporting requirements and service models have resulted to inefficiencies and gaps being inadequately addressed by bilateral agreements or comprehensive strategies for service design and development.
- Funding is heavily weighted towards public hospitals and the acute end of the mental health service spectrum and even then, there remains significant gaps.
- Prevention and early intervention are significantly underdeveloped and receives minimal investment despite an evidence base that endorses intervention early-in-life, early-in-illness, and early-in-episode.
- Services are inadequately distributed across geographical areas with incremental reforms lacking the important systems perspective.
- There is a lack of broad-based interventions and systems thinking to address the inextricable linkages between mental illness, AOD use, family violence, homelessness, and unemployment.
- Current funding models predominantly focus on the person's specific episode of care rather than on 'whole-of-person' and continuing care, including the necessary linkages across the service system to provide an integrated service response.
- There lacks transparency to assess the extent to which investments in mental health service delivery have been based on evidence, qualitative and quantitative data, and an overall systems approach resulting in further fragmentation.
- Strategies to address workforce shortages have often been uncoordinated and piecemeal and have failed to address the critical shortage of highly skilled mental health workers particularly in rural and regional areas.





The desired state

The desired mental health system is one where Victorians receive appropriate, safe, high-quality care at the right time, in the right place regardless of service and catchment boundaries and funding sources. This would be enabled by:

- A **whole-of-government approach** that takes a holistic view of health including the association with wider physical, social, cultural and economic determinants of health.
- **Holistic care** achieved through integration of mental health with primary healthcare, coordinated with a network of services at different levels of care provision and complemented by connections to the broader health system.
- Person-centred care with careful consideration of the way **care is viewed, planned, designed, delivered, arranged, contracted, funded, and monitored** that is driven by those who are seeking to access care which encompasses the whole person, families, community and continuing care requirements.
- Services that are **easier to access and navigate** with care offerings available across all age groups and, known vulnerable groups within a **common catchment**.
- A **whole-of-Victorian approach** to integrate services across all ages (infant, children, youth, adults, and older people) that aligns with the national Mental Health Stepped Care Model and facilitates access to a diverse suite of services, publicly funded mental health and suicide prevention services, and other primary health services. The approach also needs to consider **linkage with other commissioners**.

How we arrive at the desired state

The Alliance provides the following key recommendations to the Royal Commission into Victoria's Mental Health System to arrive at the desired state:

1. **Invest in and integrate with prevention and early intervention services**
2. **Invest in services that bridge tertiary with primary healthcare**
3. **Provide accessible and easy to navigate services that keeps the consumer at the centre**
4. **Ensure comprehensive and consistent support for individuals, families and carers**
5. **Integrate mental health services with alcohol and other drugs (AOD) services**
6. **Address regional and rural workforce gaps through collaborative approaches to workforce planning and development using sound data sets**
7. **Improve the clinical governance processes at a regional level to ensure safe service responses for consumers**
8. **Co-commissioning**
9. **Accountability for consumer outcomes and the delivery of high-quality person-centred care.**





The set of recommendations focuses not only on addressing the problems around the design and structural elements of the service system, but also advocates for consideration of the social determinants of health. Furthermore, the desired state requires significant reshaping of policy drivers and the service delivery system. Simplistic solutions, such as the creation of virtual arrangements or ‘hubs’ in an otherwise unchanged current state, are not considered reform, will not achieve the change required, and have the real potential to further fragment care. New initiatives that fail to address the critical issue of system design can further add complexity to an already fragmented system. Critics have noted the limits of simply adding access points to an already constrained mental health system.² Other advice has cautioned that:

*... tinkering around the edges will not deliver serious, effective and sustained health reform. By contrast, an approach that considers the system as a whole is most likely to optimise its effectiveness and efficiency and actually improve Australians’ health.*³

Recommendations

1. Invest in and integrate with prevention and early intervention services

The greatest inefficiencies in the mental health system come from providing acute and crisis response services when prevention and accessible early intervention services would have likely reduced the need for complex and costly interventions, reduced the risks of iatrogenic impact on service users, and supported people to remain in the community with families and carers.

The primary healthcare sector has a particularly important role to play in prevention, both in promoting behaviours that support positive mental health, and in the management of chronic or recurring illness, lessening the vulnerability for relapse and the negative impact of illness.

Primary healthcare plays a significant role in the integration of physical health care and mental health care. For instance, people living with a mental illness compared to other members of the community, are less likely offered standard physical health checks and screening for preventable physical health conditions such as heart disease and cancer, and consequently less likely to be offered physical health interventions.

Looking upstream to improve mental health will involve taking a life course perspective including employing strategies that improve health literacy and reduce stigma.

The role of General Practice in mental health

General Practice plays a central role in the provision of mental health care and in certain circumstances is the only point of care needed for people who require mental health services. The ongoing relationships between individuals/families and General Practice staff can facilitate early intervention for emerging symptoms, assessment of suicide risk, and effective monitoring of chronic mental illness. These relationships can also make it easier to identify and manage mental illness that is interlinked with other physical and social factors.

² McCauley, Dana. [“Full as soon as they open’: Experts warn new adult Headspace centres not enough”](#). Sydney Morning Herald, April 3, 2019.

³ Bartlett C, Butler S, & Haines L. (2016). [Reimagining Health in Australia. Taking a Systems Approach to Healthcare reform](#). PWC: Canberra, ACT, Australia. page 4.





- **Health literacy** and the ability to navigate the health system is a key prevention activity. The World Health Organization reports that inability of consumers to find, understand and use information about health and healthcare is associated with poorer overall health outcomes. Poor health literacy is attributed to an increased risk of adverse health events and higher healthcare costs.
- **Reducing the stigma associated with mental illness** is a critical step in prevention and early intervention for mental disorders. Community stigma and self-stigma are both addressed by increasing mental health awareness, knowledge and capacity in diverse communities via culturally inclusive promotion, prevention and early intervention initiatives.

From a life course perspective, risks to mental health begin in utero and can develop at different transition points in a person's life, from school, work to retirement. Hence, prevention and early intervention early-in-life, early-in-illness and early-in-episode across all ages (infant, child, adolescent, adult and aged) are important.

Early-in-life

Early detection of mental health issues and mental illness (including relapse prevention), followed by appropriate, timely intervention, and support can significantly reduce the severity, duration and recurrence of mental illness and its associated social disadvantage, no matter when in life the episode or episodes occur. Research has shown a case for prevention during the early years through:

- prevention and early intervention in perinatal depression where that poor perinatal mental health and disrupted relationships between a primary care giver and infant / child can produce long-lasting adverse impacts on emotional, physical and cognitive health and development;
- universal programs for all families and targeted programs for parents of children at risk of mental ill health, or who are already experiencing behavioural difficulties, with known benefits in the long term to the health, education, social service, criminal justice, and employment sectors upon reaching adulthood; and
- school programs that deliver mental health promotion and early identification of children and young people at risk of mental illness; as such, schools are the ideal settings for the delivery of many interventions.⁴

Intervention early-in-life includes universal and targeted approaches to build resilience. Helping children to deal with the adversities experienced during childhood, provides a foundation for developing coping skills and healthy thinking habits that enable them to deal with adversities during adolescence and adulthood.

