Australian Government

Department of Health

phn
EASTERN MELBOURNE

An Australian Government Initiative

Primary Health Networks
Primary Mental Health Core Funding

Annual Mental Health Activity Work Plan 2016–2017

Eastern Melbourne Primary Health Network

Introduction

Overview

This Plan covers activities funded under two sources:

- the Primary Mental Health Care flexible funding pool over three years commencing in 2016-17; and

- *Indigenous Australians' Health Programme* to enhance and better integrate Aboriginal and Torres Strait Islander mental health.

This is to be distinguished from the *Regional Mental Health and Suicide Prevention Plan* to be developed in consultation with Local Hospital Networks (LHNs) and other regional stakeholders which is due in 2017 (see Mental Health PHN Circular 2/2016).

Objectives

The objectives of the PHN mental health funding are to:

- 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**;

- 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;

- 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;

- 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;

- 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; and

- 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. For this Objective, both the *Primary Health Networks Grant Programme Guidelines – Annexure A1 - Primary Mental Health Care* and the *Indigenous Australians' Health Programme – Programme Guidelines* apply.

Objectives 1–6 will be underpinned by:

- evidence based **regional mental health and suicide prevention** plans and service mapping to identify needs and gaps, reduce duplication, remove inefficiencies and encourage integration; and

- 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.

1. (a) Strategic Vision

Our vision: Better primary healthcare for Eastern and North-Eastern Melbourne.

Our role: We facilitate primary care system improvement and redesign.

Our purpose: Better health outcomes. Better experience. Better system efficiency.

Our strategic objectives:

1. Leaders commit to system improvement
   1a. Joint forecasting and planning occurs
   1b. Investment decisions are targeted for highest impact
   1c. Leadership and change capacity is enhanced

2. Investment decisions are targeted for highest impact
   2a. Consumers and providers (including GPs) are engaged
   2b. Service needs are prioritized and identified gaps are filled
   2c. Improvement proposals are based
   on best evidence

3. Care processes designed for need and best use of resources
   3a. Design and re-design occurs collaboratively
   3b. Services are reoriented to better meet needs
   3c. Patients know where to go, when and why
   3d. Effective, efficient services are procured

Our values:

