Australian Government
Department of Health

phn
EASTERN MELBOURNE
An Australian Government Initiative

Updated Activity Work Plan 2016–2018: Primary Mental Health Care Funding

The updated Annual Mental Health Activity Work Plan for 2016-2018, provides a description of planned activities funded under the Primary Mental Health Care Schedule which incorporates:

i) Primary Mental Health Care funding (PHN: Mental Health and Suicide Prevention Operational and Flexible Activity); and

ii) *Indigenous Australians' Health Programme* funding (PHN: Indigenous Mental Health Flexible Activity).

Eastern Melbourne PHN

EMPHN Operating Model and the Commissioning Framework

In its role as a facilitator of primary care system improvement and redesign, EMPHN has adopted an operating model made up of a continuous improvement approach to commissioning, and governance structures geared towards collaboration and co-design.

Commissioning Framework

Commissioning is a cycle. Needs are assessed through community consultation and solutions are designed in partnership with stakeholders. Transparent processes are used to promote the implementation of these solutions, including the identification of providers from whom services may be purchased. Solutions are then evaluated and the outcomes used to further assessment and planning.

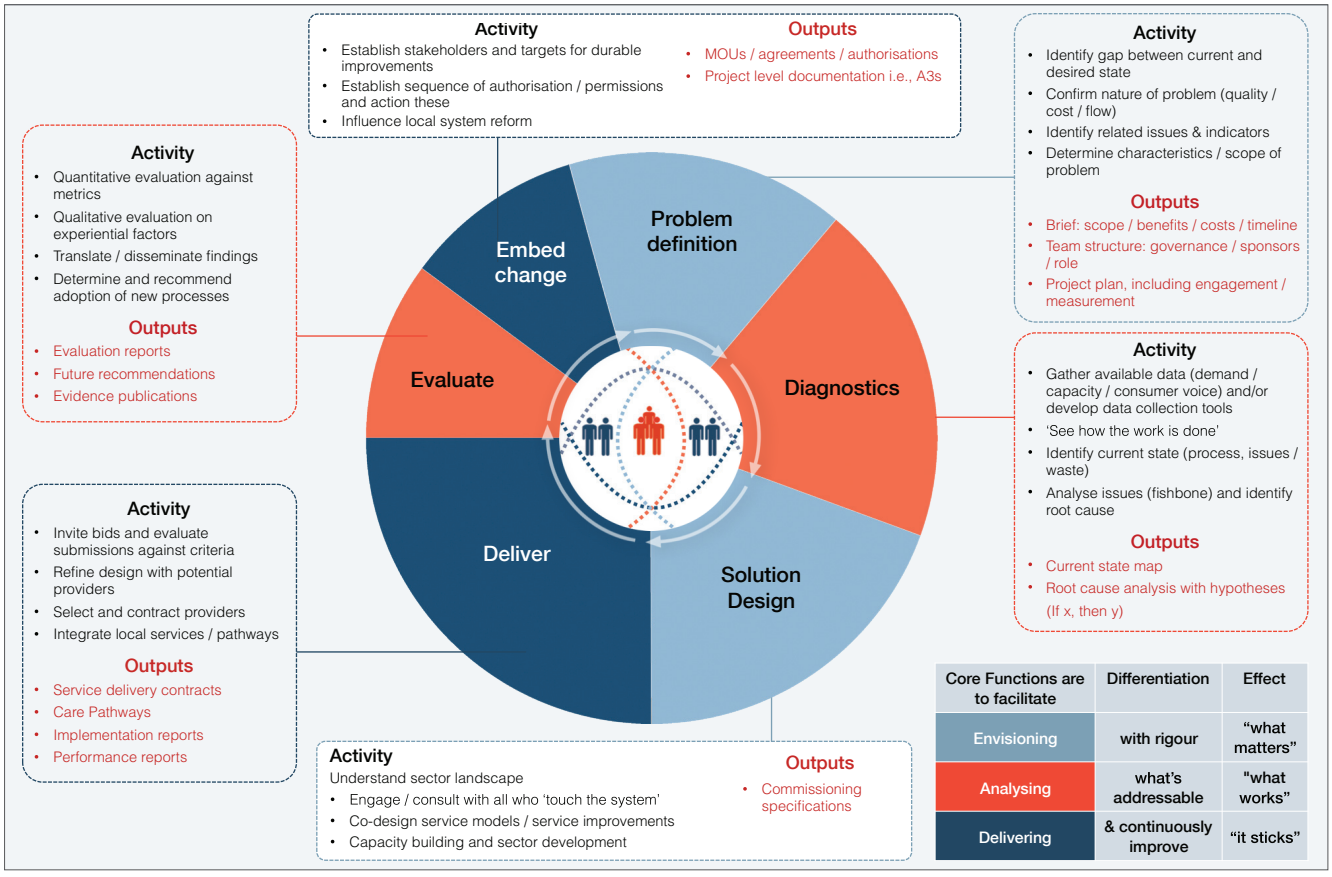


Figure 1. Commissioning cycle

Underpinning the phases of the Commissioning Cycle is a focus on ongoing relationships with consumers, providers and other stakeholders.

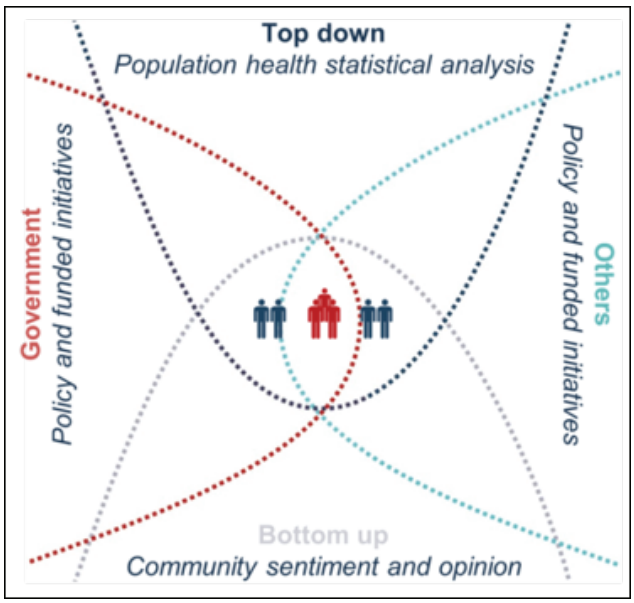


Figure 2. Prioritisation approach

Commissioning principles

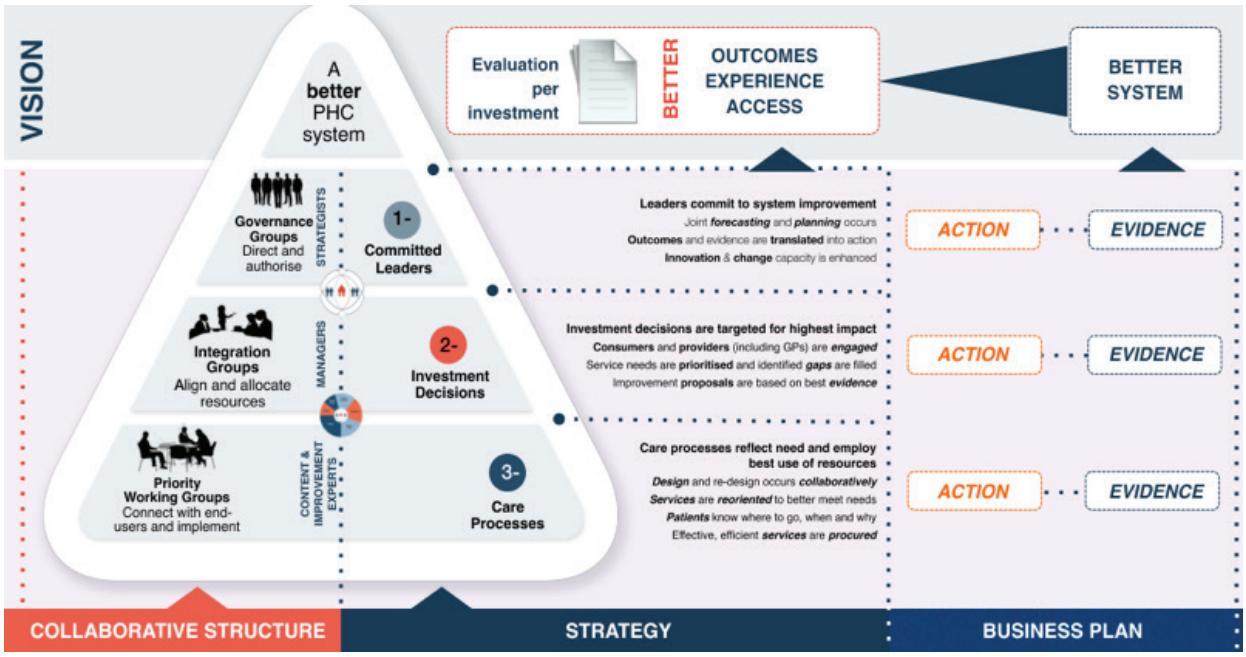
1. **Understand the needs of the community** by engaging and consulting with consumer, carer and provider representatives, peak bodies, community organisations and other funders.
2. **Engage potential service providers** well in advance of commissioning new services.
3. **Focus on outcomes** rather than service models or types of interventions.
4. **Adopt a whole of system approach** to meeting health needs and delivering improved health outcomes.
5. **Understand the fullest practical range of providers** including the contribution they could make to delivering outcomes and addressing market failures and gaps.
6. **Co-design solutions;** engage with stakeholders, including consumer representatives, peak bodies, community organisations, potential providers and other funders to develop outcome focused solutions.
7. **Consider investing in the capacity of providers and consumers**, particularly in relation to hard to reach groups.
8. **Ensure procurement and contracting processes are transparent and fair**, facilitating the involvement of the broadest range of suppliers, including alternative arrangements such as consortia building where appropriate.
9. **Manage through relationships; work in partnership**, building connections at multiple levels of partner organisations and facilitate links between stakeholders.
10. **Ensure efficiency and value for money**.
11. **Monitor and evaluate** through regular performance reporting, consumer, community and provider feedback and independent evaluation.

Consultative structures

The EMPHN Board will receive strategic advice on engagement and participation from two key groups:

- Clinical Council
- Community Advisory Committee

Collaborative structures



The EMPHN catchment will be divided into four sub-catchments for the purposes of shared planning and governance. The sub-catchments will align with the large public health services in the catchment:

- Austin Health
- Eastern Health
- Monash Health
- Northern Health

Each sub-catchment will have three similar levels of collaborative structures:

1. **Governance Group**: Strategists who "direct and authorise"
2. **Health System Integration Group**: Managers who "align and allocate resources"
3. **Priority Working Groups**: Content experts who "connect with end users and implement"

Internal structures

The EMPHN organisational structure includes programs that support and develop primary care practitioners, and that support primary care improvement and integration.

In addition to the formal governance structure, EMPHN staff work across teams within specialty area streams such as Indigenous Health, Aged Care, Refugee Health and Mental Health.

EMPHN staff also work across teams to participate in improvement and innovation initiatives.

1. (b) Planned activities funded under the Primary Mental Health Care Schedule

PHNs must use the table below to outline the activities proposed to be undertaken in the 2016-17 financial year. These activities will be funded under the Primary Mental Health Care Schedule (PHN: Mental Health and Suicide Prevention Operational and Flexible Activity; and the PHN: Indigenous Mental Health Flexible Activity).

Note 1: Indicate within the duration section of the table if the activity relates to a period beyond 2016-17.

Note 2: PHNs must complete activities under every priority area in the tables below.