The National Mental Health Commission (NMHC) recommends embedding prevention and early intervention initiatives early on in life, through service models that integrate health, mental health, education and other relevant sectors, in the context of a stepped care approach. Unlike strategies targeted to earlier points in the life course, approaches to protect mental health in older ages have not received as much attention. Available evidence has shown that actions targeted at groups of older

⁴ David McDaid, A-La Park, Kristian Wahlbeck. [The Economic Case for the Prevention of Mental Illness](#). Annual Review of Public Health 2019 40:1, 373-389





people who are at high risk for depression (e.g. those with chronic physical illness, or the bereaved) can be effective, along with the emerging evidence on the cost-effectiveness of non-medical interventions to tackle social isolation and loneliness.⁵

Early-in-illness

Early detection of mental health issues not only improves clinical outcomes, it also greatly improves the likelihood of completing education and training, retaining or securing opportunities for employment, maintaining stable accommodation, and reduces adverse outcomes such as involvement with the corrections and justice system, and disconnection from family and community.

PHN-commissioned youth initiatives include headspace centres and community-based services for young people with severe mental illness. PHNs use local knowledge, experience and expertise to commission region specific, cross-sectoral approaches to early intervention for young people with or at risk of mental illness. Victorian PHNs work closely with the headspace centres, lead agencies and consortia partners with the view of integrating headspace with other services at a regional level. In addition, PHNs address the lack of and need for services for young people with severe mental illness and complex needs, for example by commissioning youth enhanced services (e.g. Eastern Melbourne PHN), providing additional support for headspace centres through specialised workforce and assertive outreach services (e.g. South Eastern Melbourne PHN), and through the suite of services.

It is noted that there is an absence of integrated initiatives to support and optimise the development and wellbeing of the zero to 12-year-old cohort. Challenges exist in accessing specialist child and adolescent psychiatric specialists in outer regional and rural areas. General practitioners, other primary health professionals, and paediatricians have indicated the merits of clinical support structures that strengthen the capacity to deliver early identification and interventions of mental health conditions which better meet the needs of the cohort.

PHNs are not placed to comprehensively address funding of children's services. Therefore, partnerships across the Victorian Government, PHNs and non-government organisations are required to deliver innovative and integrated services to improve outcomes for children.

Early-in-episode

The early intervention and continuous monitoring of mental illness can maximise a person's chances of a fast recovery, self-sufficiency, and meeting individual life goals, including the possibility to pursue education and maintain stable employment.

The introduction of the National Disability Insurance Scheme (NDIS) will provide comprehensive and individualised support for people with severe and disabling mental illness; however, there is a gap in services for people with severe, episodic mental illness deemed ineligible for the NDIS. To address this gap, PHNs have commissioned psychosocial support services to assist people with severe mental illness to participate in activities, manage daily tasks, undertake work or study, find housing, and make connections with family, friends and community. In parallel, the Victorian Government DHHS, through 17 LHNs, commissioned the same psychosocial services, for the same target population (people with

⁵ David McDaid, A-La Park, Kristian Wahlbeck. [The Economic Case for the Prevention of Mental Illness](#). Annual Review of Public Health 2019 40:1, 373-389

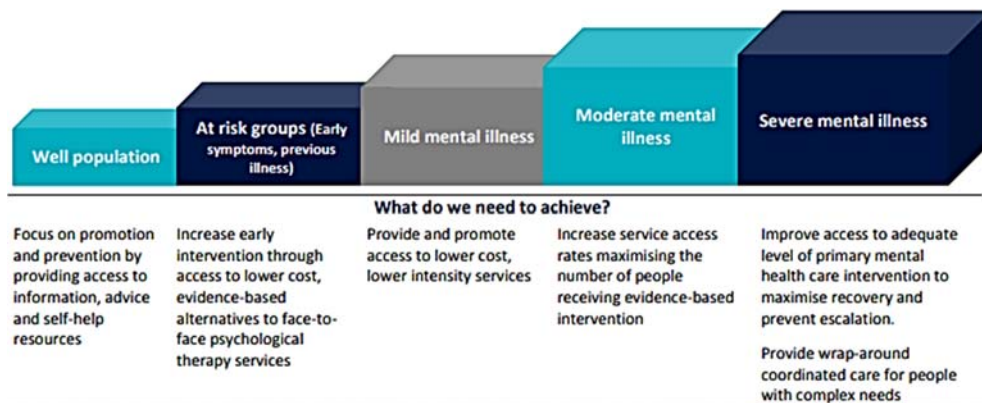




severe mental illness not yet or not eligible for NDIS), with largely the same set of service providers. The parallel approaches represented a missed opportunity for the Victorian Government and PHNs to jointly commission psychosocial support services that are easy to navigate and of high-quality, at the same time achieving greater resource efficiencies.

The national Mental Health Stepped Care Model for mental health aims to deliver the best possible care for people experiencing mental illness and to make care available in a way that best suits consumers (refer Figure 1). This is undertaken through the provision of a suite of mental health services across all ages, including evidence based psychological interventions for children and families.

Figure 1. National Mental Health Stepped Care Model



Source: Australian Government, [Stepped care: PHN primary mental health care flexible funding pool implementation guidance](#)

The stepped care approach facilitates access to, and provision of the following:

- digital mental health services for the ‘at risk groups’ with early symptoms and / or previous illness;
- low intensity face-to face psychological services interventions for people with mild mental illness; and
- face-to-face clinical services in a primary healthcare setting with support from psychiatrists for people with moderate to severe mental illness as required, in collaboration with secondary and tertiary mental health services.

The stepped care approach not only provides a platform for delivering a range of services to address local mental health needs, but also provides a reference framework for GPs to understand the range of primary healthcare services available for different intensity of mental illness, and age groups in the region.



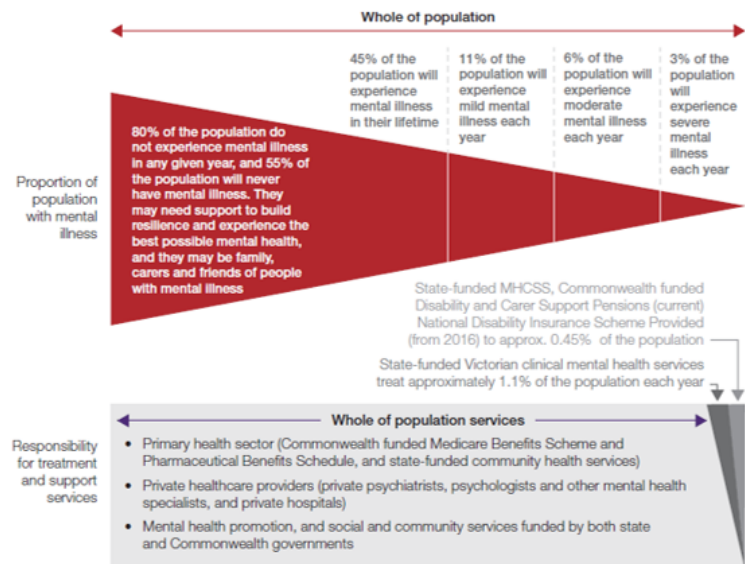


Challenges experienced in realising a stepped care approach

The range of interventions provided through the national Mental Health Stepped Care Model covers the continuum of care, supporting consumers to move fluidly as needs and circumstances change, with ongoing reviews to determine whether a step-up or step-down in care is required.