- Leadership
- Understanding
- Collaboration
- Outcomes

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.
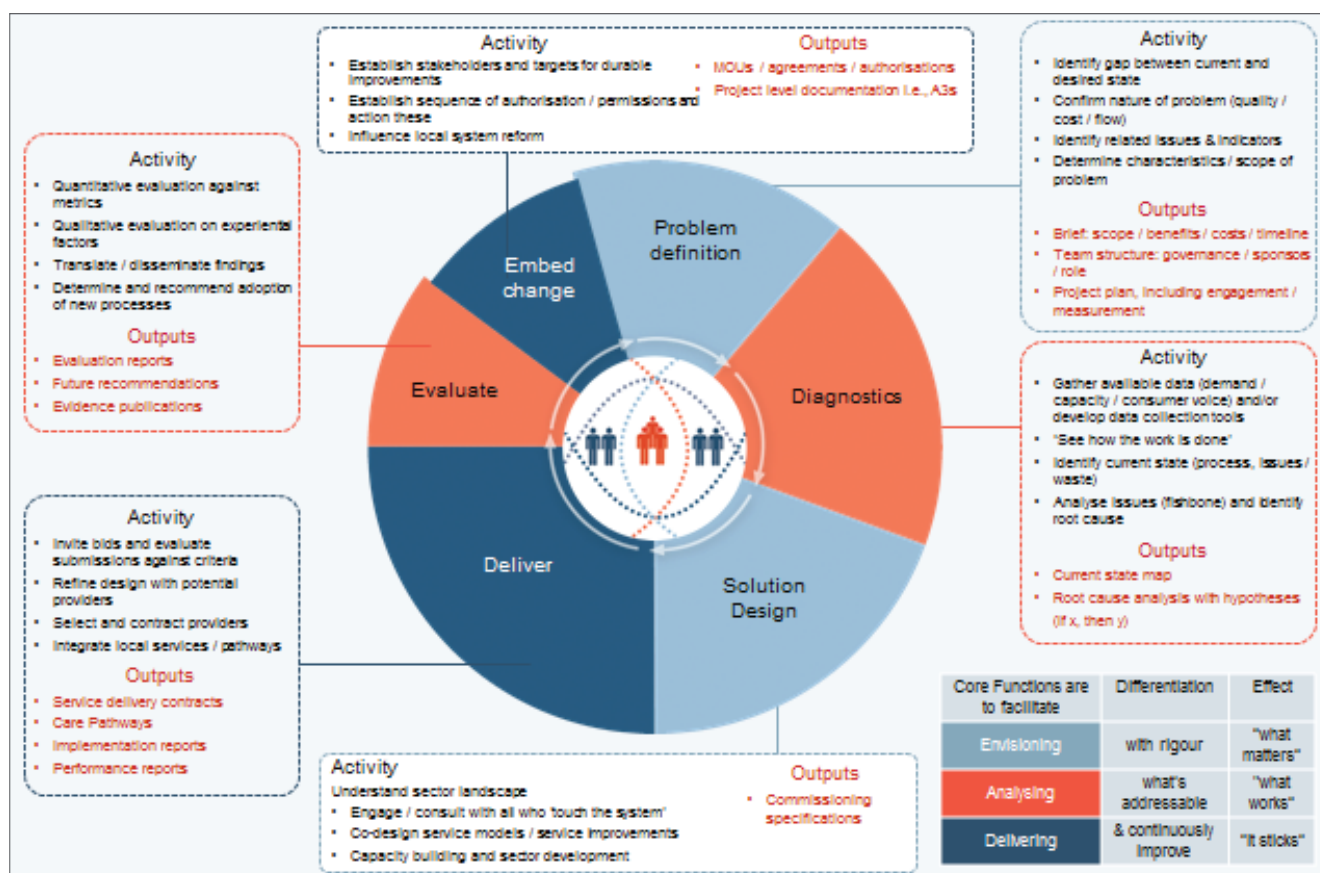

Figure 1. Commissioning cycle

Underpinning the phases of the Commissioning Cycle is a focus on ongoing relationships with consumers, providers and other stakeholders.
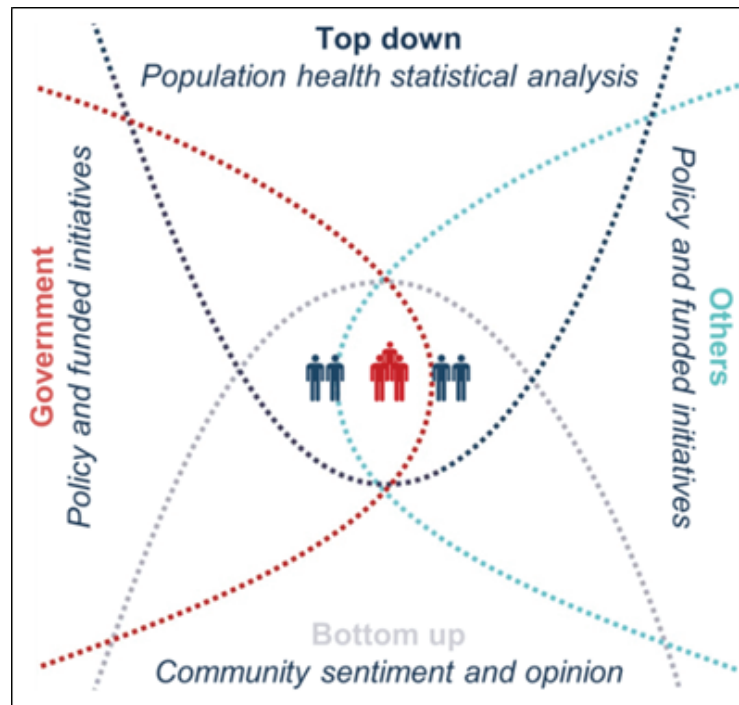
Figure 2. Prioritisation approach