Proposed Activities	
Priority Area 1: Low intensity mental health services	• Improve targeting of psychological interventions to most appropriately support people with or at risk of mild mental illness at the local level through the development and/or commissioning of **low intensity mental health services.**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**1.1 EMPHN Alternative Low Intensity Services** **1.2 EMPHN Innovative Perinatal Program.** **1.3 Referral Pathways**
Existing, Modified or New Activity	**1.1 EMPHN Alternative Low Intensity Services (ALIS)** This is a new activity. Although model development will begin in 2016 – 2017, service delivery capacity is planned for July 2017. **1.2 EMPHN Innovative Perinatal Program (IPP).** This is a new activity. **1.3** Referral Pathways This is an ongoing activity
Description of Activity(ies) and rationale (needs assessment)	**1.1 EMPHN Alternative Low Intensity Services (ALIS)**

	EMPHN needs assessment and other information advising this task – It is well documented that people living in circumstances of low socio-economic position have poorer health outcomes and diminished capacity to access primary health services. Very often, fee for service mental health is not viable for people from low SES backgrounds and travel to services can be a significant issue for people in remote areas because of financial issues and/or poor public transport within their LGA of residence. EMPHN needs assessment data has identified that there are multiple LGAs within the EMPHN catchment with low SES and these populations will require an accessible psychological services program that is free of charge. Areas such as Whittlesea and the Yarra Ranges which are among a number of outer urban and rural areas within the EMPHN catchment, have poor public transport making access to services harder. The Yarra Ranges and Whittlesea also both have poor access to services due to the low numbers of services available. The feedback from multiple stakeholders around the ATAPS and Better Access programs illustrates that the particular facets of the referral process and service delivery inhibit effective service delivery and are ultimately not client centred. **Aim:** To commission the delivery of EMPHN ALIS for the 2017 - 2018 reporting period. This will focus on the hard to reach populations who might benefit from a low intensity therapeutic service that is distinctly different from individual Psychological Strategies (formerly known as ATAPS) and IPS (see priority three). This initiative will focus on increasing access to services for hard to reach populations but also on providing an alternative model of therapy to people who might benefit from a brief intervention/level of care lower in intensity than a short term face to face psychological intervention, or group therapy approach. This activity will consist of the EMPHN Lead Site pilot and EMPHN Group Therapy Services. The Lead site pilot will comprise an innovative model of psychological strategies service delivery and the implementation of a decision tool to clinically inform referral type suggestions within the low intensity space. Referral suggestions will range from the EMPHN lead site to other low intensity services with proven benefits, not delivered by EMPHN. The EMPHN Group Therapy Services initiative will provide stakeholders with access to a suite of evidence based psychological services delivered in a group therapy format. **How the activity will address the priority:** This activity will address the priority by delivering appropriate low intensity psychological strategies to people with or at risk of mild mental health disorders who would benefit from a low intensity psychological intervention different from IPS. This program will be delivered by an appropriately skilled and supported group of mental health workers commissioned by EMPHN.

1.2 EMPHN Innovative Perinatal Program (IPP)

EMPHN needs assessment and other information advising this task: Evidence from historical quantitative data and qualitative stakeholder feedback is that people with perinatal depression are underserviced within the Eastern Melbourne PHN (EMPHN) catchment, as this pertains to low to moderate intensity psychological services. In a substantial number of anecdotal accounts, and other feedback from professionals and clients, it is apparent that although EMPHN do provide valuable mental health services to this specific population, access to services is still an issue for people experiencing perinatal depression. Current models in ATAPS and Better Access do not in their entirety resolve the issue of access for this cohort within our community. Also, some research findings are that a number of factors are likely to contribute to reduced likelihood of accessing services for mothers with postnatal depression. It is also important to note that childbearing is most often between 16 – 40 years old and that females in that age bracket make up a significant proportion of the EMPHN catchment population.

Aim: In line with this information and feedback, and further structured collaborative processes with external stakeholders, EMPHN are dedicated to commissioning innovative approaches to low intensity psychological services for people with perinatal depression.

How the activity will address the priority: This activity will address the priority by delivering appropriate low intensity psychological strategies to people with or at risk of mild to moderate perinatal depression who would benefit from an intervention different from Psychological Strategies or IPS. This program will be delivered by an appropriately skilled and supported group of mental health workers commissioned by EMPHN.

1.3 Referral Pathways

Promotion of access and entry points to the mental health service system can facilitate all-of-service response to people presenting with a range of mental health needs. Integrated intake systems that support cross-sector communication and integration will assist people to access the appropriate level of care when needed and with understanding referral pathways available. This supports our understanding of service utilisation within a stepped care model, client outcomes and will inform our future planning and quality improvement activities. This includes cross-sector relationship building to

	facilitate care for clients who have difficulty contacting mainstream mental health service system access points. (modified)
Target population cohort	**1.1 ALIS** **Target population cohort:** People with or at risk of mild mental health presentations who would benefit from low intensity/ brief psychological interventions. These people may have sub-threshold mental health issues and not meet criteria for interventions such the Psychological Strategies, IPS and Better Access programs. **1.2 IPP** **Target population cohort:** People with or at risk of mild to moderate perinatal depression. **1.3** Support to practitioners
Consultation	**1.1 ALIS** Consultation for this activity was facilitated through the low intensity psychological services forum held on 24 November 2016 and EMPHN Community Advisory Committee and Clinical Council lead site workshop held on 5 September 2016. **1.2 IPP** Consultation for this activity was facilitated through the low intensity psychological services forum held on 24 November. **1.3** NA

Collaboration	**1.1 ALIS** EMPHN will look to engage with the following stakeholders during this activity; LHNs – Adjacent PHNs to establish collaborative relationships to ensure access to services for the target population as a priority. State Government - liaison around statistics/ information/ resources that may identify at risk populations. Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Banyule Community Health, and Wadamba Wilam - to partner in developing a commissioning strategy to increase access to services and service usage for Aboriginal and/or Torres Strait Islander people. Consumer representatives – To inform the ongoing commissioning cycle for low intensity mental health. Carer representatives –To inform the ongoing commissioning cycle for low intensity mental health. Mental health professional representatives – To inform the ongoing commissioning cycle for low intensity mental health. Consumer organisations – Headspace, others to be identified. To inform the ongoing commissioning cycle for low intensity mental health for specific target groups. NGOs – Connections UnitingCare, Anglicare, EACH, Melbourne East GP Network (MEGPN), others to be identified. To inform the ongoing commissioning cycle for low intensity mental health and potentially partner in service delivery. Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Link Health and Community and others to be identified - to inform the ongoing commissioning cycle for low intensity mental health and potentially partner in service delivery. Tertiary Health – Eastern Health, Austin Health, Monash Health and Northern Health – to partner in stepped care of target groups where appropriate. **1.2 IPP** EMPHN will look to engage with the following stakeholders during this activity;

	LHNs – Adjacent PHNs to establish collaborative relationships to ensure access to services for the target population as a priority. State Government - liaison around statistics/ information/ resources that may identify at risk populations. Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Banyule Community Health, and Wadamba Wilam - to partner in developing a commissioning strategy to increase access to services and service usage for Aboriginal and/or Torres Strait Islander people. Consumer representatives – To inform the ongoing commissioning cycle for low intensity mental health. Carer representatives –To inform the ongoing commissioning cycle for low intensity mental health. Mental health professional representatives – To inform the ongoing commissioning cycle for low intensity mental health. Consumer organisations – Headspace, Perinatal Anxiety and Depression Australia (PANDA) and others to be identified. To inform the ongoing commissioning cycle for low intensity mental health for specific target groups. NGOs – Connections UnitingCare, Anglicare, EACH, Melbourne East GP Network (MEGPN), others to be identified. To inform the ongoing commissioning cycle for low intensity mental health and potentially partner in service delivery. Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Link Health and Community and others to be identified - to inform the ongoing commissioning cycle for low intensity mental health and potentially partner in service delivery. Tertiary Health – Eastern Health, Austin Health, Monash Health and Northern Health – to partner in stepped care of target groups where appropriate.
Duration	Anticipated activity start and completion dates (excluding the planning and procurement cycle). **1.1 ALIS** Start: July 2017

	Completion: October 2018 (evaluation completion) **1.2 IPP** Start: July 2017 Completion: October 2018 (evaluation completion) **1.3 Referral Pathways** Ongoing
Coverage	Entire PHN catchment for 1.2 and 1.3. For 1.1, Lead Site will offer coverage for the entire catchment whilst Group Therapy Services will be offered from Eastern, Inner Eastern and Northern locations.
Commissioning approach	All activities will follow the EMPHN commissioning framework. All contracted services will be monitored and evaluated by establishment of program specific Key Performance Indicators. These will be largely guided by the Minimum Data Set although integration with stepped care services, innovation, cost efficiency and project timelines will also be important evaluation criteria. Program evaluation is likely to include but may not be exclusive to; • Session numbers • Client numbers • Time between referral and first session delivery • Client retention rates (average session numbers) • Geographical spread of services/ accessibility • Unit cost of sessions • Pre and post outcome measure results (K10 and the like) • Delivery of services across identified target groups
Approach to market	**1.1 ALIS** Services to be contracted from appropriate mental health organisations via an open competitive tender process.

	1.2 IPP Services to be contracted from appropriate mental health organisations via an open competitive tender process. **1.3 Referral Pathways** - NA
Performance Indicator	The mandatory performance indicators for this priority are: • Proportion of regional population receiving EMPHN commissioned mental health services – Low intensity services. • Average cost per EMPHN commissioned mental health service – Low intensity services. • Clinical outcomes for people receiving EMPHN commissioned low intensity mental health services. In addition, the performance indicators for 1.1 and 1.2 will be equity of access for EMPHN identified target groups across the LGAs in the catchment. This is an outcome indicator. This will be measured by the number of service locations for appropriate services, client access across different LGAs in EMPHN, availability of services for CALD populations and numbers of clinicians with specific training standards.
Local Performance Indicator target (where possible)	**1.1 ALIS** Minimum Data Set (MDS) will be used for the performance targets for this activity. As Lead Site is a pilot, there is no comparable baseline. Although Group Therapy Services is also a pilot, Psychological Strategies baseline data can be used for comparison. **1.2 IPP** Minimum Data Set (MDS) will be used for the performance targets for this activity. The baseline indicator will be the 2016 -2017 Psychological Strategies (formerly known as ATAPS) MDS figures for session numbers for people with perinatal depression. The disaggregation will be defined by MDS data points as defined by Department of Health.

	1.2 IPP Services to be contracted from appropriate mental health organisations via an open competitive tender process. **1.3 Referral Pathways** - NA
Performance Indicator	The mandatory performance indicators for this priority are: • Proportion of regional population receiving EMPHN commissioned mental health services – Low intensity services. • Average cost per EMPHN commissioned mental health service – Low intensity services. • Clinical outcomes for people receiving EMPHN commissioned low intensity mental health services. In addition, the performance indicators for 1.1 and 1.2 will be equity of access for EMPHN identified target groups across the LGAs in the catchment. This is an outcome indicator. This will be measured by the number of service locations for appropriate services, client access across different LGAs in EMPHN, availability of services for CALD populations and numbers of clinicians with specific training standards.
Local Performance Indicator target (where possible)	**1.1 ALIS** Minimum Data Set (MDS) will be used for the performance targets for this activity. As Lead Site is a pilot, there is no comparable baseline. Although Group Therapy Services is also a pilot, Psychological Strategies baseline data can be used for comparison. **1.2 IPP** Minimum Data Set (MDS) will be used for the performance targets for this activity. The baseline indicator will be the 2016 -2017 Psychological Strategies (formerly known as ATAPS) MDS figures for session numbers for people with perinatal depression. The disaggregation will be defined by MDS data points as defined by Department of Health.

	1.3 Referral Pathways Support activity only
Local Performance Indicator Data source	The data sources are stated in the above section where appropriate. EMPHN will plan to collect data throughout the reporting period with the above-mentioned methods from July 2017. MDS is a national data set.