The stepping-up of care requires a reliable and responsive interface with tertiary mental health services and establishing and strengthening this interface with LHNs. This has been particularly challenging for the Victoria PHNs with service coordination made more difficult by the geographic catchments of LHNs not aligned both in terms of aged-based service groupings (e.g. child and youth with adult area mental health services and older person's mental health services) and with PHN boundaries.

PREVALENCE OF MENTAL ILLNESS IN THE ADULT POPULATION



Source: Victoria's 10 year mental health plan (2015)

PHNs and LHNs are tasked with regional population-based planning and prioritisation of mental health services, including suicide prevention services and facilitation of place-based solutions. Stepped care is central to the Commonwealth Government's mental health reform agenda, as such, joint regional mental health planning by PHNs and LHNs, and subsequent co-commissioning of services need to be organised through a stepped care approach.⁶ LHNs require a sound understanding of the national Mental Health Stepped Care Model to facilitate partnership with PHNs in developing practical pathways and capabilities to enhance acceptance of referrals, deliver more assertive follow-up, family support and acute care to achieve better outcomes.

Another challenge is the structural service gap between the 1.1% of the adult population that State-funded Victorian clinical mental health services treat each year versus the 3% of the population that will experience severe mental illness each year.⁷ Consequently, the national Mental Health Stepped Care Model is relied on to deliver services that can cater to the needs of the 1.9% of people with severe mental illness not seen by State funded services. For example, within the North Western Melbourne PHN catchment, CareinMind provides clinical nursing services for people with severe mental illness and other complex needs. These services deliver medication support, care co-ordination and liaison (clinical and non-clinical services), family support and liaison, and improving access to psychiatrist and psychological care.

⁶ Australian Government, Department of Health, [Stepped care: PHN primary mental health care flexible funding pool implementation guidance](#), n.d., p. 1.

⁷ Victorian Government, Department of Health and Human Services, [Victoria's 10-year Mental Health Plan](#), November 2015, p. 8





The national Mental Health Stepped Care Model, Medicare Benefit Scheme (MBS) funded services, and the private system are therefore required to deliver a range of mental services for effectively 98% of the population.

2. Invest in services that bridge tertiary care with primary healthcare

Across the care continuum, the Commonwealth Government, including PHNs, address needs of people with mild-to moderate conditions comprising much of the population, while Victorian Government funded services are theoretically providing care for people at the severe end of the mental illness spectrum.

A significant number of people fall in the middle range of this spectrum, with more complex needs than can generally be effectively managed by GPs and primary health providers but not considered 'severe enough' to be able to access specialist state funded mental health services. These people experience combinations of moderate and complex mental illness, issues with alcohol and other drugs, comorbid physical conditions and other social issues, and are at risk of falling through the service gaps within the health system. The group also include a significant number of people with mental health conditions who are too complex for primary healthcare but not severe enough to qualify for tertiary clinical care including hospital admission, or access to NDIS package of community-based support and care.

The Victoria Government's lack of investment in secondary mental health services has resulted in resources from PHN procured stepped care services being diverted towards the moderate and severe end of the service continuum. To address the gap and better support primary healthcare providers, some PHNs (e.g. Eastern Melbourne PHN) have resorted to commissioning new services that provide general practices access to secondary consultation and advice from private psychiatrists and mental health nurse practitioners.

Funding service models that can respond to the needs of this 'middle' group can reduce preventable hospital presentations and admissions, and more importantly, provide integrated and seamless community-based care that is responsive to people's changing needs, whilst simultaneously achieving allocative efficiencies.

It is therefore critical to address this issue by giving more priority to secondary mental health services, both clinical and non-clinical, to bind primary and acute systems and create a more durable continuum of care.

Addressing the need for secondary mental health services in Victoria is a shared challenge which requires investment and support from all levels of government and across different funders and service providers, including the private sector, in order determine workable solutions.

Investment in secondary service models to address the needs of people with high prevalence disorders and complex needs (such as trauma / AOD / suicidality / personality disorders etc.) could support the following components:

- multidisciplinary teams (comprising psychiatrists, allied health professionals, and peer workers);
- access to mental health specialist expertise across all age cohorts to provide primary and secondary consultations, particularly for people at first presentation or who are experiencing early onset of illness and are not suitable for acute services;





- health professionals with expertise in AOD or dual diagnosis (co-occurring mental illness and AOD issues) and knowledge in navigating available services in the area; and
- support to enhance the capacity and capability of primary healthcare providers especially GPs.

Secondary mental health services with these components would not only address the needs of people falling in the middle range of the mental health service spectrum but would also assist in breaking down the silos between mental health and AOD through enhancing workforce capability.

This secondary mental health service would also include consultation services currently provided by a range of specialist mental health services. These statewide specialist services offer secondary mental health services but are delivered by and located in select metropolitan LHNs. Regionalisation of the following statewide specialist services has the capacity to strengthen any secondary mental health service model:

- Acquired brain injury or neurodegenerative conditions with associated psychiatric disorders (Royal Talbot Rehabilitation Centre and Mary Guthrie House);
- Personality disorders (Spectrum);
- Neuropsychiatry (The Royal Melbourne Hospital Neuropsychiatry Unit); and
- Dual disability - Developmental disability such as intellectual disability or autism spectrum disorders) and a mental illness (St Vincent's Hospital Melbourne).

To address the increasing prevalence of eating disorders, expansion of the community engagement and support services for eating disorders in regional areas is recommended (currently delivered by The Butterfly Foundation, Eating Disorders Victoria, and The Victorian Centre for Excellence in Eating Disorders). Replicating the treatment services for eating disorders (currently delivered by The Royal Children's Hospital, Austin Health and St. Vincent's Hospital Melbourne) is another consideration.

Secondary mental health service models with the aforementioned service components are possible joint co-commissioning opportunities not only between the Victorian Government and PHNs, but also with private health insurers and private hospitals.





3. Provide accessible and easy to navigate services

Access

The Victorian publicly funded clinical mental health services are grouped into age (child, adult, older people) and regional (metropolitan and rural) catchments with the consumer's place of residence determining which service they can access.⁸

The term 'access' is a multifaceted concept with five relevant dimensions to the client-service interaction namely: acceptability, affordability, availability, physical accessibility and accommodation.⁹

Victoria's 10 year Mental Health Plan (DHHS 2015 pg. 3) has two outcomes related to access also cited in the Victorian Auditor General's Report (VAGR) on Access to Mental Health Services (VAGRa 2019).

- Universal access to public services where people with mental illness and their families and carers have access to high-quality, integrated services according to their needs and preferences; and
- Access to specialised mental health services where people with mental illness and their carers and families have access to the public treatment and support services according to their needs and preferences.

Four years on, these two outcomes related to access have not been achieved in terms of availability (meeting demand), physical accessibility (geographical distribution) and accommodation (integrated holistic care).

Five dimensions of access

Acceptability: attitudes and beliefs of users and providers about each other's characteristics.

Affordability: cost implications to the patient in relation to need; this includes both direct and indirect costs and perceptions of value.

Availability: adequacy of supply given by the relationship between volume and type of services (provision) and volume and type of needs (demand).

Physical accessibility: defined by the suitability of the location of the service in relation to the location and mobility of the patient (geographical and physical barriers).