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.
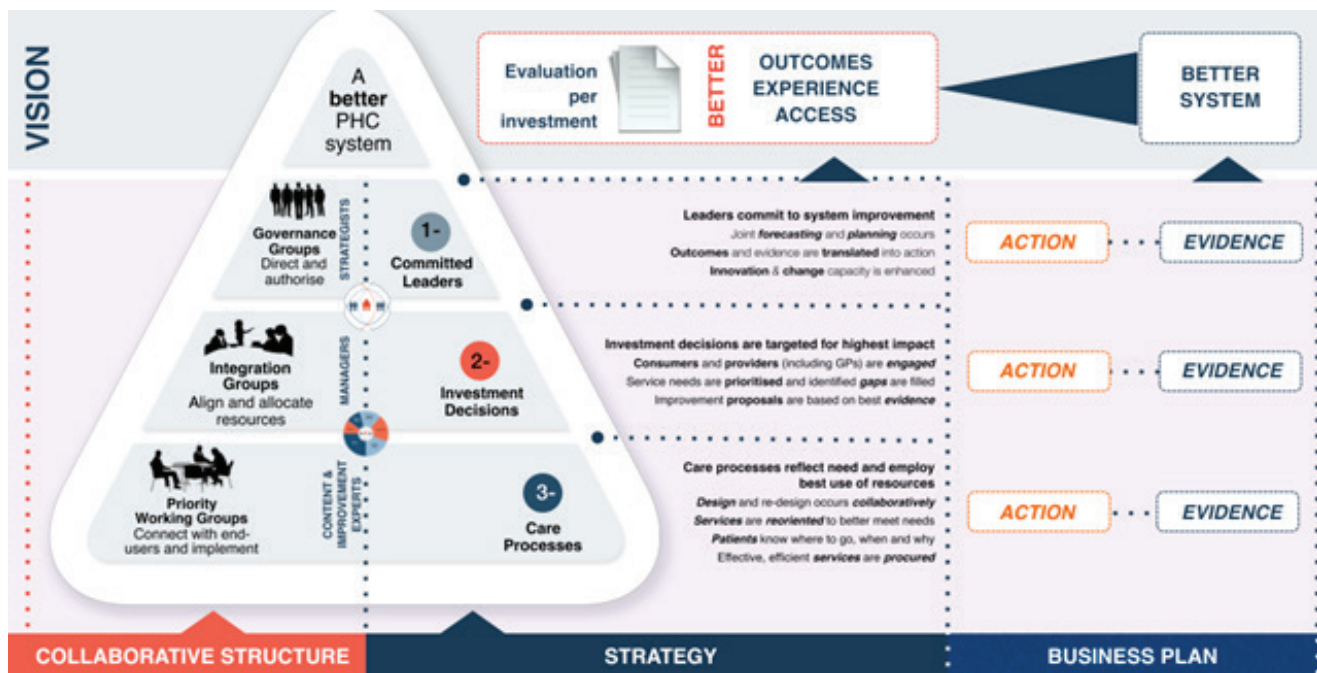
Consultative structures

Figure 2. 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 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 initiative.

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

Proposed Activities	
Priority Area 1: Low intensity mental health services	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • 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 Reference	1.1 High prevalence / Low Acuity Hard to reach (formally Access to Allied Psychological Services ATAPS) This program includes specific strategies to target children, people from Aboriginal and Torres Strait Islander backgrounds and those experience mental illness in the perinatal period. 1.2 EMPHN e-health program 1.3 Development of a low intensity face to face mental health service model with client centred innovation as the predominant developmental influence
Description of Activity and rationale	**1.1 High prevalence / Low Acuity Hard to Reach (HTR)** **EMPHN needs assessment informing 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 socio-economic status (SES) backgrounds. The EMPHN needs assessment 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 have poor public transport making access to services harder and there are a number of remote areas within the EMPHN catchment. The Yarra Ranges and Whittlesea also both have low numbers of services available.