Proposed Activities	
Priority Area 2: Youth Mental Health Services	• Support region-specific, cross sectoral approaches to early intervention for **children and young people** with, or at risk of mental illness (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group.
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	2.1 Continue collection and review of data on current situation to enable a deeper dive scoping of current situation utilising collaboration with stakeholder organisations. (Existing) 2.2 Commissioning of Headspace services (3 currently in operation) and ongoing contract management with commissioned services including developing relationships with Headspace National (HNo). (Existing) 2.3 Co-design of services targeting the youth population experiencing severe mental health conditions including first episode psychosis. Commissioning of Youth Severe MH services across the EMPHN catchment. (commenced Jan 2017) 2.4 Collaborate with youth services across the EMPHN catchment including State funded mental health services, AOD specific services and education. (Existing) 2.5 Working with providers in the Low Intensity space promoting access for children and families with high prevalence conditions (please see priority 1). (Existing with scope for innovation) 2.6 Building collaborative partnerships to target specific areas of need. For example, supporting the Eastern Metropolitan Region Post Suicide Communication Protocol and scoping the need for a similar protocol in the North East. (Existing) NB Youth AOD included in the AOD Needs Assessment and AWP.
Existing, Modified, or New Activity	As noted in above: Existing: 2.1, 2.2, 2.4, 2.5, 2.6 New: 2.3

	Noting: 2.1 Existing Collaborative process with stakeholders and consumers to discuss targeted interventions and explore the evidence base for early intervention and identification, and supporting those with severe difficulties. For example, family-based interventions, community approaches and school-specific approaches. Ideas may include school promotion activities; Council/LGA based youth promotion activities (Monash Council has run a Youth Expo annually), peer mentoring/support, social media education, for example in the less intensive/early intervention stepped model of care. Specific interventions targeting need across the stepped model of care to be designed. 2.2 Ongoing Facilitate co-design processes to establish targeted interventions at the stepped care level identified using partnerships with appropriate agencies
Description of Activities and Rationale	The primary referral pathway for hard to reach target groups of children and young people is through EMPHNs relationship with the local General Practitioner network. Through ongoing stakeholder engagement and collaboration practices EMPHN continues to develop this referral pathway to its mental health services with GPs and other relevant stakeholders, including clients and carers. This pathway is facilitated by a number of referrers from the EMPHN community, including GPs, school principals, maternal and child health nurses and staff at community based and not for profit organisations. The primary program servicing this client cohort is the Psychological Strategies program although children and young people also access the Mental Health Nurse Incentive (MHNIP) and Support Facilitator programs. The EMPHN Clinical Intake and Community Engagement Team (CICET) is integral to this referral pathway and process referrals to the suite of Psychological Strategies, MHNIP and Support Facilitator programs, for children and young people, Ultimately services are provided via agencies and individual contractors from a large number of service locations as identified in Priority One and Three, and via methodology articulated in these priorities, EMPHN has made significant efforts to increase access to this hard to reach target group. Headspace centres receive young people who 'walk in', or present with a referral from their GP and CICET work closely with EMPHN commissioned Headspace centres to ensure 'warm' handover of referrals appropriate to Headspace services, to support the young person as they seek and access care. CICET also support allied health providers commissioned through the Psychological Strategies program to 'step up' care to tertiary services if needed, or assist with appropriate discharge planning with providers and GPs. (Existing; CICET commenced activity in July 2016 and continues to contribute to access and pathways within the mental health stepped model of care).

	Needs assessment identified: Young people experience difficulties in access to care. Linked with activity 2.1, 2.2, 2.3, 2.4, Mental Health issues and self-harm were noted among the youth population in Boroondara, Manningham, Maroondah, Monash, Nillumbik and Whittlesea. Monash had the highest proportion of adolescents who report experiencing bullying. Linked with activity 2.3, 2.4, 2.5, 2.6 Suicide rates (including young people) are particularly high in areas of Whittlesea, Maroondah, Knox and Whitehorse. Current service gaps in these LGAs particularly in Whittlesea, with service access issues identified in Monash. Linked with activity 2.6, 2.2, 2.3, 2.4
Target population cohort	Children and young people, with scope to include families. Age range under 25 considered within the youth population.
Consultation	Consultation: Youth Severe MH Community and stakeholder forum held in December 2016.
Collaboration	Collaboration and co-design processes to include engagement with young people in the EMPHN catchment. The "YAGS" groups established with each Headspace Centre will be consulted. Other avenues to engage young people include engaging Monash Youth and Family Services, School and other youth-oriented supports (eg. Belgrave Youth Services). Services to be engaged in collaborative processes include: General Practices; GPs to be supported in their role of anchoring the primary care needs of a young person and coordinating service access. CAMHS/CYMHS across Area Mental Health Services including Eastern Health, Austin, Monash Health

	Regional EPYS Headspace including Hawthorn, Greensborough and Knox; with lead agency and consortia members Family support services such as Anglicare, Doncare, Camcare etc Child Protection Services Local council youth services Youth AOD services including YSAS; particularly those servicing the Nillumbik area. Maternal and Child Health Nursing services Private providers including those who provide services under ATAPS funding Local community health services – particularly in the Manningham and Nillumbik areas Mental Health Nurses who identify capacity to support young people with a number of Mental Health Nurses embedded in the regional headspace centres. Local schools and the Education Department <u>Established groups engaged:</u> Headspace consortia EMPHN Clinical Council EMPHN Community Advisory Committee
Duration	*Anticipated activity start and completion dates (excluding the planning and procurement cycle).* *Activity start date: Early 2016/17 to run for 12 months with review as part of normal annual review cycles.* <u>Activity 2.2; Headspace contracts</u> Ongoing with quarterly reviews, annual work plans developed and reviewed. Contract until June 2018. <u>Activity 2.3; Youth Severe Mental Health initiative</u> Approach to Market Jan 2017, contract ETA March/April 2017 and contacted to June 2018. <u>2.4 Collaborative activities</u> Ongoing. <u>2.5; Please see priority 1.</u> <u>2.6; EMR Youth Post Suicide Communication Protocol</u>

	Existing. Draft protocol estimated March 2017, implementation and review will be an ongoing process involving collaborative relationships.
Coverage	Activities involving mental health care service delivery to young people will involve the whole EMPHN catchment. Early intervention, health promotion and activities involving digital health will cover the whole EMPHN catchment.
Commissioning method (if relevant)	*All commissioning will follow the EMPHN commissioning framework* Commissioning of co designed services will include incorporation of evidence-based practice informing model development, target-specific evaluation and clear clinical governance reporting in accordance with the National Mental Health Standards (2010). Compliments and complaints procedures in accordance with commissioned services procedures and in line with EMPHN complaints process.
Approach to market	**Youth Severe Funding** : Approach to market will be a dual approach; EOI in the first instance with a follow up invited Request for Tender with proposals received under the EOI that are considered viable and meeting both an evidence-base requirement, and population need within the EMPHN catchment. EOI opened for application January 2017 to commence procurement process.
Decommissioning	NA
Performance Indicator	Priority Area 2 - Mandatory performance indicators: • Support region-specific, cross sectoral approaches to early intervention for **children and young people** with, or at risk of mental illness (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group. • Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services. Local Performance Indicator Development of a local service map for youth specific mental health services (output) Service satisfaction measures will be explored and where appropriate implemented, including our 3 catchment headspace sites. Output measures will be collected by our client management system with agreed response times included in service contracts with mandated clinical quality indicators. The Headspace HAPI system will deliver

	Headspace data including client satisfaction and clinical measures, activity and output. Quarterly contract meetings will include review of process. Youth Severe Funding performance indicators will be developed through the procurement process and will be part of the EOI and RFT evaluation; EMPHN will ask each applicant how they will demonstrate performance and outcomes incorporating Commonwealth mandated clinical quality indicators.
Local Performance Indicator target (where possible)	<u>Headspace reporting;</u> See below re the HAPI system and reporting pathways. Headspace targets are in negotiation and will be included in the annual work plan. <u>Youth Severe Mental Health;</u> Performance reporting will be part of the tender application process and reporting and review part of the contractual relationship between EMPHN and the successful applicant.
Local Performance Indicator Data source	<u>HAPI Headspace data will be collated and distributed by headspace National Office and include:</u> Client satisfaction Activity Diagnosis where appropriate Clinical outcome measures Demographic information (age, gender, postcode, cultural background) Budget reporting <u>Youth Severe MH services will provide:</u> Clinical outcome measurement Activity data Demographic information Budget reporting *Other measures as determined through the procurement process occurring in Jan/Feb 2017

Proposed Activities	
Priority Area 3: **Psychological therapies for rural and remote, under-serviced and /or hard to reach groups**	Address service gaps in the provision of psychological therapies for people in **rural and remote areas and other under-serviced and/or hard to reach populations**, making optimal use of the available service infrastructure and workforce.
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	Please note that activities for this priority are linked to activities in Priority 1 **3.1 Improve access to services and/or service usage across EMPHN in line with EMPHN needs assessment and other information outlined in priority one, through collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment.** **3.2 Commissioning of Alternative Low Intensity Services (ALIS) and Innovative Perinatal Program (IPP).** **3.3 Implementation of Innovative Psychological Strategies (IPS) with capacity to increase access to services for refugees/humanitarian entrants who find it difficult to access Medicare Benefit Schedule based therapeutic services. IPS will deliver psychological strategies to hard to reach target groups, via face-to face and telephone counselling, and culturally appropriate social and emotional well-being support.**
Existing, Modified, or New Activity	**3.1 Improve access to services and/or service usage across EMPHN in line with EMPHN needs assessment and other information outlined in priority one, through collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment.** This is a modified activity. Although the key principles of collaboration, commissioning and equity remain unchanged, the programs used to delivery this activity have changed, as per the priority one. **3.2 Commissioning of Alternative Low Intensity Services (ALIS) and Innovative Perinatal Program (IPP).** This is a new activity. Although model development will begin in 2016 – 2017 for ALIS, service delivery capacity is planned for July 2017.

	3.3 Implementation of Innovative Psychological Strategies (IPS) with capacity to increase access to services for refugees/humanitarian entrants who find it difficult to access Medicare Benefit Schedule based therapeutic services. IPS will deliver psychological strategies to hard to reach target groups, via face-to face and telephone counselling, and culturally appropriate social and emotional well-being support. This is a modified activity. This activity currently consists of the Psychological Strategies (formerly known as ATAPS) program which will continue to be delivered in combination with four pilot programs. • A new model of low to moderate intensity psychological strategies with GPs at the centre of care. • Three different models of psychological strategies/culturally appropriate social and emotional well-being support, for Aboriginal and/or Torres Strait Islander people.
Description of Activity	**3.1 Improve access to services and/or service usage across EMPHN in line with EMPHN needs assessment and other information outlined in priority one, through collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment.** **EMPHN needs assessment and other information advising this task**: • MDS data and stakeholder engagement have identified a number of hard to reach populations in the EMPHN catchment. • Identified suboptimal alignment of mental health service locations with areas of greatest need and paucity of services in new growth and in outlying areas of disadvantage. • As per priority one, there are a number of notable populations within EMPHN with poor access to services. • As per priority one there are a number of low SES populations in EMPHN. • Elder abuse (neglect and financial) reported in Knox, Lower Hume, Manningham and other inner east areas. • Poor social and emotional wellbeing outcomes experienced by Aboriginal and/or Torres Strait Islander peoples, including significantly higher levels of psychological distress.