Accommodation: the way services are organised in relation to the client's needs and the patient's perception of their appropriateness (opening times, booking facilities, waiting times).

Source: Pechansky & Thomas 1981

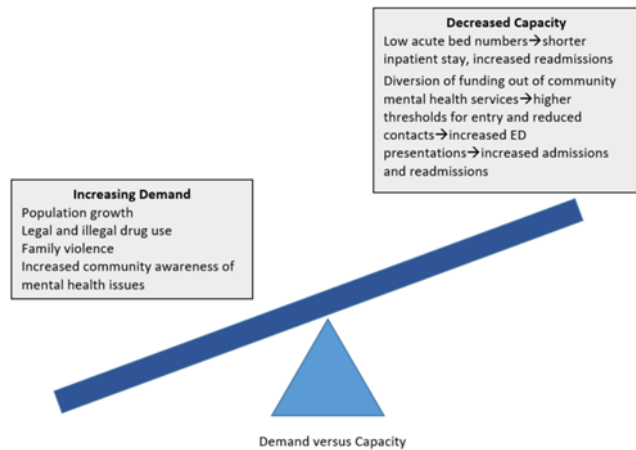
⁸ Victorian Auditor-General's Report (2019). [Access to Mental Health Services Report](#). Victorian Auditor-General's Office, Victorian Government Printer, March 2019.

⁹ Pechansky, R & Thomas, W. (1981). The concept of access. *Medical Care*. 19:127–40.





The recent Victorian Auditor General’s Report on Access to Mental Health Services acknowledged that the decade long funding shortfalls have resulted in LHNs’ Area Mental Health Services having ‘to focus on acute and crisis treatment at the expense of earlier intervention services in the community’.¹⁰ Consequently, the threshold to access community-based mental health services has increased, consequently, only those assessed to be in crisis are seen.

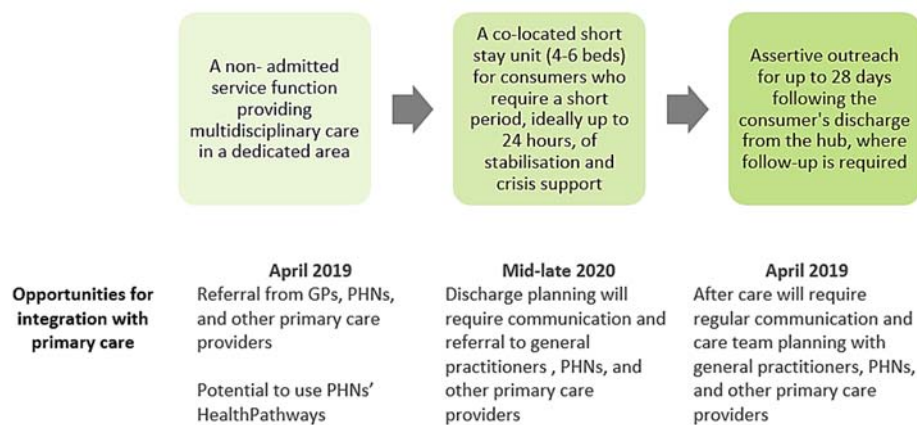


Access issues are more evident in rural and regional areas. Rural general practitioners treat the acutely mentally ill in general beds of the LHN due to lack of availability of, and inability to gain access to mental health beds in the larger centres.¹¹

To address increasing demand, the 2018-2019 Victorian Budget has funded Mental Health and AOD Emergency Department (ED) Crisis Hubs (ED Crisis Hubs) to provide a specialised stream of emergency department care for people presenting with high acuity mental health and AOD issues.¹² This is a welcome investment in mental health care but again focuses on the crisis and severe end of the system.

The six ED Crisis Hubs are located across four Victorian PHN regions. Early engagement with these PHNs will assist integration of services through promotion of this new service to GPs and General Practice staff, PHN referral and access services, and to the variety of primary healthcare providers in the region. Collaboration with primary healthcare providers in each element of the ED Crisis Hub service model has the potential to provide care that is more integrated thereby increasing the likelihood of delivering better consumer outcomes and experience of care (refer Figure 2).

Figure 2. ED Crisis Hub service model and opportunities for integration with primary healthcare



¹⁰ Victorian Auditor-General’s Report (2019). Access to Mental Health Services Report. Victorian Auditor-General’s Office, Victorian Government Printer, March 2019, page.41.

¹¹ Hungerford, C. (2006). Treating acute mental illness in rural general hospitals: Necessity or choice? *Aust J Rural Health*. Aug; 14(4):139-43.

¹² Victorian Government, Department of Health and Human Services, [Victoria's mental health services annual report 2017–18](#), October 2018, p. 39.





To address the increasing demand for services in major growth areas, the Victorian Government has committed \$675 million to build ten Community Hospitals that aim to transform the way healthcare is delivered in suburban and regional Victoria, improving access to care for communities close to home when needed.

The range of health services in each Community Hospital will be tailored for each community with services ranging from early intervention, primary and community care, and day hospital services, all aimed at managing health needs locally. Services may include community mental health, AOD and chronic disease management programs. Hence, there is an opportunity for Community Hospitals to deliver coordinated programs that can collectively address the physical, mental health and AOD needs of people living in growth corridors where service offerings are limited. The program, managed by the Victorian Health and Human Services Building Authority, constitutes an investment to upgrade or expand existing health services and support new developments, with construction expected to start by 2022 and finish by 2024. The ten Community Hospitals will be in five PHN regions in areas where PHNs have already significantly invested in programs and services based on the respective population health needs assessment.

The Victorian Government must actively engage PHNs in the planning of the ED Crisis Hubs and the Community Hospital program. The early and thoughtful consideration to engage with PHNs, local GPs and the broader system in the planning of these two programs is an excellent opportunity to provide well-integrated local networked services. Otherwise, the risks remain that these two new programs may just end up improving discrete parts of the system without careful consideration of the underlying system constraints and need for stronger links with the broader health system.

Navigation

Inadequate coordination of planning and service delivery has led to a service environment that is difficult to navigate, with silos and duplication across providers and funders (because of lack of clinical and organisational accountabilities within and across services), and inadequate targeting of efforts. This is further impacted by a lack of capacity for localised service delivery models to effectively and efficiently flex and adapt in response to ongoing changes in need.





The current structure of Victoria’s clinical mental health system makes navigation difficult, if not impossible, for consumers, families and carers, GPs and other service providers. This is significantly more challenging for people who require support from multiple services, particularly in the absence of service coordination and universal records.

There are several limitations associated with the current LHN Area Mental Health Service model. Local Hospital Networks manage different age components of the service requiring multiple and various types of collaborative arrangements are required because publicly funded clinical mental health services. There is also a lack of internal alignment, with clinical catchments not aligned across the three age-related components child and adolescent (0-18 years), adult (16-64 years) and aged persons (65+ years). The current range of services include:

- 13 child and adolescent mental health services provided in five metropolitan and eight rural catchments
- 21 adult mental health service provide in 13 metropolitan and eight rural catchments
- 17 aged person mental health service provided in nine metropolitan and eight rural catchments.