Aim: To commission the delivery of a stepped care model that encompasses the EMPHN HTR program for the 2016 - 2017 reporting period. This will focus on but not be restricted to the hard to reach populations/target groups outlined in the Guidelines and EMPHN Commissioning of services will include selected appropriate individual contractors and selected organisations currently delivering services through contracting arrangements. EMPHN HTR will also focus on improving equity of access and service delivery to low income/disadvantaged and children and young people with new individual contractors identified as appropriate via a needs analysis conducted by EMPHN.

How the activity will address the priority: This activity will address the priority by delivering focused psychological strategies in a stepped care model to people from low income/disadvantaged backgrounds and children and young people with mild to moderate mental health presentations and/or those people within the EMPHN catchment who would benefit from short term psychological interventions. Face to face services will be the predominant focus of this activity.

Target population cohort:

- People not able to access Medicare funded mental health services or who are less able to pay fees.
- People with mild to moderate mental health presentations and/or those people who would benefit from low intensity/ short term psychological interventions.
- Children and young people with a particular focus on identified at risk groups.

1.2 EMPHN E-health Program

EMPHN needs assessment informing 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 socio-economic status (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. The EMPHN needs assessment 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 remote 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.

Aim: To commission the delivery of an EMPHN e-health program for the 2016 - 2017 reporting period. This will focus on the hard to reach populations/target groups outlined in section three who might benefit from a low intensity e-health based therapeutic service. 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.

How the activity will address the priority: This activity will address the priority by delivering low intensity focused psychological strategies to people from with mild to moderate mental health presentations and/or those people within the EMPHN catchment who would benefit from a low intensity brief e-health psychological intervention, supported by an appropriately skilled group of mental health workers commissioned by EMPHN.

Target population cohort:

- People with mild to moderate mental health presentations and/or who would benefit from low intensity/ brief psychological interventions. These people may have sub-threshold mental health issues and not meet criteria for short term interventions such the HTR/ATAPS and Better Access Initiatives.

1.3 Development of a low intensity face to face mental health service model with client centred innovation as the predominant developmental influence

EMPHN needs assessment informing this task – Again, the EMPHN needs assessment has identified that there are hard to reach populations within the EMPHN catchment that would benefit from an accessible free psychological services program. The feedback from multiple stakeholders around the ATAPS and Better Access programs is however that the particular facets of the referral process and service delivery inhibit effective service delivery are ultimately not client centred.

	Aim: To develop a new short term focused psychological strategies service model. The defining characteristics would be flexibility to identified client need and client centred access.
	How the activity will address the priority: This activity will improve access to services for people comprising the low intensity target group 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.
	Target population cohort: • People with mild to moderate mental health presentations and/or those who would benefit from short-term/low intensity psychological interventions.
Collaboration	**1.1 HTR/ATAPS** 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. Federal Government – To develop a commissioning strategy to improve access to services and service usage for Aboriginal and/or Torres Strait Islander people. Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Healesville Indigenous community Services (HICSA), Victorian Aboriginal Health Service (VAHS), Victorian Aboriginal Child Care Agency (VACCA), Mullum Mullum Indigenous gathering Place 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 be identified through Community Advisory Committee. To inform the ongoing commissioning cycle for low intensity mental health.

Carer representatives – to be to be identified through Community Advisory Committee. To inform the ongoing commissioning cycle for low intensity mental health.

Mental health professional representatives – to be to be identified through Clinical Council (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 with youth target group as focus.

NGOs – Connections UnitingCare, Anglicare, EACH, Melbourne East GP Network (MEGPN), others to be identified.

Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Monashlink – to partner in commissioning of ATAPS services.

Individual private therapists - to partner in commissioning of ATAPS services.

Tertiary Health – Eastern Health, Austin Health, Monash Health and Northern Health – to partner in stepped care of target groups where appropriate.

1.2 EMPHN E-health Program

The PHN will look to engage with the following stakeholders during this activity;

LHNs – adjacent PHNs to establish collaborative partnerships to improve commissioning of e-health pilot projects.