	Aim: Commission IPS, Mental Health Nurses and Support Facilitators to improve access to services across the catchment and support equitable access to services. **How the priority will address the activity:** This activity will aim to reduce service gaps for hard to reach populations and develop a catchment wide plan to provide equitable access to services. **3.2 Commissioning of Alternative Low Intensity Services (ALIS) and Innovative Perinatal Program (IPP).** **EMPHN needs analysis informing this task** – identified access to service issues across various parts of the catchment as previously outlined. **Aim:** Collaboratively implement ALIS and IPP to increase access to services for hard to reach populations. **How the activity will address priority –** This activity will improve access to services as access can be facilitated via methods other than face to face therapy. **3.3 Implementation of Innovative Psychological Strategies (IPS) with capacity to increase access to services for refugees/humanitarian entrants who find it difficult to access Medicare Benefit Schedule based therapeutic services. IPS will deliver psychological strategies to hard to reach target groups, via face-to face and telephone counselling, and culturally appropriate social and emotional well-being support.** **EMPHN needs analysis informing this task** – The EMPHN needs assessment has identified that there are multiple LGAs within the EMPHN catchment with low socio-economic status (SES) and hard to reach target groups, and these populations will require an accessible psychological services program that is free of charge. Needs assessment data also showed that significant numbers of general practitioners indicate that anxiety and depression were the leading mental health conditions treated, and treatment of psychological disorders took up the majority of GP time. These conditions are also the ones that practitioners feel they need the most support with and the primary focus of low intensity mental health services. Of note was Whitehorse, with the highest rate of people experiencing affective and anxiety issues. Anxiety was most prominent for males in Whitehorse and females in Whittlesea-Wallan and needs assessment data showed that the highest rate of high or very high psychological distress among

	people aged 18 years and over was in Whittlesea-Wallan. There were also significant reports of depression and anxiety in Boroondara, Manningham, Maroondah, Nillumbik and Whittlesea-Wallan. Mental health issues were also significant among men in Nillumbik, particularly related to the psychological impacts following the bushfires, with increased suicide rates reported among 50-55 year olds. Also of note is paucity of mental health services catering to refugee/humanitarian entrant needs and high prevalence of mental illness noted among refugees, particularly in Whittlesea. In terms of mental health issues and self-harm among young people, significant numbers were noted in Boroondara, Manningham, Maroondah, Monash, Nillumbik and Whittlesea. In particular, high prevalence conditions and the associated psycho-social impacts, including school absenteeism and social isolation. On a whole, nine EMPHN LGAs out of 12 (75%), have suicide numbers higher than the state average. Excluding the partially-held LGAs of Mitchell and Murrindindi, for which relatively low populations may artificially elevate rate-based calculations, Maroondah had the highest suicide rate at 12.6/10,000. This was above the state average of 11.8/10,000. An additional three LGAs, had rates less than 2.0 below the state average. **Aim:** To commission the delivery of a stepped care model that encompasses the EMPHN Innovative Psychological Strategies (IPS) for the 2017 - 2018 reporting period. This will focus on some of the hard to reach populations identified in the EMPHN hard to reach target groups document, including the refugee/humanitarian entrant population, client centred care and access to appropriate services. EMPHN will continue to focus on improving equity of access and service delivery to low income/disadvantaged community members in partnership with organisations, with access to services maintained at implementation of a sole organisation partnership model. **How the activity will address the priority:** This activity will address the priority by delivering appropriate psychological strategies in a stepped care model to people from low income/disadvantaged backgrounds within the EMPHN catchment, who would benefit from short to moderate term psychological interventions. This activity will improve access to appropriate services by drawing on the strengths of the ATAPS and Better Access initiatives and building on these with a model that is driven by the needs of people with mild to moderate mental health presentations, and improved accessibility for them and other relevant stakeholders. Face to face services will be the predominant focus of this activity with capacity for individual and group therapy modalities.

	How the activity will address the priority: This strategy aims to increase access to services for hard to reach target groups.
Target population cohort	**3.1 Target population cohort** Hard to reach populations across the catchment as identified by MDS data, needs assessment data and through stakeholder engagement. **3.2 Target population cohort** Hard to access populations who have phone and/or access to the internet, and have low intensity mental health support needs. **3.3 Target population cohort** • People not able to access Medicare funded mental health services or who are less able to pay fees. • People with or at risk of mild to moderate mental health presentations and/or those people who would benefit from low intensity/ short term psychological interventions. • People from hard to reach target groups, including Aboriginal and/or Torres Strait Islander people, and refugees/humanitarian entrants.
Consultation	Consultation for activities 3.1, 3.2 and 3.3 were facilitated through the low intensity psychological services forum held on 24 November and consultation for activity 3.2 was also facilitated through the EMPHN Community Advisory Committee and Clinical Council lead site workshop held on 5 September. The forum held on 24 November was attended by professionals from: • Community health Organisations • Not For Profit Organisations • Aboriginal Health Organisations • Private Practice • Tertiary Health • Universities

	• EMNPH There was also Department of Health, Australian Psychological Society, carer and consumer representation at the forum.
Collaboration	**3.1 Improve access to services and/or service usage across EMPHN in line with EMPHN needs assessment and other information outlined in priority one, through collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment.** The PHN will look to engage with the following stakeholders during this activity; LHNs – Adjacent PHNs to establish collaborative relationships to ensure access to services for the target population as a priority. State Government - liaison around statistics/ information/ resources that may identify at risk populations. Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Banyule Community Health, and Wadamba Wilam - to partner in developing a commissioning strategy to increase access to services and service usage for Aboriginal and/or Torres Strait Islander people. Consumer representatives – To inform the ongoing commissioning cycle for appropriate mental health services. Carer representatives – To inform the ongoing commissioning cycle for appropriate mental health services. Mental health professional representatives –GP, clinician and other appropriate professionals. To inform the ongoing commissioning cycle for low intensity mental health. Consumer organisations – Headspace, others to be identified. To inform the ongoing commissioning cycle for low intensity mental health for appropriate target groups. NGOs – Connections UnitingCare, Anglicare, EACH, Melbourne East GP Network (MEGPN), others to be identified. To inform the ongoing commissioning cycle for stepped mental health care and potentially partner in service delivery.

	Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Link Health and Community - To inform the ongoing commissioning cycle for stepped mental health care and potentially partner in service delivery. Tertiary Health – Eastern Health, Austin Health, Monash Health and Northern Health – to partner in stepped care of target groups where appropriate. **3.2 Commissioning of Alternative Low Intensity Services (ALIS) and Innovative Perinatal Program (IPP).** The PHN will look to engage with the following stakeholders during this activity; LHNs – Adjacent PHNs to establish collaborative relationships to ensure access to services for the target population as a priority. State Government - liaison around statistics/ information/ resources that may identify at risk populations. Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Banyule Community Health, and Wadamba Wilam - to partner in developing a commissioning strategy to increase access to services and service usage for Aboriginal and/or Torres Strait Islander people. Consumer representatives – To inform the ongoing commissioning cycle for appropriate mental health services. Carer representatives – To inform the ongoing commissioning cycle for appropriate mental health services. Mental health professional representatives –GP, clinician and other appropriate professionals. To inform the ongoing commissioning cycle for appropriate mental health services. Consumer organisations – Headspace, PANDA and others to be identified. To inform the ongoing commissioning cycle for low intensity mental health for appropriate target groups. NGOs – Connections UnitingCare, Anglicare, EACH, Melbourne East GP Network (MEGPN), others to be identified. To inform the ongoing commissioning cycle for stepped mental health care and potentially partner in service delivery.

	Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Link Health and Community - To inform the ongoing commissioning cycle for stepped mental health care and potentially partner in service delivery. Tertiary Health – Eastern Health, Austin Health, Monash Health and Northern Health – to partner in stepped care of target groups where appropriate. **3.3 Implementation of Innovative Psychological Strategies (IPS) with capacity to increase access to services for refugees/humanitarian entrants who find it difficult to access Medicare Benefit Schedule based therapeutic services. IPS will deliver psychological strategies to hard to reach target groups, via face-to face and telephone counselling, and culturally appropriate social and emotional well-being support.** The PHN will look to engage with the following stakeholders during this activity; LHNs – Adjacent PHNs to establish collaborative relationships to ensure access to services for the target population as a priority. State Government - liaison around statistics/ information/ resources that may identify at risk populations. Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Banyule Community Health, and Wadamba Wilam - to partner in developing a commissioning strategy to increase access to services and service usage for Aboriginal and/or Torres Strait Islander people. Consumer representatives – To inform the ongoing commissioning cycle for appropriate mental health services. Carer representatives – To inform the ongoing commissioning cycle for appropriate mental health services. Mental health professional representatives –GP, clinician and other appropriate professionals. To inform the ongoing commissioning cycle for appropriate mental health services. Consumer organisations –Asylum Seeker Project, Asylum Seekers Resource Centre, Migrant Resource Centre and others to be identified. To inform the commissioning of refugee mental health services.

	NGOs – Connections UnitingCare, Anglicare, EACH, Melbourne East GP Network (MEGPN), others to be identified. To inform the ongoing commissioning cycle for stepped mental health care and potentially partner in service delivery. Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Link Health and Community - To inform the ongoing commissioning cycle for stepped mental health care and potentially partner in service delivery. Tertiary Health – Eastern Health, Austin Health, Monash Health and Northern Health – to partner in stepped care of target groups where appropriate.
Duration	Anticipated activity start and completion dates (excluding the planning and procurement cycle). **3.1 Improve access to services and/or service usage across EMPHN in line with EMPHN needs assessment and other information outlined in priority one, through collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment.** Start: July 2017 Completion: October 2018 (evaluation completion) **3.2 Commissioning of Alternative Low Intensity Services (ALIS) and Innovative Perinatal Program (IPP).** Start: July 2017 Completion: October 2018 (evaluation completion) **3.3 Implementation of Innovative Psychological Strategies (IPS) with capacity to increase access to services for refugees/humanitarian entrants who find it difficult to access Medicare Benefit Schedule based therapeutic services. IPS will deliver psychological strategies to hard to reach target groups, via face-to face and telephone counselling, and culturally appropriate social and emotional well-being support.**

	Start: July 2017 Completion: October 2018 (evaluation completion)
Coverage	**3.1** Entire EMPHN catchment **3.2** Entire EMPHN catchment for all activities apart from Group Therapy services, which will be offered from Eastern, Inner Eastern and Northern locations. **3.3** All activities will focus on particular geographical locations within the PHN, as per current needs analysis data, other research information and stakeholder liaison. There will however be some Eastern and Northern coverage for all activities.
Continuity of care	**3.1 Improve access to services and/or service usage across EMPHN in line with EMPHN needs assessment and other information outlined in priority one, through collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment.** Clients current with EMPHN commissioned services at 1 July 2017 will continue to receive ongoing care with their current service providers from 1 July until their episode of care is completed or they are transferred to another appropriate clinician in consultation, unless provider circumstances beyond EMPHN control do not permit this. In circumstances where a current commissioned provider is not contracted to deliver services for the 2017 – 2018 reporting period these organisations or individual providers will be offered variations to contract to facilitate ongoing services with clients current at 30 June 2017, until episodes of care are completed or clients are transferred to another appropriate clinician in consultation, to ensure continuity for these clients. **3.2 Commissioning of Alternative Low Intensity Services (ALIS) and Innovative Perinatal Program (IPP).** These programs are new EMPHN initiatives. As such there will be no active clients until July at the earliest, and clinicians will have capacity to see clients from July 2017 to September 2018. Client

	centred transition arrangements for active clients in September 2018 is a component of funding agreements, and will be reviewed in light of 2018 – 2019 contractual arrangements at a later date. **3.3 Implementation of Innovative Psychological Strategies (IPS) with capacity to increase access to services for refugees/humanitarian entrants who find it difficult to access Medicare Benefit Schedule based therapeutic services. IPS will deliver psychological strategies to hard to reach target groups, via face-to face and telephone counselling, and culturally appropriate social and emotional well-being support.** As per 3.2 except that one Aboriginal and/or Torres Strait Islander pilot will have service capacity up until June 2019.
Commissioning method (if relevant)	All activities will follow the EMPHN commissioning framework. All contracted services will be monitored and evaluated by establishment of program specific Key Performance Indicators. These will be largely guided by the Minimum Data Set although integration with stepped care services, innovation, cost efficiency and project timelines will also be important evaluation criteria. Program evaluation is likely to include but may not be exclusive to; • Session numbers • Client numbers • Time between referral and first session delivery • Client retention rates (average session numbers) • Geographical spread of services/ accessibility • Unit cost of sessions • Pre and post outcome measure results (K10 and the like) • Delivery of services across identified target groups
Approach to market	**3. 1 Improve access to services and/or service usage across EMPHN in line with EMPHN needs assessment and other information outlined in priority one, through collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment.**