The situation is compounded by a mix of eligibility arrangements, with some services treating young people up to the age of 25 (child and youth mental health services or CYMHS) whilst other youth services only treat people up to 18 years (child and adolescent mental health services or CAMHS), as highlighted in the Victorian Auditor-General’s Report on Child and Youth Mental Health.¹³ According to this report, the inconsistency in age eligibility across services is attributed to an incomplete rollout of the CYMHS model following a change of government.¹⁴

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, aged) and across services. Reform with the goal of improving value for the consumer will involve commitment and funding for a multi-year implementation plan that includes:

- reviewing legacy service delivery models and payment structures;
- shifting to funding models and service distribution based on population needs that considers the changing demographics;
- consideration of a ‘whole-of-life’ area mental health service model that is significantly aligned to both PHN and local government area boundaries; and
- permeable rather than restrictive catchment boundaries, aligned with primary healthcare services, facilitating a flexible and joined-up system that is focused on the needs and views of consumers and which maximises the potential to participate.

The multitude of access and navigation issues discussed in this section highlights the need for a system redesign because as it stands, the design of Victoria’s publicly funded mental health system limits its performance.

¹³ Victorian Auditor-General’s Report (2019). [Child and Youth Mental Health](#). Victorian Auditor-General’s Office, Victorian Government Printer, June 2019.

¹⁴ Ibid, page 9.





4. Ensure comprehensive and consistent support for individuals, families and carers

The National Mental Health Commission reported that people living with mental illness and families and carers often had a poor experience of care, in part because the system was fragmented and did not consider all aspects of a person's life.¹⁵

The Fifth National Mental Health and Suicide Plan (2016) recognises and emphasises the essential role of consumers and carers in overseeing improvements across all areas of mental health care particularly in regional planning and service delivery (*Priority Area 1*), reducing stigma and discrimination (*Priority Area 6*), and safety and quality in mental health care (*Priority Area 7*).

An improvement in an individual's mental health can provide flow-on benefits not just in terms of increased social and economic participation, engagement and connectedness, and productivity in employment, but also in lowering the burden on informal carers and in promoting more rewarding relationships with family and friends.

Families inevitably must take on the role of informal carers coordinating healthcare, providing emotional support, and assisting with day-to-day living. The potential impact on informal carers includes reduced workforce and education participation and mental health risks.

The introduction of NDIS and the transition of Victorian Government funded Mental Health and Community Support Services (MHCSS) will likely impact negatively on carer supports and services in the short-term, however it is acknowledged that the NDIS has the potential to reduce the need for carer services if implemented as intended.

The new Commonwealth funded Integrated Carer Support Service (ICSS) will deliver a suite of services through Commonwealth, Victorian and Local Government and non-government providers including the NDIS, for carers including in-person and phone-based coaching, counselling and peer support, access to emergency crisis support, and service navigation assistance.¹⁶

The ICSS model was developed through extensive consultations, and although not yet fully implemented, will have six service areas in Victoria aligned with each PHN region.

Advantages of this model include:

- a smaller number of service areas which means each service area has a higher number of carers, making service delivery more viable for providers;
- 'economies of scale' in the administration of services, which in turn maximises the amount of program funds that can be directed to support carers;
- new service areas located within state and territory borders thereby removing the added complexity that occurs when services deliver across jurisdictions;
- recognition that rural and remote regions have quite different characteristics that are best served by treating them as distinct areas for service delivery;

¹⁵ National Mental Health Commission (2014). [Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programs and Services](#), National Mental Health Commission Sydney.

¹⁶ Australian Government Department of Social Services. [Integrated Carer Support Service Model](#), 3 April 2019.





- alignment with PHN boundaries provides the opportunity to leverage the needs assessment process undertaken by the PHNs with potential to provide insights into carer needs within the service area;
- provision of opportunities to identify hidden carers via the health services linked to PHNs; and
- opportunities to leverage existing patterns of service partnerships or collaborations.

The ICCS model, appears to be well planned and designed, taking into consideration the importance of aligning with existing service structures. The Victorian Government should consider the design elements of the ICSS model in commissioning family and carer support services, and as part of its overall review and redesign of the mental health service system.

5. Integrate mental health with alcohol and other drugs (AOD) and other services

There is a high rate of people concurrently experiencing from both mental ill health and addiction often requiring treatment or support for both issues. Structural differences between the AOD treatment sector and the community mental health sector, such as differing service models, historical practices, workforce capability, and funding silos, make it challenging to deliver holistic and integrated services that are easy to navigate.

In the previous decade, the Victoria and Commonwealth Governments have both allocated a range of funding streams to enhance the capacity of AOD treatment services and mental health services to respond to consumers with concurrent mental ill health and addictions. Some of the capacity building components funded included training and professional development for staff and community training to improve literacy and destigmatise mental illness and substance use.

The Victorian Government funded the Victorian Dual Diagnosis initiative (VDDI) in 2001 as a cross sector approach involving AOD, MHCSS and clinical mental health providers, to develop clinician, agency and sector capacity and capability to recognise and respond effectively to people with co-occurring mental ill health and substance use concerns. Victorian Dual Diagnosis initiative services were structured to foster sector collaboration. The VDDI has been successful in improving access to treatment and building stronger pathways for people with serious drug and alcohol issues and co-occurring mental illness. However, over the past few years, oversight and support for VDDI have waned and is currently only sustained by the remaining workforce including dual diagnosis champions passionately trying to improve treatment outcomes through an integrated system of care. The VDDI is one of several worthwhile and initially well-funded mental health policies that unfortunately has petered out from lack of follow-through, a consequence of competing funding priorities and changes in the policy environment (e.g. transition of MHCSS to NDIS). The VDDI workforce may be better placed as part of the proposed secondary mental health service, providing the much-needed expertise and advice to the primary healthcare sector.

The development of packages or bundles of care to provide integrated care arrangements for people with mental illness and co-occurring AOD, as well as other health and social complexities (e.g. homelessness), should be another consideration. A primary healthcare model that is supported by blended bundled funding, has the potential to incentivise alignment and collaboration between health





service providers across the care continuum, resulting in partnerships across specialties and settings that maximises quality and efficiency, and improves patient outcomes.

Integration between AOD, mental health and primary healthcare services is at the core of PHNs' commissioning approach. PHNs have commissioned primary healthcare focused AOD services that address not only co-occurring mental illness but other complex physical conditions and social issues including chronic disease, family violence and homelessness.

The funding allocated to Victorian PHNs for AOD and mental health is limited, requiring collaboration and partnership with other funding bodies, such as the Victorian Government, to identify and action opportunities that enhance the AOD treatment system. Working together to jointly commission integrated services can potentially reduce barriers to treatment such as stigma, culture, distance, appropriateness, and waiting times. Pooled efforts between state and PHNs will deliver accessible, easily to navigate entry points and care pathways that achieve coordinated care.

6. Address regional and rural workforce gaps

The mental health workforce includes a variety of professionals across a range of treatment settings, who are funded through different levels of government and in different departments. Professionals include psychiatrists, mental health nurses, general registered nurses, enrolled nurses, general and other medical practitioners, occupational therapists, social workers, psychologists, Aboriginal mental health workers, consumer and carer consultants, and peer workers.