State Government - liaison around statistics/ information/ resources that that may identify appropriate populations for low intensity e-health initiatives.

Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Healesville Indigenous community Services (HICSA), Victorian Aboriginal Health Service (VAHS), Victorian Aboriginal Child Care Agency (VACCA), Mullum Mullum Indigenous gathering Place and Wadamba Wilam - to partner in developing a commissioning strategy for the culturally appropriate commissioning of a low intensity brief e-health model of therapy.

Consumer representatives – to be identified through Community Advisory Committee – to aid in commissioning of client centred models of e-health.

Carer representatives – to be to be identified through Community Advisory Committee. To aid in commissioning of client centred models of e-health.

Mental health professional representatives – to be to be identified through Clinical Council (GP, clinician and other appropriate professionals). To inform the ongoing commissioning cycle for low intensity mental health.

Consumer organisations – Headspace (to provide input to youth appropriate commissioning of e-health), Beyond Blue - Potential e-health program provider and partner for EMPHN pilot.

NGOs – Connections UnitingCare, Anglicare, EACH, Melbourne East GP Network (MEGPHN), others to be determined.

Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Monashlink, – Potential partners in commissioning of e-health pilot. Turning Point – Potential e-health program provider and partner for EMPHN pilot.

Individual mental health support workers - to partner in commissioning of e-health program

Tertiary Institution – Deakin university - Potential e-health program provider and partner for EMPHN pilot.

Tertiary Health – Austin Health - Potential e-health program provider and partner for EMPHN pilot.

1.3 Development of a low intensity face to face mental health service model with client centred innovation as the predominant developmental influence

The PHN will look to engage with the following stakeholders during this activity;

LHNs – Adjacent PHNs to establish collaborative relationships in the development of the new model.

State Government - liaison around statistics/ information/ resources that may identify appropriate target populations for the new model.

	Federal Government – To partner in development of therapeutic service.
	Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Healesville Indigenous community Services (HICSA), Victorian Aboriginal Health Service (VAHS), Victorian Aboriginal Child Care Agency (VACCA), Mullum Mullum Indigenous gathering Place and Wadamba Wilam - to partner in developing a model that is culturally appropriate for this part of the community.
	Consumer representatives – to be identified through Community Advisory Committee. To inform the ongoing commissioning cycle for low intensity mental health.
	Carer representatives – to be to be identified through Community Advisory Committee. To inform the ongoing commissioning cycle for low intensity mental health.
	Mental health professional representatives – to be to be identified through Clinical Council (GP, clinician and other appropriate professionals). To inform the ongoing commissioning cycle for low intensity mental health.
	Consumer organisations – Headspace - to provide input to youth appropriate commissioning of low intensity health innovations, others to be identified.
	NGOs – Connections UnitingCare, Anglicare, EACH, Melbourne East GP Network (MEGPHN), others to be identified.
	Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Monashlink, others to be identified– to partner in low intensity mental health service innovation.

Duration	Anticipated activity start and completion dates (excluding the planning and procurement cycle).
	
	1.1 Hard to Reach / (ATAPS)
	
	    Start: July 2016
	
	    Completion: August 2017 (evaluation completion)
	
	1.2 EMPHN E-health program
	
	    Start: August 2016
	
	    Completion: August 2017 (evaluation completion)