	Services to be contracted from appropriate mental health organisations via open competitive tender process. **3.2 Commissioning of Alternative Low Intensity Services (ALIS) and Innovative Perinatal Program (IPP).** Services to be contracted from appropriate mental health organisations via open competitive tender process. **3.3 Implementation of Innovative Psychological Strategies (IPS) with capacity to increase access to services for refugees/humanitarian entrants who find it difficult to access Medicare Benefit Schedule based therapeutic services. IPS will deliver psychological strategies to hard to reach target groups, via face-to face and telephone counselling, and culturally appropriate social and emotional well-being support.** Services to be contracted from appropriate mental health organisations via open competitive tender process.
Decommissioning	There is the potential for a 2016 – 2017 provider organisation to be an unsuccessful applicant for the same/relevant service contract for 2017 – 2018. If this occurs the strategy described under continuity of care will apply to relevant decommissioning. The strategies detailed for those new services in 3.2 and 3.3, for continuity of care, will apply to decommissioning as required.
Performance Indicator	Priority Area 3 - mandatory performance indicators: • Proportion of regional population receiving PHN-commissioned mental health services – Psychological therapies delivered by mental health professionals. • Average cost per PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals. • Clinical outcomes for people receiving EMPHN commissioned psychological therapies delivered by mental health professionals.

	Local Indicators **3.1** Outcome – Data supporting increase in number of people from hard to reach populations accessing EMPHN mental health services. Also data supporting increased geographical spread of EMPHN mental health services across the catchment. **3.2** Outcome – Data demonstrating use of ALIS initiatives across the catchment. **3.3** Outcome – Data supporting increase in hard to reach target groups accessing IPS.
Local Performance Indicator target (where possible)	**3.1** Performance target – An increase in people from identified hard to reach populations accessing EMPHN mental health services as compared to available 2016 - 2017 baseline data. Baseline: 2016 – 2017 MDS data for ATAPS, MHNIP, PIR in addition to internal appropriate population health data. Effective Date: 1 July 2017 **3.2** Performance target – Use of EMPHN ALIS and IPP initiatives by hard to reach populations in the catchment. Baseline: No baseline data is applicable to this activity given its pilot status within the EMPHN. Effective Date: N/A **3.3** Performance Target – Use of EMPHN IPS initiative by hard to reach target groups. Baseline: No baseline data is applicable to this activity given its pilot status within the PHN.
Local Performance Indicator Data source	The data sources are stated in the above section. The PHN will plan to collect data through the above-mentioned methods from July 2017. MDS is a national data set.

Proposed Activities	
Priority Area 4: **Mental health services for people with severe and complex mental illness including care packages**	Commission primary mental health care services for people with severe mental illness being managed in primary care, including clinical care coordination for people with severe and complex mental illness who are being managed in primary care including through the phased implementation of primary mental health care packages and the use of mental health nurses.
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**4.1: Timely access to Mental Health Services across the Eastern Melbourne catchment** **4.3: Cultural and Linguistically Diverse Communities (CaLD) and Refugee mental health care and how to assist MH consumers and carers within these communities to gain better access to mental health services.** **4.4: Suicide Prevention strategies.** **4.6: A focus on co-occurring ongoing physical illness and severe enduring mental health needs.** **4.7: Development of an EMPHN Stepped Model of Mental Health Service 2017.**
Existing, Modified, or New Activity	Modified (2016-17)
Description of Activity	The Department of Health estimates that there are up to 60,000 Australians who live with severe and enduring mental illness and also have complex service needs. Regional population estimates determine that more than 3,600 people currently living in the Eastern Melbourne Primary Health Network catchment could be categorised as having severe and enduring mental illness with complex service needs. (Data includes ABS 2011 –ref- PP42- Partner in Recovery Operational Guidelines – May 2013 DoH) After Hours Needs Assessment showed: • Mental health issues one of top two issues in the after-hours reported by Ambulance Victoria. • Limited community-based services for people with mental health needs after hours. Lack of capacity to provide onsite psychological support as a second response to mental health crisis situations during the after-hours period.

	The aim of undertaking activities below includes: • Commission primary mental health care services for people with severe mental illness being managed in primary care, including clinical care coordination for people with severe and complex mental illness through the phased implementation of primary mental health care packages and the use of mental health nurses. • Close working relationship with the NDIS services as they roll out across the Eastern PHN catchment during 2016-19. It is anticipated that a significant number of people with severe and enduring mental health needs in the region will be eligible for NDIS Individual Funded Packages (IFPs). • EMPHN services and supports are designed to complement the NDIS and provide options for those with serious and episodic mental health need who may not meet the NDIS eligibility criteria. • EMPHN Stepped Care Model supports a service system which provides effective options for people with severe and enduring mental health needs. • NGOs, primary health and private providers are commissioned to provide timely and quality services to consumers and carers. **4.1: Improve access to Mental Health Services** through current and planned projects (current) **4.1.1. Monitor wait list times** for people seeking psycho-social support. (new) **4.1.2. Monitor wait list times for people seeking mental health services** (new) **4.1.3. Investigation of After Hours Service Availability** and need for people seeking mental health support/ advice/ treatment (new) **4.1.4. Referral Pathways: Promotion of access and entry points to the mental health service system** can facilitate all-of-service response to people presenting with a range of mental health needs. Integrated intake systems that support cross-sector communication and integration will assist people access the appropriate level of care when needed and understanding referral pathways available. This supports our understanding of service utilisation within a stepped care model, client outcomes and will inform our future planning and quality improvement activities. This includes cross-sector relationship building to facilitate care for clients who have difficulty contacting mainstream mental health service system access points. (modified)

	4.3: **Cultural and Linguistically Diverse Communities (CaLD) and refugee mental health care** and how to assist MH consumers and carers within these communities to gain better access to mental health services, and how to build service provision with capacity to provide care in culturally appropriate and safe environments. (existing) **4.3.1Promote *better awareness of the needs of Cultural and Linguistically Diverse Communities*** *(CaLD) and Refugee mental health care and how to build capacity in the service network. (existing)* ***4.3.2 Assist consumers and carers*** *within these communities to increase their utilisation of the mental health and primary health services. (EMPHN Needs Analysis pp: 57) (existing)* **4.6: A focus on co-occurring ongoing physical illness and severe enduring mental health needs**. **4.6.1. Seek analysis of the extent of comorbidity in this population in EMPHN.** **4.6.2. Recommendations for supporting both better physical and mental health outcomes for this population.** **4.6.3. Research focus- looking at other national and international studies in this area.** Also focus on Aboriginal services and CCSS work. (EMPHN Needs Analysis pp13) **4.7 Development of an EMPHN Stepped Model of Mental Health Service 2017** EMPHN along with all PHNs will design and implement a stepped care approach to consumers with mental health need to access the appropriate services, supports and treatment in a timely and informed manner. **4.7.1. : Provision of flexible treatment and support models to people experiencing severe and enduring mental health conditions (packaged models of care)** These to be built into the EMPHN Stepped Model of mental health service -2017. **4.7.2. Consolidation and review of current eligible organisations supporting Mental Health Nurse programs** within the EMPHN catchment; trial of alternative funding model with an established EO, and review of population need in relation to geographic locations of EOs and service points for mental health nurses and clients with the EMPHN catchment. Review of the MHN operational models

	and capacity to integrate across mental health service sector to allow for clients to access the care and treatment as needed. These considerations will be built into in the EMPHN stepped care model.
Target population cohort	Members of our community with Severe and Complex mental health needs as identified by MDS data, needs assessment data and through stakeholder engagement.
Consultation	Meetings were held with individual MHNIP providers (eligible organisations and credentialed MH nurses) as part of the transition management plan , and provided several support options for the MH nurses in using the new client information management system (CIMS). Used information from community consultations and service usage profile data to review and address underserviced areas in the catchment. Provided information to consumers, carers, referrers and other stakeholders (e.g. ACMHN) about the transition to EMPHN including the priority of ensuing continuity of care. A Co-design forum with MHNIP providers is planned for early 2017 to inform them about and engage them with the development of the MH Stepped Model of Care.
Collaboration	Key Stakeholders across all areas above include: EMPHN Severe & Enduring Team/EMPHN Health Pathways Project Team / Clinical MH triage services/ AMH Service leaders/ Consumer carer reps /MHCSS/ EMPHN Epidemiology/ PIR Consortium agencies / GP Engagement Team /Council Services/ CCSS/ Victorian Aboriginal Health Service (various teams – CCSS/ ASK/ Family Services) / Local AoD Partners / EMPHN AoD team/ DHHS / PACERs & ED /Acute and sub-acute services/ CaLD Providers- Neami / Refugee and CaLD specific regional agencies/ CaLD Consumer & carer reps/ ADEC / MHCSS: Mind /Neami/ Mi Fellowship/ Co Health. Mental Health Peak Bodies- VICSERV Tandem/ VMIAC/ VTMHS.
Duration	All of the above activities built into the Annual Plans for EMPHN commissioned services to commence during and to be completed according to various timelines over the 2017/18 year.
Coverage	In most cases the scope of the above activities should be relevant to the whole of the EMPHN region.

	In some cases the separation of program activities within the EMPHN areas may reduce the reach and relevance of certain initiatives. A focus on hot spots and the catchment areas of partner agencies might also limit the scope of some activities. Also, the demographic differences across the region might make certain projects more relevant to certain LGAs and less so in others (i.e. CaLD groups concentrated in parts of the region and less present in other areas). Each project/ initiative will clearly set out any such coverage limitations if relevant.
Continuity of Care	Current implementation plan of mental health stepped care includes a transition period of continuing current programs for a period of time with a reduction in allocated new clients to reflect changes as the new model is implemented and becomes ready to receive existing clients and consumers requiring care.
Commissioning method (if relevant)	Commissioning activities will follow the EMPHN Aboriginal Health and Wellbeing Commissioning Framework (attached) which is premised on self-determination and co-design, the first principle being that EMPHN will request selective tenders, working through the ACCOs as lead agencies. Further scope of data, both currently available and highlight data gaps, to assist clear problem definition. Scoping activities to be done in collaboration with stakeholders, co-design of activities to address issues articulated in the needs assessment or arising in the further scoping activities. Activities to address diverse ranges of need across the mental health stepped-care levels including health promotion activities in the well population, activities to target hard-to-reach populations including those who have difficulty accessing transport to attend service sites, or those who are challenged in attending face-to-face services. Direct care services to be included in further scoping, to ascertain commissioning activities to enhance existing services or create innovative strategies in this space to address needs across the stepped-care model.
Approach to market	Services to be contracted from appropriate mental health organisations will be via an open competitive tender process.
Decommissioning	NA
Performance Indicator	Priority Area 4 - mandatory performance indicators: • Proportion of regional population receiving PHN-commissioned mental health services – Clinical care coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses).