In Victoria, there are insufficient mental health workers particularly in rural and remote areas with the recruitment, retention and management of the workforce identified as significant obstacles in the provision of accessible services.¹⁷

The mental health workforce, particularly in rural and remote areas, experience challenges including fewer options for referral, lack of specialist services, lack of career opportunities, long hours with on-call requirements, and substandard accommodation. Inadequate remuneration, lack of professional development opportunities, loss of anonymity in small communities, lack of opportunities for spouses and children, and professional isolation, also contribute to difficulties in the recruitment and retention of experienced professionals. Remote area workforce safety is also of concern, as staff may experience inadequate staffing levels, night calls and violence in the workplace.

In primary healthcare, there is lower utilisation of mental health specific MBS items in the outer regional and remote areas of Victoria. This situation is not reflective of population need but rather an indication of limited access to an appropriate workforce such as GPs and qualified mental health professionals. The 2014-15 MBS data on mental health specific services in Gippsland, Victoria illustrates this issue (overleaf).

¹⁷ Victorian Auditor-General's Report, [Access to Mental Health Services Report](#), Victorian Auditor-General's Office, March 2019, p.9





In contrast to the lower utilisation of mental health specific MBS items, regional and remote areas have a higher rate of prescription medications for mental health medications, including anti-depressants, likely attributed to the lack of referral options in the area, particularly for psychological therapies.

MBS data for mental health service provision in Gippsland:

- East Gippsland has the lowest proportion of its population claiming a mental health item (7.3%), while Baw has the highest proportion claiming (11.1%).
- Gippsland service provision was provided primarily by allied health professionals (38% compared to 28% for Australia) and GPs (34% compared to 30%), with less services provided by psychiatrists (14% compared to 24%) and clinical psychologists (14% compared to 18%).
- East Gippsland and Wellington residents have an especially low usage of psychiatrists and clinical psychologists compared to other Local Government Areas.

Source: Department of Health, MBS mental health items by patient for PHN and SA3, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Health_Data

Improving access to suitable services in regional and remote areas requires flexible tailored workforce solutions. Workforce solutions may be networked across service providers to ensure viability. Improving access to telehealth and use of digital mental health options have been utilised to address workforce shortages, albeit not comprehensively and consistently. There remains a need to address the systemic issue of workforce shortages beginning with collecting and understanding quantitative (numbers / remuneration) and qualitative (types / context) workforce data, followed by developing a comprehensive capability framework. These information sets will assist in planning, monitoring and evaluation of the effectiveness of the Victorian mental health workforce.

PHNs welcome the establishment of the Victorian Centre for Mental Health Learning (CMHL), the new central agency for public mental health workforce development (including people with lived experience) that will support access to quality, contemporary learning and development. CMHL's online workforce development activities will also be available to NGOs, PHNs and the private sector.

Workforce learning and professional development is just one part of the broad umbrella of workforce development, with the deficit of suitable workforce in regional and remote areas requiring a range of strategies including investment in more upstream approaches. Dedicated approaches are also required to support the Aboriginal and Torres Strait Islander workforce who are identified as integral in achieving a culturally responsive mental, social and emotional wellbeing system. Culturally safe mainstream services and service providers are also acknowledged as having an essential role in achieving this objective.

The mental health peer workforce is another important element of the wider mental health workforce and of the multidisciplinary team environment. The peer workforce represents an important evolution in workforce development, but governance arrangements will need further refinement to ensure proper utilisation of this valuable resource.

Despite LHNs and PHNs collectively recognising the value of the mental health workforce, each service funds positions and training opportunities separately and in parallel. This situation results in differences in the structures, remuneration, and opportunities for career progression that can be disincentives for mental health workforce retention.





Systematic and collaborative approaches are likely to be required to address workforce issues, including embedding the peer, indigenous and diverse mental health workers within the workforce framework to augment the effectiveness of programmes and services.

7. Improve the clinical governance processes at a regional level to ensure safe service responses for consumers

The DHHS is responsible for facilitating and monitoring the safety and quality of care in mental health services delivered by LHNs. DHHS are supported by Safer Care Victoria and Victorian Agency for Health Information (VAHI) as administrative offices.

Effective governance is a prerequisite for high-quality healthcare delivery. In Victoria's devolved governance arrangement, the Boards of LHNs play an active role in the pursuit of safe and high-quality care of respective organisations.

In 2014, DHHS contracted The King's Fund to undertake an independent review of Victoria's devolved governance of health services. The report acknowledged that the principles of devolved governance were fundamentally sound; however, it recommended greater DHHS involvement in both the planning and oversight of clinical services including making incremental improvements and avoiding damaging and destabilising changes.¹⁸ Transparent reporting of performance data was identified as an area for improvement with the aim to strengthen accountability to the public, support health care providers to compare performance with others, identify areas for improvement, and as 'a powerful means of providing an early warning of performance problems'. Increased transparency and more readily available data on safety and quality would also provide LHN boards with the information needed to discharge responsibilities.

A 2015 study conducted by Leggat and Balding explored the impact of the organisational quality systems on quality of care in Victorian health services.¹⁹ The study revealed that there was a significant gap between board and senior management aspirations and beliefs about point of care quality, and the on-the-ground reality. Quality system confusion, over-reliance on compliance, and inadequate staff engagement contributed to the gap. The authors recommended five essential actions to assist LHN boards to close the gap and increase the relevance and robustness of clinical governance.²⁰

A shared clinical governance framework between the Victorian Government DHHS and the six Victorian PHNs is considered essential. A shared clinical governance framework would support a shared understanding of clinical governance (irrespective of service funding source) and would establish a shared responsibility for safe and high-quality mental health and suicide prevention activities which foster continuous improvement.

¹⁸ C Ham, & N Timmins, [*Managing health services through devolved governance: A perspective from Victoria, Australia*](#). 2015, London: Kings Fund, p. 5.

¹⁹ SG Leggat & C Balding C, '[Bridging existing governance gaps: five evidence-based actions that boards can take to pursue high quality care](#)', *Australian Health Review*, 2017, vol. 43, pp. 126-132.

²⁰ *Ibid*, page 131.





8. Co-commissioning

Although commissioning can stimulate improvements in quality, access, and value for money, it has the potential to fragment care and disrupt relationships between services. Commissioning approaches can contribute to system fragmentation when:

- there are multiple commissioning bodies operating in the same sector but delivering parallel and unaligned initiatives, with different accountability requirements;
- physical and mental health care is separated for people with mental illness despite being inextricably linked;
- commissioned services are too narrowly defined;
- partnering providers must then compete for contracts;
- successful tenderers have minimal connections in the area; and
- procurement is based on cost rather than quality (and potential for integration).

Both governments have a strong commitment to integrating care however it is acknowledged that this goal is challenging to obtain due to the different funding mechanisms that exist between States (through LHNs) and the Australian Government (through PHNs).

PHNs and LHNs working together will have a greater impact on local health outcomes than either body working alone. It is therefore reasonable, where appropriate, to try to pool resources and consider joint approaches to commissioning and service procurement. It is also important to acknowledge that local governments and Victorian Government departments such as the Departments of Education and Justice and Community Safety administer services that contribute to ‘mental health care’.

PHNs and LHNs can work together to advance and improve the regional mental health care delivery architecture and enable system integration. Regional and local planning efforts will have a collective vision, built through a genuine process of co-design, consultation, partnership and the shared use of data and evidence.

The Victorian Government, LHNs, and Aboriginal Community Controlled Health Services, have made a commitment to actively engage and participate with PHNs in regional and local mental health, and suicide prevention planning.