	1.3 Development of a low intensity face to face mental health service model with client centred innovation as the predominant developmental influence Start: August 2016 Completion: May 2017
Coverage	Entire PHN catchment for 1.1 and 1.2. EMPHN will plan to pilot 1.3 in next reporting period.
Commissioning approach	All commissioning of EMPHN services will follow the EMPHN commissioning framework. **1.1 HTR/ATAPS** Services to be contracted from appropriate clinicians, CHS and NGOs **1.2 EMPHN E-health Program** E-health programs contracted from CHS and/or NGOs. In some instances the actual e-health platforms and programs will have to be purchased prior to the contracting of the clinical service delivery components. **1.3 Development of a low intensity face to face mental health service model with client centred innovation as the predominant developmental influence** Services delivery will occur during the 2016 -2017 reporting period with services developed and rolled out as part of our commissioning and ongoing consultation. Include a description of how contracted services will be monitored and evaluated. Contracted services will be monitored by establishment of program specific Key Performance Indicators. These will be largely guided by the as yet not released Minimum Data Set which is likely to include but may not 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 (HONOS and the like) - Delivery of services across identified target groups
Performance Indicator	The mandatory performance indicators for this priority are: - Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services. - Average cost per PHN-commissioned mental health service – Low intensity services. - Clinical outcomes for people receiving PHN-commissioned low intensity mental health services. In addition to the mandatory performance indicator, you may select a local performance indicator. What local performance indicator will measure the outcome of this activity? Is this a process, output or outcome indicator? The performance indicator 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.
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). What is the baseline for this indicator target and what is the effective date of this baseline? What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age)

	1.1 HTR/ATAPS Minimum Data Set (MDS) will be used for the performance targets for this activity. The baseline indicator will be the 2016-2017 ATAPS MDS figures. The disaggregation will be defined by MDS data points as defined by Department of Health. **1.2 EMPHN e-health program** A data set will need to be established for evaluation of this pilot. As this is a pilot the 2016 - 2017 evaluation will provide EMPHN with a set of data on which to select a performance indicator/s for the second year of this model of service delivery. **1.3 Development of a low intensity face to face mental health service model with client centred innovation as the predominant developmental influence** To be determined based on the system put in place for the trial.
Local Performance Indicator Data source	Provide details on the data source that will be used to monitor progress against this indicator. Is this indicator sourced from a national data set? If so, what national data set? Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection? The data sources are stated in the above section where appropriate. The PHN will plan to collect data throughout the reporting period with the above-mentioned methods from July 2016. MDS is a national data set.

Proposed Activities	
Priority Area 2: Youth mental health services	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding:

	• 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 Reference	2.1 Deeper dive scoping of current situation utilising collaboration with stakeholder organisations. 2.2 Collaborative process discussion with stakeholders and consumers to discuss targeted interventions and explore the evidence base. 2.3 Facilitate co-design processes to establish targeted interventions at the stepped care level identified using partnerships with appropriate agencies 2.4 Collaborate with current services in Manningham, explore history of service evolution and process of increasing service gaps to establish and enhance pathways of referral .] 2.5 Liaison with youth-specific services including Headspace Hawthorn and family support agencies covering Manningham, Austin CYMHS and YSAS/AOD services. 2.6 Identification of Undertaking a service commissioning or recommissioning response to identified need
Description of Activity and rationale	Needs assessment identified: 2a. School absenteeism and social isolation; particularly associated with high prevalence disorders and spread across the LGAs of Boroondara, Manningham, Maroondah, Monash, Nillumbik and Whittlesea. <u>Linked with activity: 2.1, 2.2, 2.3</u> 2b. Youth AOD issues; Nillumbik identified as experiencing high levels of problematic AOD use. <u>Linked with activity: 2.1, 2.4, 2.5</u> 2c. Service gaps identified in Manningham. <u>Linked with activity: 2.1, 2.8, 2.9, 2.10, 2.11</u> 2d. Youth specific support identified as issue across the region. <u>Linked with activity: 2.1, 2.8, 2.9, 2.10, 2.11</u>

	Activities include: 2.1 Collaborative process discussion with stakeholders and consumers to discuss targeted interventions and explore the evidence base for interventions including 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 Facilitate co-design processes to establish targeted interventions at the stepped care level identified using partnerships with appropriate agencies 2.3 Collaborate with current services in Manningham, explore history of service evolution and process of increasing service gaps. Strategic activity to include establishment and enhancement of pathways of referral that allow a person to access higher levels of care and lower as their MH needs change through the course of their illness. Referral pathway discussions and shared service sector discussions are commencing between the key stakeholders with specific reference to suicide prevention; with EMPHN taking a leadership role, referral pathway discussion to incorporate all levels of stepped care. 2.4 Liaison with youth-specific services including Headspace Hawthorn and family support agencies covering Manningham, Austin CYMHS and YSAS/AOD services. ATAPS PS4Kids scoping activity currently in process re local community health services. 2.5 Identification of Undertaking a service commissioning or recommissioning response to identified need
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 may 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; including 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
	Established groups to engage:
	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.
Coverage	Activities involving mental health care service delivery to young people will involve the EMPHN catchment. Early intervention, health promotion and activities involving digital health will cover the EMPHN catchment.
	Specific targeted activities, such as further scoping of the alcohol and drug use by young people in the Nillumbik area will begin with scoping the EMPHN catchment to include baseline and consider coverage of interventions across regions.