	• Average cost per PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness. **Service delivery indicators** **All appropriate service delivery indicators as detailed in the Primary Mental Health program schedule will be included.** **4.1: Eastern Melbourne timely access to Mental Health Services (Investigation/report/consultancy):** **a** Compilation of current service availability **b** Report with recommendations for EMPHN commissioning activities. Service coordination improvements and the likely impacts of current sector reforms (NDIS/ SCM) **c** Propose how more access to a/h GP services could mitigate the need. d Performance of clinical intake system including referrals processed **4.3: Cultural and Linguistically Diverse Communities (CaLD) and Refugee mental health care and how to assist MH consumers and carers within these communities to gain better access to mental health services.** **a** Increased uptake by CaLD consumers of health services. **b** Better health and wellbeing outcomes for CaLD participants **c** Greater cultural awareness among EMPHN staff and practitioner's in partner agencies. **d** CaLD family members feel better informed and involved in health service decisions. **4.4: Suicide Prevention strategies.** **a** All region report with recommendations for coordinated suicide prevention approaches and gap filling proposals. b Review of reporting to DHHS related to the Place Based Suicide Prevention Project. 2017-2021 **4.6: A focus on co-occurring ongoing physical illness and severe enduring mental health needs.**

	a All region report with recommendations for targeted health & MH approaches and hot spot focused proposals. 4.7.1 MHNIP organisations are engaged and trial established
Local Performance Indicator target (where possible)	MHCSS data /Co-Health and EACH MHCSS data sets. Links to Acute Service data – Emergency Departments s/ PACERS/ AMHS (where possible) ATSI data through DHHS and VAHS. MHNIP availability relative to service need (geographically) PIR reporting to DoH – Including progress reports, MDS, NDIS Monthly Reports and Annual Plans.
Local Performance Indicator Data source	To be considered above.
Note	Transitional funding in discussion with Commonwealth - To date, conversations have occurred around additional interim funding in 2017-18 (to provide for continuity of care to clients as the stepped model of care is implemented and MHNIP is no longer quarantined) however this has not been confirmed by the Commonwealth. Uncertainty remains regarding the interim funding amount that may be allocated to EMPHN and the conditions of commissioning around these dollars. This will impact on our implementation of the AWP and the stepped care model

Proposed Activities	
Priority Area 5 Community Based Suicide Prevention Activities	• Encourage and promote a systems based regional approach to **suicide prevention** including community based activities and liaising with Local Hospital Networks (LHNs) and other providers to help ensure appropriate follow-up and support arrangements are in place at a regional level for individuals after a suicide attempt and for other people at high risk of suicide, including Aboriginal and Torres Strait Islander people.
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	5.1 Localised data collation and analysis. Community engagement with key stakeholders. Scoping of need within the community, including current service models, referral pathways and barriers to service access. 5.2 Health planning and program development and commissioning targeting the at risk populations. For example; Initial analysis of national data informs us that the following groups are at higher risk of suicide: • Post episode of care (discharge from ED relating to suicide attempt) • Indigenous • Those with mental illness • Males aged 85+ years 5.3 Collaborative data exploration, health planning and program development and commissioning targeting the indigenous population which will include the Collaboration with 6 Victorian PHNs and Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and Life Line to develop Aboriginal version of SafeTalk Suicide Alert Program 5.4 Health planning and program development and commissioning targeting the aging population. 5.5 Health planning and program development targeting those with a mental illness, and/or those who have presented to an emergency department post a suicide attempt. 5.6 In collaboration with key stakeholders and community members, review of current service provision, consumer experience of access and care and mapping of service gaps in relation to

	identified population need. Service review to align with stepped model of care; review of early intervention access and indicators, services that target those at risk, and collaboration with services that provide care for those at high risk of suicide. 5.7: Place-Based Suicide Prevention Initiative:
Existing, Modified, or New Activity	5.1-5.6 Existing activity; 5.7 Place based co-investment with the Victorian State Government will commence March 2017 with recruitment of staff and establishment of work plans around identified shared goals as negotiated in the coinvestment space.
Description of Activity	<u>5.1 There are areas where localised data is not sufficiently detailed and granular to provide actionable intelligence – we will source local, current and up to date data on the completed suicides in the EMPHN catchment through:</u> • ongoing liaison with local hospitals, and births, deaths and marriages to obtain local, up to data relevant data. • ongoing review of trends within the data exploring populations at risk of suicide and determinants that can be identified around risk. <u>5.2 From the data available, more men will complete suicide at a rate of approximately 3:1</u> Scoping of current situation through: • Initial engagement with key stakeholders – and those currently delivering services, who are the target groups, and what successes in driving down suicide rates? • Develop community engagement strategy in collaboration with EMPHN Community Advisory Council, and key stakeholder services • Establishing and commissioning service development approaches that support frontline staff in the identification of risk and promote service access and support, and further health promotion which promotes resilience, and community cohesiveness.

	These activities will form the base of the Place-Based Suicide Prevention Initiative, particularly targeting LGAs identified as holding higher levels of risk of suicide. These LGAs are Whittlesea and Maroondah. It is envisioned that the learnings and resources developed in focussing on these two LGAs can be further developed to support all LGAs in the EMPHN catchment over time. <u>5.3 People of Aboriginal descent are 2 times more likely to complete suicide in comparison to non-aboriginal people (proportional to population)</u> EMPHN is committed to working with the other five Victorian PHNs and Victorian Aboriginal Community Controlled Health Organisation (VACCHO) on a state-wide project to develop and deliver an ATSI version of SafeTalk on a train-the-trainer and train the layperson basis. Resources will be developed to support the roll-out. <u>5.4 From the 2013 data, Within the male population, the most at risk age groups 85 + years (38.3 in 100,000).</u> <u>Closely followed by</u> <u>45-49 (23.9 in 100,000)</u> <u>50-54 (23.9 in 100,000)</u> <u>and 80-84 (22.2 in 100,000)</u> • In addition to Activity 5.6, specific targeted interventions such as clinical education in dealing with the aging community, and their factors that uniquely contribute to suicide risk. Provision of education to General Practitioners and key stakeholders in liaison with local Aged Psychiatry services. Factors that uniquely contribute to suicide risk such as social isolation, declining physical health, loss or physical/personal integrity, increasing vulnerability and loss or bereavement. • Scope potential programs/ social inclusiveness programs currently available. • Co-investment in a suicide prevention model with the State Government through the commitment of funds to replicate the proposed model for Whittlesea in the Maroondah catchment, noting Maroondah has the highest rate of successful suicide in the EMPHN region, particularly middle aged males.

	• Work with services in 'the space' to collaborate and commission services designed to support and enable access for high risk populations and co-design workshops to facilitate service model development and evaluation. These activities will be included in the Place-Based Suicide Prevention Initiative. 5.5 Those found to be at higher risk of attempting and completing suicide are those recently discharged from ED following a suicide attempt, and those with a pre-existing mental illness **Links to activity 5.6 above.** • Continuity of current Commonwealth funded state wide SPS programs including Incolink and Jesuit Social Services has been confirmed; Quarterly contract meetings, Annual Work Plans and reviews incorporate quality and performance measures. • Scoping of current situation including all strategies in operation capturing those who have presented to ED, or to identify when it is a suicide attempt (versus Deliberate Self Harm). Review of particular times and factors associated with increased risk and barriers to service access, current strengths and system gaps in supporting people at times of greater need. • Analyse current and relevant data – looking for patterns and trends. Is there a 'hot spot' for a potential intervention? Review and commission harm minimisation, support access and family/carer support initiatives. • Build relationships with Local Psychiatric Inpatient Units and Emergency Departments to enhance and build on capacity to engage consumers in care following an episode of care. This may include greater support and links between acute care and general practice, and promotion of communication tools such as the My Health record. Link service collaboration, data scoping and service mapping activities to relevant population activities such as AOD, children, young people and families, and aged care. Review potential for enhancing linkages and relationships between service sectors to facilitate cross-sector care and consistent assessment, management and care for those presenting at risk of suicide. **5.7 EMPHN partnering with DHHS will establish two (2) place based suicide prevention initiatives** covering primarily Whittlesea and with a second focus on Maroondah. These initiatives will have an overall goal of reducing suicide in these two LGAs and act as trial sites for future SPS initiatives.

	EMPHN will encourage and promote a systems and regional based approach to suicide prevention including community based activities and liaising with Local Hospital Networks (LHNs), area mental health services (AMHS) and other providers to help ensure appropriate follow-up and support arrangements are in place at a regional level for individuals after a suicide attempt and for other people at high risk of suicide, including Aboriginal and Torres Strait Islander peoples. Coordinate with all other SPS approaches in the region- ATAPS (Community Health)/ DHHS / PACERs & ED /Acute and sub-acute services/ AMHS/ MHCSS/ AoD services. (Established March 2017 – ongoing)
Target population cohort	Suicide prevention activities cover the EMPHN catchment and all community members. Particular focus for promotion and support include populations identified as experiencing higher level of suicide risk, such as the Aboriginal and Torres Strait Islander population, aged populations in some LGAs, males and those touched by the experience of suicide.
Consultation	Joint consultation event to be held in March 2017 between EMPHN and Eastern Health (Eastern Health have been identified as a hospital-based pilot site for Victorian State funding targeting suicide prevention). Community event will target people who have had contact with Maroondah Emergency Department, or have had family or friends who have. The agenda is to identify the patient experience, discuss service and support gaps across the catchment and to explore strengths in proposed models to support people experiencing suicide. Ongoing consultation includes: • EMPHN Clinical Council • EMPHN Community Advisory Committee • Eastern Melbourne Collaborative and North East Melbourne Collaborative • Commissioned Services • Services providing support to people experiencing risk of suicide.
Collaboration	EMPHN will engage with a range of stakeholders across the catchment to ensure we develop a system wide approach, including:**Victorian Department of Health and Human Services.** *Through the Place Based Suicide Prevention initiatives, EMPHN has begun a co-commissioned service with DHHS.*

	Over the next four years this initiative will work in parallel with other related PHNs across Victoria and work towards a national goal of reducing suicide by 50% by 2025. **Hospitals within the catchment**- both public & private with an emergency department: • Maroondah Hospital- Ringwood • Box Hill Hospital- Box Hill • Angliss Hospital- Ferntree Gully • Mercy Hospital for Women- Heidelberg • Austin Hospital-Heidelberg • Northern Hospital- Epping • Monash Health- Clayton • Knox Private - *Eastern Health and Northern Health and Austin Health are engaged with EMPHN through the clinical council and through many other PHN projects. Private clinics and hospital are also key stakeholders in many of EMPHNs primary health work. Through these networks EMPHN will engage the hospital networks in better post discharge and transition planning for vulnerable patients.* **Targeted Psychological Strategies- SPS service providers (EMPHN**). ***Also including*** **Private Providers including psychologists and psychiatrists.** *EMPHN will continue to support targeted psychological interventions delivered by skilled, accredited Allied Health Professionals. EMPHN will also make efforts to engage the experience, practice and sector knowledge of these practitioners in designing and refocussing suicide prevention efforts in this area.* **General Practitioners and Private Practice:** *Recognising the reach of General Practice in the community EMHPN place based SP will work with the EMPHN GP Engagement teams to target SP capacity building and training to through GP accredited training and also to practice nurses and mental health nurses in the catchment.* **Area Mental Health Services (Northern, Austin, Eastern and Monash):** *AMHS provide much of the crisis Mental Health response in the community and within hospital EDs. These services will be key*

	stakeholders when considering how to provide more responsive follow up to those who present with suicidal ideation, and who may be discharged to the community while at risk of relapse and suicide. **Mental health support services such as Community Mental Health Support Services, PHaMS**: *As these services support their current consumers to transition to NDIS supports, there is likely to be a great deal of disruption in relationships with long term providers. EMHN through its extensive relationship developed through leading Partners in Recovery Services in the region will continue to collaborate with MHCSS providers to support better SP responses within the sector and to mitigate the risk that the NDIS presents to many vulnerable consumers.* **Local Government service, volunteer and other community providers:** *EMPHN will engage at a local level within Whittlesea and Maroondah to open up the connections with local services and volunteer organisations.* **Schools/ TAFE/ Education facilities and family services:** *Reaching vulnerable youth through school and family based services. Partnerships with headspace providers and their comprehensive local networks will also support this work.* **Services based in the AOD sector.** *Collaboration with AoD services is being supported within the Mental Health team at EMPHN. Suicide risk and substance use, will be a focus of many of the AoD projects which EMHN is commissioning and the SP team will support and seek collaboration with local AoD service providers.* Mental health support services such as Community Mental Health Support Services, PHaMS. Family Services Schools/ TAFE/ Education facilities Private Providers including psychologists and psychiatrists. Incolink Foundation Limited Jesuit Social Services Ltd SANE Australia Services based in the AOD sector.