Strengthening regional mental health planning processes will enable both PHNs and LHNs to target investment decisions, and to commission appropriate programs that elicit greater outcomes for consumers, address gaps and inequity.

Diverse accountability lines, agreements, funding streams and organisational key performance indicators, can make strategic regional partnerships challenging. Formalised governance structures are required to optimise partnerships that enhance the coverage, quality, integration and effectiveness of services.

Regional planning

Regional mental health needs analysis can inform local service demand and identify gaps to include: local prevalence; regional population mental health needs by geography, age, gender and underserved target population groups; and projected mental health care demand profiles, including emergency department presentations, admitted patient hospitalisation, suicide rates, self-harm rates.

Delivering sophisticated regional needs assessment using robust analytical processes requires data sharing agreements, investment in infrastructure and support. Key findings from the needs assessment will support regional planners to identify characteristics and mental health priorities for the region.





Partnering with PHNs to achieve an integrated mental health system will require commitment from the Victorian Government to:

- Endorse a formalised approach to planning, funding and oversight of mental health and suicide prevention services, where system improvement and improved health outcomes are the focus irrespective of political cycle.
- Adequately invest in capacity to deliver on:
 - Regional Planning of Mental Health and Suicide Prevention as mandated in the Fifth National Plan which has the potential to facilitate partnerships and deliver innovative models of care
 - NDIS implementation of services for people with psychosocial disabilities related to mental health
 - action against the recommendations of the Royal Commission into Victoria’s Mental Health System and the Victorian Auditor General’s Office Reports on Access to Mental Health Services and Child Youth Mental Health
 - alignment of mental health and alcohol and other drug approaches, and distribution of services relative to need and local service context
 - shared data and intelligence to inform planning and service development.

Upstream and downstream approaches to promote mental health and manage mental illness are complex undertakings, as such, will benefit from collaboration with PHNs to deliver place-based systems rather than a one-size-fits-all approach.

Do we need a Victorian Mental Health Commission?

In aiming to achieve an integrated mental health system, the Commonwealth and four State governments have gone the way of establishing Mental Health Commissions.

Mental Health Commissions are independent statutory agencies responsible for monitoring, reviewing and improving mental health and wellbeing for the population. Mental Health Commissions are uniquely placed to work in strong partnership with people with lived experience and carers, the community, service providers, government, non-government and private organisations, industry, clinicians, and academic institutions. Mental Health Commissions also work across government agencies including housing, health, education, employment, justice and disability.

Aside from the NMHC established in 2012, there are Mental Health Commissions in Queensland (QMHC), New South Wales (NSWMHC), Western Australia (WAMHC) and South Australia (SAMHC) which vary in functions and form.²¹

The WAMHC established in 2010, provide whole-of-government policy advice and allocate funding for mental health services delivered by government and non-government service providers. The QMHC was

²¹ Public Service Commission (2016). [Queensland Mental Health Commission effectiveness review](#). State of Queensland.





set up under the Queensland Mental Health Commission Act 2013 with separate functions from the Queensland Department of Health, to provide greater capacity to influence and leverage reform.

A Victorian Mental Health Commission (VMHC) could be comparable to and linked with the NMHC, providing leadership, fostering partnerships, giving independent advice on required system reforms, and with the capability to identify opportunities for joint initiatives that align with both State and Commonwealth plans and priorities.²²

The Victorian PHNs operating as an Alliance would be placed to work closely with any structure to ensure that there is a balance between regional responsiveness and statewide consistency. The Alliance considers that delivering an integrated mental healthcare system is achievable through strong collaboration between the six PHNs, the Commonwealth Government, and the Victorian Government.

Commitment has already been formalised through the Memorandum of Understanding (MoU) between DHHS and Victorian PHNs executed in 2018.²³ Early work includes defining the scope of primary health care; establishing principles to guide prioritisation of effort; describing the governance of the strategic partnership; and identification of enablers, platforms and shared resourcing. Place based planning, data sharing, joint or co-commissioning, are some of the priorities included in the MoU.

9. Accountability for consumer outcomes and the delivery of high-quality person-centred care

Once recommendations have been made and reforms planned, initiated and generated, consideration must be given on how these would be monitored and managed to create accountability to the Victorian community on its investment. This paper has highlighted several examples where sound policy has yielded comprehensive programs that have subsequently eroded due to an apparent lack of solid performance management and monitoring. It is not adequate to fund services and not comprehensively monitor the outputs and outcomes for people who live with mental illness.

Building accountability will require an agreed mandate and set of indicators, as well as utilisation of levers and incentives. Focusing on accountability would not only help generate a system-wide perspective on health sector reform but identify connections among individual improvement interventions.

These results can support synergistic outcomes, enhance system performance, and contribute to sustainability. A sharpened focus on accountability can help identify gaps in strengthening efforts and environmental constraints that extend beyond the health sector.²⁴

²² National Mental Health Commission, [The National Review of Mental Health Programmes and Services](#), 2014, vol.2, National Mental Health Commission, Sydney

²³ Please contact Jade Hart, VTPHNA for more information

²⁴ Brinkerhoff, Derick. January 2003. [Accountability and Health Systems: Overview, Framework, and Strategies](#). Bethesda, MD: The Partners for Health Reform *plus* Project, Abt Associates Inc. page 3.





Implementing the recommendations

PHNs noted that the Victorian Government has made a commitment to accept all the recommendations of the Royal Commission in Victoria's Mental Health System.²⁵

The planning and fidelity of recommendation implementation is considered fundamental to the success of the commission and associated reform process. This may require a fundamental review of roles and how these are delivered synergistically amongst parties. There is a need for sufficient attention to the heterogeneity that exists across population and places. A mainstream approach which is focused on a narrow perspective of State Government roles and state funded service provision in the absence of all others, will have its limits.

The Alliance proposes the following considerations for implementation planning:

- **Comprehensive implementation planning that is both consumer and sector responsive**
The approach to implementation planning must not be limited to strategies that improve the clinical mental health services in isolation; it requires broadening to include a whole-of-government and cross-sectoral approach.
- **A coordinated Victorian approach to achieve value for the health system**
A cost-effective approach may be facilitated through a formalised, collaborative and regional approach whereby the vision for care is incorporated into broad but nationally consistent pathways. Outputs of this type may mitigate issues of unwarranted clinical variation and potentially conflicting messages. This is considered essential for ensuring both a user-oriented approach for consumers and service providers who may traverse PHN catchment boundaries, and to address the Victorian Government's focus on realising value. There may be implications for PHN schedules and resourcing commitments to support the efforts described in the recommendations.

²⁵ Media release. [Giving Victorians A Voice At The Mental Health Royal Commission](#). 17 April 2019, Office of the Premier, Melbourne, Australia.





Supplemental detail: Context for response

Appendix 1. Primary Health Networks

The objectives of Primary Health Networks (PHNs) are to increase the efficiency and effectiveness of medical services and improve coordination of care to ensure patients receive the right care, in the right place, at the right time. PHNs apply a regional perspective, informed by the needs of consumers, carers, and communities examining and supporting:

- the health workforce
- organisational processes
- networked systems of care.