Duration	12 months: establishment of collaborative relationships; further data scoping and problem definition and commissioning of services to occur in first year along with supporting service continuity for current services from July 1 2016. Duration of Place Based Suicide Prevention Initiative is approximately 4 years (to align with Victorian State Government funding commitment)
Coverage	Place-based suicide prevention approach with co-investment from Victorian State Government will target LGAs of Whittlesea and Maroondah; both LGAs have been identified as areas of higher risk for suicide and risk of suicide. It is envisioned that the learnings and approach established, as well as training resources and collaborative relationships established, will benefit the EMPHN catchment. Jesuit Social Service provide counselling in Richmond, and provide psychological support by phone, service capacity building within the EMPHN catchment and group work as required at sites of high need.
Commissioning method (if relevant)	Commissioning will follow the EMPHN Commissioning Framework. Commissioning approach begins with further population and data exploration, then collaborative approaches with services in the geographic area who service identified need to be scoped regarding shared problem definitions. Commissioning of co designed services will include target-specific evaluation and clear clinical governance reporting in accordance with the National Mental Health Standards (2010). Compliments and complaints procedures in accordance with commissioned services procedures and in line with EMPHN complaints process. The co-commissioning and solution design of suicide prevention services in Whittlesea (funded by Vic DHHS) and Maroondah (funded by EMPHN) is in the process of being negotiated with data sharing to identify hotspots and gender/age most affected has been undertaken, and collaboration in generating a workplan for those employed to undertake the Place Based Suicide Prevention initiative.

Approach to market	Our approach to procurement will be dependent on the outcome of our engagement and stakeholder work. To be advised. Purchased services of Incolink and Jesuit Social Services continues an arrangements in place prior to the PHN establishment.
Decommissioning	NA
Performance Indicator	**Service delivery indicators** **All appropriate service delivery indicators as detailed in the Primary Mental Health program schedule will be included.** The mandatory performance indicator for this priority is: • Number of people who are followed up by PHN-commissioned services following a recent suicide attempt. In addition, local performance indicators include: • Tracking of the effectiveness of interventions through key performance indicators, yet to be established- this may be the Sheehan's Suicide tracking scale for example. There will be a common tool to be established that will be used by all of the commissioned services. Tracking the number of client presenting to local ED's, and targets set around an expected referral volume into commissioned services. This will also involve tracking fall out rates, non-attendance to initial engagement appointments, and any further escalation in behaviours that would place the client at further, or ongoing risk, and any escalation of referrals into more acute tertiary services. • An increase in supports received, and uptake in local SPS services. • Reduction in completed suicides with the EMPHN catchment, as measured through a reduction in DOA to ED as a result of suicide.
Local Performance Indicator target (where possible)	Place-based Performance targets currently in negotiation with Victorian State government as co-investors in this initiative. Reporting period will cover commencement of initiative, then 6 monthly reporting for the term of the initiative.

	Jesuit Social Services quarterly reporting includes data on gender, age, residential LGA and mode of referral in addition to activity data. Incolink quarterly data reporting includes gender, age, location of TAFE institute and satisfaction measures including self report regarding changes in awareness of help seeking behaviour and supports available.
Local Performance Indicator Data source	Commissioned services- minimum data-set and internal population data Place Based Suicide Prevention – outcomes designed around building capacity and systems, training delivered and potentially change in supported services outcome data working with people presenting with risk. Local Health Network – Emergency Departments Births/ death/ marriages; Coroners data, ABS data

Proposed Activities - Priority Area 6 – Aboriginal and Torres Strait Islander Mental Health Services	
Priority Area 6: **Aboriginal and Torres Strait Islander Mental Health Services**	Enhance access to and better integrate **Aboriginal and Torres Strait Islander mental health** services at a local level facilitating a joined up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services.
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	Since submission of the 2016-17 Activity Work Plan, EMPHN's consultation and collaboration activities, which included solution co-design, have led to a more refined understanding of commissioning requirements which meet the above objective. This has resulted in activities being integrated or modified as follows: 6.1 Commission peer led programs for the outer east and north communities, to be based in Aboriginal Community Controlled Organisations (ACCOs) or co-located with their partners, to engage and support community members who wish to address their social and emotional wellbeing to: • access mental health (and AOD) services. • discuss service options with a peer worker who will "walk the journey" with the client and their family This activity will link with Integrated Team Care activities to drive a program that supports services (particularly AOD, mental health, general practice, community health) to become culturally safe. 6.2 Commission ACCOs and their partners (in the 2 key communities, outer north and outer east) to deliver peer-led recovery programs and support the communities to build their capacity to improve social and emotional wellbeing. 6.3 Commission ACCOs and their partners to deliver "Connection to Culture" programs which reconnect community members with mental health diagnoses to culture, land and community (building on models being piloted by Victorian Aboriginal Health Service and the growing evidence-base in New Zealand Maori programs). 6.4 Support the development of EMPHN's Stepped Care Model for Mental Health to build the capacity of providers of low, medium and high intensity clinical mental health services to deliver trauma-informed culturally-safe services in outer east Healesville communities and north communities.

	6.5 Develop ATSI-specific mental health pathways and work with LHN Area Mental Health Services to respond more quickly (when person recognises mental illness and is at the point of readiness)
Existing, Modified, or New Activity	Modified activity (2016-17 Activity Work Plan)
Description of Activity	*Additional Information* In developing EMPHN's ATSI Commissioning Strategy (post CNA), it was identified that the recommissioning of Victoria's AOD services led to complicated and reduced access to services generally and specifically for Aboriginal people. The recommissioning of Victoria's Mental Health Community Support Services (which are soon to be subsumed into NDIS) led to a similar outcome. Based on information gathered since the initial CNA, EMPHN's approach is to build the capacity of communities and the existing service system to meet the needs of its Aboriginal communities by commissioning peer-led recovery and connection to culture programs. EMPHN will integrate a cultural safety and trauma-informed approach for its overarching stepped model of care.
Target population cohort	Activities and initiatives within this priority area will target people from the Aboriginal and/or Torres Strait Islander Community, their families and carers.
Consultation	EMPHN has consulted with Victorian Department of Health and Human Services East Division; Eastern Metropolitan Aboriginal Health and Wellbeing Network; Healesville Integrated Services Hub Development Group including representation by Victorian Department of Health & Human Services, Eastern Health, Inspiro and EACH community health services, Shire of Yarra Ranges, mental health, AOD, community legal, VACCHO and Woor-Dungin Inc., Mullum Mullum Indigenous Gathering Place, Healesville Indigenous Community Services Association (HICSA), Bubup Wilam, Access Services for Koories, Victorian Aboriginal Health Service, Boorndawan Wilam, Banyule Community Health Service, Plenty Valley Community Health Service.
Collaboration	<u>Key stakeholders include:</u> • Aboriginal and/or Torres Strait Islander people living in the Eastern Melbourne PHN catchment • Local Aboriginal and Torres Strait Islander community controlled organisations: Healesville Indigenous Community Services Association, Mullum Mullum Indigenous Gathering Place, Boorndawan Willam • Victorian Aboriginal Health Service • Wadamba Wilam • Access Services for Koories (ASK)

	• Victorian Department of Health and Human Services Inner East, Outer East and Goulburn Divisions • General practices • Local community health services • Local Hospital Networks • Primary Care Partnerships
Duration	To June 2018.
Coverage	Targeted areas of the catchment where there are higher populations of Aboriginal and Torres strait Islanders (Yarra Ranges, Banyule and Whittlesea LGAs).
Commissioning method (if relevant)	Commissioning activities will follow the EMPHN Aboriginal Health and Wellbeing Commissioning Framework (attached) which is premised on self-determination and co-design, the first principle being that EMPHN will request selective tenders, working through the Aboriginal Controlled Community Organisations (ACCOs) as lead agencies or organisations as determined by the community.
Approach to market	Direct engagement.
Decommissioning	Not applicable.
Performance Indicator	Priority Area 6 - Mandatory performance indicator: • Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate.
Local Performance Indicator target (where possible)	Data will be disaggregated by gender, age, local government authority of client residence, number and type of services accessed. As at least one the contracted services is entering into a new service delivery area, a baseline is unavailable. Targets are set for the activity as a whole, as follows: • 10 (year 1) people from Aboriginal communities access EMPHN commissioned programs • 20 (year 2) people from Aboriginal communities access EMPHN commissioned programs • 25 (year 3) people from Aboriginal communities access EMPHN commissioned programs (links to 6.1, 6.2, 6.3).

	• 10 mainstream mental health and AOD services access cultural safety training facilitated by EMPHN or EMPHN commissioned programs in each year.
Local Performance Indicator Data source	Evaluation data will include: • Program attendance data from commissioned agencies/communities • Number of clients supported to access alcohol and other drugs and mental health treatment as a result of EMPHN commissioned Programs. These data will be reported quarterly by contracted organisations. This indicator is not sourced from a national data set. The commencement date of the data collection will be February 2017 (outer east) and April 2017 north).

Proposed Activities	
Priority Area 7: Stepped Care Approach	• A continuum of primary mental health services within a person-centred **stepped care approach** so that a range of service types, making the best use of available workforce and technology, are available within local regions to better match with individual and local population need.
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	7.1 Application of a stepped model approach across mental health service delivery for EMPHN 7.1.2 Implementation of a clinical intake system as a central entry point to the primary mental health service system to coordinated and direct people to most appropriate services at point of entry 7.2 Lead site implementation of low intensity services 7.3 Development of a Mental Health Stepped Care document that underpins all commissioned activities and articulates the operationalisation of the steps within the stepped care model. This document (currently in development) will guide screening and triage of clients to different steps within the model, articulate interventions available within each step, and pathways as people move across the continuum of the service model and may include – step up as need for care increases in intensity, or down as clients become increasingly well. The Mental Health Stepped Care document will include activity and access for at risk populations including CALD and people from Aboriginal and Torres Strait Islander backgrounds. The document will underpin the development of processes within the Stepped Model of Care, including approaches to client handover between providers (as clinically indicated). Early discussions have identified client handover should be driven by clinical need rather than program specifications and the document will be the EMPHN starting point for model development addressing these issues.
Existing, Modified, or New Activity	Development of a stepped care model is an ongoing activity in both the 16/17 AWP and the current plan.
Description of Activity	7.1 Establishing a stepped model of care through services delivered by EMPHN and connections with other associated services that allow consumers the ability to access the right service according to the presentation and complexity and transverse the different levels of intensity across the stepped care services according to acuity and recovery for a seamless patient journey. This will include the transition of previously ATAPS and MHNIP services into flexible funded services under the stepped care model along with commissioning new services as required to fill identified gaps to meet the needs of the EMPHN community. The model will be designed to respond to client needs along a continuum of care.