PHNs are change agents for health improvement at the 'meso' or middle layer of the Australian primary healthcare system, acting as a conduit between individual providers / services and State, Territory and Commonwealth Governments. PHNs provide a nationally consistent infrastructure for solutions design and implementation support at the local level. Central to this are inclusive and participatory methods involving consumers and providers to design and achieve change. PHNs achieve objectives by:

- Understanding the health care needs of PHN communities through analysis, planning in collaboration with clinical and community / consumer advisory groups (and other consumer engagement and co-design mechanisms), while maximising value and efficiency.
- Providing practice support services so that GPs are better placed to provide care to patients subsidised through the MBS and Pharmaceutical Benefits Scheme and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals.
- Supporting general practices in attaining the highest standards in safety and quality through showcasing and disseminating evidence of best practice. This includes aggregating and reporting data to support continuous improvement.
- Assisting general practices in understanding and making meaningful use of digital health systems, to streamline the flow of relevant patient information across the local health provider community.
- Working with other funders of services and purchasing or commissioning health and medical / clinical services for local groups most in need.

The Victorian and Tasmanian PHNs support the primary healthcare services using system levers in a range of ways.

As an improvement partner – PHN provider and whole-of-organisational support for quality improvement efforts. PHNs are one of several primary healthcare service improvement partners, which is reflective of inter-organisational or networked approaches to patient safety and quality. Victorian and Tasmanian PHN contributions include:

- Facilitating all general practice staff to have access to meaningful data analytical capability using data, and supporting data integrity
- Collaborative approaches to change implementation, involving clinical support and networking





- Delivery of continuous professional development training for the primary healthcare workforce including GPs, nurse / nurse practitioners, allied health and pharmacy.

As a commissioner – PHNs commission primary healthcare services in areas of community need and operate consistent with the relevant clinical governance policies and protocols. This includes commissioning of the following:

- Mental health stepped care services, utilising a diverse mental health workforce, including allied health professionals, mental health nurses, and other workforce structures.
- Alcohol and other drug services, general practices and community pharmacies for the provision of afterhours support
- Providers to assist Aboriginal and Torres Strait Islander people access primary healthcare services and better manage complex and chronic health needs through care coordination and outreach support.

PHNs provide a unique contribution to system capacity to advance **safety and quality** within primary healthcare.

As a commissioner, PHNs have a role in developing and shaping primary healthcare services to deliver evidence-based models of care across a geographical area. These services are understood as ‘the market’ in economic terms, and the task of procuring primary healthcare services cannot occur in isolation of market development to mitigate the risk of market failure. PHNs have a lead role in working alongside primary healthcare services and fostering a market which can meet expectations in relation to a suite of measures of effectiveness, including safety and quality expectations (e.g. scope of practice, clinical supervision and workforce credentialing).

As an improvement partner, 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.

PHN enablers

PHNs have a host of enablers to assist the Victorian Government in the implementation of mental health reforms, encompassing prevention through to early intervention, treatment and recovery services.

These enablers demonstrate that Victorian PHNs have the capacity and capability to collaborate with the Victorian Government to address the mental health issues that will be identified in the Royal Commission into Victoria’s Mental Health System.





Organisational governance and accountability

PHN governance arrangements encompass the diverse expertise and interests of regional communities. These include:

- Good governance of the commissioning process will ensure that public money is spent in an efficient and effective way and that PHNs are held accountable for the decisions made and the impact on the local health population.
- Clinical governance structure which recognises the importance of delivering clinically safe and effective services and which holds service providers accountable for the way in which services are delivered on behalf of the organisation.
- Clear accountability between funders and providers of services, in relation to the volume, quality, equity, and community / patient satisfaction with services provided.

Population health planning and performance measurement

PHNs commission programmes that generate the best return on investment, with a focus on improving mental health outcomes and high-quality service provision. PHNs monitor and evaluate the efficacy and effectiveness of commissioned mental health programmes by managing service provider performance against a specified mental health outcomes framework, demonstrating value for money and supporting continuous improvement processes.

Community and clinical participation

Commissioning is undertaken in partnership through co-design with consumers and carers, communities, clinicians and service providers.

People with lived experience inform and support PHN commissioned activities and evaluate the quality and efficacy of care provided and drive best outcomes.

PHNs acknowledge that for consumers and carers to control, lead and participate directly in the decisions that affect them. Consumers and carers require information and support in order to effectively self-manage mental ill health, make health care choices and to interact with a variety of services to obtain the clinical and psychosocial support.

PHNs empower people with lived experience of mental health and suicide by providing information and support to enable them to participate in all stages of commissioning.

PHNs engage stakeholders and develop partnerships and trusting relationships, representing the diversity of consumers and carers. This includes children, youth and aged, Aboriginal and Torres Strait Islanders, culturally and linguistically diverse (CALD) and lesbian, gay, bisexual, transgender, and intersex (LGBTI) communities.

PHNs have established formal mechanisms to engage mental health clinicians and service providers through representation in PHN Clinical Councils, Community Advisory Groups, and reference groups, along other opportunities for participation in all phases of the mental health commissioning cycle.

PHNs have a comprehensive approach to engaging clinicians to understand the demand for mental health services and the value of a person-centred approach to mental health service delivery. Person-





centred care is about adopting a social determinants and inclusive approach, and requires consideration of the individual's desires, values, family situations, social circumstances, lifestyles and mental health status. The national Mental Health Stepped Care Model provides an appropriate range of interventions made available across the continuum of care, with consumers supported to move fluidly between programmes, service providers and sectors as needs change.

Quality improvement and workforce development

In commissioning mental health services, PHNs appropriately consider and support the mental health workforce necessary to deliver evidence-based, integrated, sustainable, quality and safe care.

PHNs provide mental health training and workforce development activities to General Practices and other clinical and community service organisations to support the regional integration of services.

PHNs collaborate closely with mental health stakeholders to build the social and cultural competency of the workforce to provide appropriate care to Aboriginal and Torres Strait Islanders, CALD and lesbian, gay, bisexual, transgender and intersex (LGBTI) communities.

PHNs endeavours to break down silos across programmes and jurisdictions by facilitating advocating for cross-sector coordination and collaboration across service providers in order to deliver sustainable, quality, safe and evidenced based services. Coordination of programmes and service delivery is essential, particularly at transition points, in order to deliver seamless care and a smoother consumer journey.

Digitally enhanced care pathways

PHNs develop primary healthcare led pathways (referral and access) to ensure communities are supported to receive seamless referral to tertiary and primary healthcare in the region. PHNs develop and drive digital platforms tools and usage across our region to ensure quality use of these progressive opportunities and enable meaningful data capture to support ongoing regional planning and design.

PHNs provide and support HealthPathways, a web-based information portal designed to support local GPs and primary healthcare providers by providing evidence-based information to assist in the assessment and management of a range of medical conditions; and support referral processes for GPs, to assist patients to access local specialists and services.

PHNs and service providers leverage technology to engage and involve consumers and carers in the planning and co-design of reforms. PHNs also support improved information flow by promoting the use of MyHealthRecord and the eReferral system to consumers and service providers in each region.

Communication and engagement

PHNs deliver communications and engagement initiatives to raise awareness of mental health and wellbeing issues.

PHNs ensure that commissioned activities and approaches are shared with regional communities and the sectors in a meaningful way through consultations, practice visits, publications and newsletters.





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