	7.1.2 A key component of establishing a stepped care model of care is the implementation of the central intake point to the system allowing the consumer to have choice in their care, whilst still being directed to the right services. If a consumer needs their care to step up or down this can be coordinated by the centralised Intake team to reduce the need for multiple assessments and to ensure continuity of care and smooth transition. In July 2016, EMPHN established the Clinical Intake and Community Engagement Team (CICET); this team has core function of screening and processing referrals at the point of entry, as well as supporting referrers and the community in establishing their recovery goals and identifying services relevant to those goals and appropriate to the client's presenting clinical issues. CICET continues to develop and build relationships with providers and stakeholders within the primary care setting and mental health service sector to facilitate integration of client care across the sector. 7.2 As a lead site, EMPHN will be responsible for innovation in stepped care, regional planning and integration, and the development of **low intensity** interventions for people with emerging or mild mental health issues. EMPHN is currently commissioning low intensity mental health services targeting people with, or at risk of, mild mental illness. This will form a strategic early component of the stepped model of care. The EMPHN Mental Health Team, building on community forums and stakeholder collaboration, has explored multiple models and platforms that may offer clinically significant interventions and associated positive outcomes in the Low Intensity Mental Health step of the model of care. In order to develop a Low Intensity model that is qualitatively different to the Better Outcomes (ATAPS) or Better Access treatment, with the capacity to deliver emerging yet evidence-based interventions for less cost, the team have compiled a list of core and key components that the Low Intensity model would need to meet. The core components of the model proposed are: • CBT-based content targeting anxiety and depression; content supported with computer-based platform • Therapist-led brief sessions (approximately 6 per intervention) • Feedback loop to referring GP Key components of the model will include: • Access points to the intervention (supporting GPs to refer clients presenting with mild or emerging symptoms) • Education to community and GPs regarding free-to-access computer-only platforms

	available as a step prior to the Low Intensity intervention with the goal of increasing scope of client choice, and potentially an earlier intervention, before symptoms become more appare • Evaluation of efficacy including: Referral rate retention data symptom improvement user-experience GP feedback Financial reporting
Target population cohort	Entire EMPHN Catchment population including people experiencing high prevalence or early signs of mental health disturbance, through to people experiencing severe and complex mental health conditions.
Consultation	The PHN will look to engage with the following stakeholders during this activity; Local health networks – Adjacent PHNs Mental health professional representatives – to be to be identified through Clinical Council (GP, clinician and other appropriate professionals). Consumer representatives – to be identified through Community Advisory Committee Carer representatives – to be to be identified through Community Advisory Committee The establishment of a mental health reference group for the region will help to guide activity and assist in the co-design process with stakeholders and providers to plan and commission service delivery in the region. This mental health reference group is expected to include representation from the following sectors: General Practice, community mental health, acute mental health services, private providers and carer and consumer representation. The PHN will liaise with the above mentioned stakeholders in a collaborative process of scoping the positives of the current mental health system, and the gaps, barriers and requirements for a commissioning approach for a stepped care model.

Collaboration	List stakeholders that will be involved in implementing the activity, including Local Hospital Network or state/territory government. Describe the role of each party. Implementation of new activities is currently in the procurement stage of commissioning. Various collaborative forums have driven mental health stepped care model design to date including: The Eastern Melbourne Collaborative and North East Melbourne Collaborative. The Collaborative structures (described in the Strategic section above) provide a platform for consultation and collaboration at multiple levels within local organisations from the CEO/Executive level to management and strategic roles. The Collaborative agenda is to enhance and build on existing services, identify gaps and jointly develop initiative to address identified gaps. Mental Health service system has been a focus of both Collaborative structures, with input from Commonwealth and State funded services. Community and stakeholder forums have been held to explore and generate key principles of care for specific mental health initiatives including; • Youth Severe Mental Health • Low Intensity Lead Site • Hard to Reach populations and approaches that facilitate access and care. Forums to be held in February 2017 include; • Mental Health Nurse forum • Community Suicide Prevention Forum (jointly held forum between EMPHN and Eastern Health) An Alcohol and Other Drug Reference Group also met through 2016 to drive identification of priorities for the EMPHN catchment, discuss the evidence base for intervention and relevance to the EMPHN catchment demographic, and propose commissioning approaches. EMPHN has also presented early model development and conceptualisation of the MH Stepped Model of Care to the EMPHN Clinical Council and the Community Advisory Committee, both of which include consumers, carers and people with expertise in the delivery of MH services.

Duration	Initial Stepped Care Model document (in conjunction with engaged Consultancy firm Synergia) to be delivered Feb 2017 and will drive stages of change from existing service provision and contractual arrangements to the stepped care model.
Coverage	EMPHN Catchment
Commissioning method (if relevant)	Commissioning to follow the EMPHN Commissioning Framework. Commissioning of low intensity services will be undertaken in line with the lead site arrangements. It is anticipated that an assessment of the market and approach will be undertaken for purchase of services. Contracted services as per all contracts will include specified performance, reporting and evaluation requirements to ensure progress is monitored and EMPHN is able to work with services that are unable to meet contract expectations. Co-design of interventions to meet identified need will occur in collaboration with key stakeholders, including those currently delivering service to develop alternate funding models and pilots to be tested. Innovative models in commissioning process in January/February 2017 and will continue through 17/18; evaluation and review at regular intervals (quarterly) to contribute to annual planning in early 2018.
Approach to market	Approach to market is described in each priority plan.
Decommissioning	NA.
Performance Indicator	The mandatory performance indicator for this priority is: 7.1.1 Evidence of a stepped model approach applied in service planning and commissioning (process) 7.1.2 Review of clinical intake and referrer feedback data demonstrates accessibility to the appropriate commissioned services in a timely fashion (impact) 7.2 Proportion of PHN flexible mental health funding allocated to low intensity services, psychological therapies and for clinical care coordination for those with severe and complex mental illness. (mandatory)
Local Performance Indicator target (where possible)	7.1.1 A review of services by consumers and stakeholders identifies a stepped model of care approach has been applied to the range of services commissioned by the PHN with good accessibility and ability to transition between services, and levels of care.

	7.1.2 90% of referred clients are able to access services within set threshold of time and referrer feedback indicates 90% appropriate service accessed for their client. Data is expected to be disaggregated for gender, age (particularly for youth) and acuity level (low intensity conditions vs high intensity) 7.2 Proportion of funding is in line with budget in initial set-up and data from 7.1.2 indicates appropriate allocation for demand
Local Performance Indicator Data source	7.1.1 Service Model design and commissioning specifications, consumer and provider consultation data, spot evaluation of patient journey for consumers willing to participate in evaluation. Client journey information will be explored as pathways to care are being established through the Stepped Model of Care and will incorporate consumer feedback and experience of the service system. 7.1.2 Clinical intake KPI data, Complaints/Feedback mechanism data, stakeholder consultations including GP's, reported Category 1 and 2 incidents. 7.2 Budget data, evaluation data from establishment of low intensity services including e-mental health.

Proposed Activities	
Priority Area 8: Regional mental health and suicide prevention plan	Evidence based **regional mental health and suicide prevention** plans and service mapping to identify needs and gaps, reduce duplication, remove inefficiencies and encourage integration.
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	8.1 Continued engagement and collaboration with State funded Catchment Planners to build upon the existing catchment planning needs assessment and plan and incorporate the Commonwealth funded and primary care perspectives.
Existing, Modified, or New Activity	Existing activity
Description of Activity	It has been recognised through the needs assessment that significant work has been undertaken in the consultation of providers and review of available data to date to establish regional priorities. These assisted in the development of the mental health needs assessment with further service mapping undertaken by EMPHN, particularly of commonwealth funded services, as catchment planners have a focus on state funded service. Through this process the recognition of the need to work together due to stakeholder consultation fatigue and the need for both Commonwealth and State funded services to be recognised in order to obtain a true regional needs assessment and planning approach was noted. In line with our commissioning approach as articulated in Section 1a of this plan, collaborative co-design approaches underpin the planning and commissioning of services. Therefore building upon the catchment planning and engaging the Eastern Melbourne Collaborative and North East Melbourne Collaborative will be key approaches in the development of a robust regional mental health and suicide prevention plan and commissioning of services. In collaboration with key stakeholders and community members, review of current service provision, consumer experience of access to care and mapping of service gaps in relation to identified population need. Service review to align with stepped model of care; review of early intervention access and indicators, services that target those at risk, and collaboration with services that provide care for those at high risk of suicide.
Target population cohort	EMPHN catchment
Consultation	In recognition of the significant catchment planning underway in the region regarding state funded mental health and AOD services, EMPHN is working collaboratively to establish shared data

	arrangements with local catchment planners to reduce duplication, expedite access to data and bolster consultation efforts. EMPHN will utilise current established networks and alliances such as the Eastern Mental Health Service Coordination Alliance (EMHSCA), 3 PIR consortiums and 3 headspace consortiums to garner their knowledge and experience of the service system and to collaborate with local service providers. In addition, the engagement with the Collaborative structure for the region will help to guide activity and assist in the co-design process with stakeholders and providers to plan and commission service delivery in the region. The EMPHN Clinical Council and Community Advisory Committee include consumers and carers, GPs and local service providers in mental health, in addition to those with experience across primary care. These established structures provide a platform for collaboration and early co design to inform the developing model of Mental Health Stepped Care localised to EMPHN catchment needs, gaps and community profile.
Collaboration	Implementation of new activities is currently in the procurement stage of commissioning. Various collaborative forums have driven mental health stepped care model design to date including: The Eastern Melbourne Collaborative and North East Melbourne Collaborative. The Collaborative structures (described in the Strategic section above) provide a platform for consultation and collaboration at multiple levels within local organisations from the CEO/Executive level to management and strategic roles. The Collaborative agenda is to enhance and build on existing services, identify gaps and jointly develop initiatives to address identified gaps. Mental Health service system has been a focus of both Collaborative structures, with input from Commonwealth and State funded services. Community and stakeholder forums have been held to explore and generate key principles of care for specific mental health initiatives including; • Youth Severe Mental Health

	• Low Intensity Lead Site • Hard to Reach populations and approaches that facilitate access and care. Forums to be held in February 2017 include; • Mental Health Nurse forum • Community Suicide Prevention Forum (jointly held forum between EMPHN and Eastern Health) An Alcohol and Other Drug Reference Group also met through 2016 to drive identification of priorities for the EMPHN catchment, discuss the evidence base for intervention and relevance to the EMPHN catchment demographic, and propose commissioning approaches. EMPHN has also presented early model development and conceptualisation of the MH Stepped Model of Care to the EMPHN Clinical Council and the Community Advisory Committee, both of which include consumers, carers and people with expertise in the delivery of MH services.
Duration	Ongoing.
Coverage	EMPHN Catchment
Commissioning method (if relevant)	This activity will be undertaken by Mental Health Team staff to inform commissioning activity
Approach to market	NA
Decommissioning	NA
Performance Indicator	The mandatory performance indicator for this priority is: • Evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery. • Establishment of a collaborative process and structures with mental health expertise to inform planning and commissioning • Ongoing development of mental health service system mapping providing an overview of the current services system and population health needs to inform future service system planning.
Local Performance Indicator target (where possible)	Established meeting structures for:

	- data sharing - integrated regional planning and service design/delivery Collaborative structures established with representation of primary care, acute and community sectors. Established data profile of the catchment that will support the identification of services gaps within pockets of the catchment and also reference to 'hard to reach', and at risk groups of the population.
Local Performance Indicator Data source	Meeting minutes and frequency (may be participation in existing networks in addition to data sharing meetings with catchment planners) Setting of Mental Health agenda within the Collaborative structure and priorities. Engagement with community representatives and stakeholders around specific initiatives within the mental health model of stepped care, in addition to the over-arching model development and implementation plan. Commissioned services- minimum data-set and internal population data Local Health Network – Emergency Departments

FOR MORE INFORMATION

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