Commissioning approach	*All commissioning will follow the EMPHN commissioning framework* Commissioning approach begins with further data exploration, then collaborative approaches with services in the geographic area who service identified need to be scoped regarding shared problem definitions. Co-design of interventions to meet identified need will occur in collaboration with key stakeholders with consideration of joint commissioning with Victorian DHHS. 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.
Performance Indicator	The mandatory performance indicator for this priority is: • Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services. Development of a local service map for youth specific mental health services 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 such as the HONOSCA
Local Performance Indicator target (where possible)	Indicators to be refined over the initial period (1st quarter 2016/17)
Local Performance Indicator Data source	Data source outlined above. Additional performance indicators to be gathered following discussions and collaboration with headspace national office. Headspace indictors are currently collected at each of our 3 sites however we have not as yet been privy to negotiations between HNO and the Commonwealth around reporting etc.

Proposed Activities	
Priority Area 3: Psychological therapies for rural and remote, under-serviced and /or hard to reach groups	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • 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 Reference	Provide a list of activities to be commissioned under this priority area and your own reference for the activity. **3.1 Identification of hard to reach populations and needs analysis of services available for hard to reach populations.** **3.2 Improve access to services and/or service usage across the PHN with particular focus on the LGA's of Whittlesea, Yarra Ranges, Manningham, Knox, Monash and Maroondah.** **3.3 Collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment. This will focus on commissioned ATAPS, Mental Health Nurse Incentive Program and Support Facilitator Programs.** **3.4 Collaborative planning and trial and commissioning of e-health therapeutic program pilots (see activity 1).** **3.5 Collaborative planning for a strategy to increase access to services for refugees who find it difficult to access Medicare Benefit Scheme based therapeutic services.**
Description of Activity and rationale	Provide a short description of each activity relating to the priority area. This <u>may</u> include, but is not limited to: aim of activity; how the activity will address the priority; target population cohort. You must also demonstrate alignment with the PHN mental health funding objectives. **3.1 Identification of hard to reach populations and needs analysis of services available to hard to reach populations.**

EMPHN needs assessment information informing this task: The lack of catchment wide needs analysis for a comprehensive representation of rural and remote, under-serviced and /or hard to reach groups has highlighted the need for this activity.

Aim: A comprehensive analysis of hard to reach target groups. This will include;

- People who find it difficult to access Medicare funded mental health services
- People from Culturally and Linguistically Diverse backgrounds (CALD)
- People who are less able to pay fees
- Carers with a diagnosis of mental illness
- Aboriginal and Torres Strait Islander people
- People who are experiencing or are at risk of homelessness
- Children with or at risk of developing a mental disorder
- People in remote locations
- People who have self-harmed, attempted suicide or are at risk of suicide
- People with perinatal depression
- People in remote locations
- People with a dual disability
- Elderly people
- Youth 11 -25
- Unemployed people
- People living in areas of paucity of mental health services

How the activity will address the priority: This needs analysis will be the planning foundation to address service gaps and increase access to services and service usage for the hard to reach populations in the EMPHN catchment. It will also provide EMPHN with the information to commission services in a way that makes optimal use of the available service infrastructure and workforce.

Target population cohort: As outlined above

3.2 Improve access to services and/or service usage across the PHN with particular focus on the LGA's of Whittlesea, Yarra Ranges, Manningham, Knox, Monash and Maroondah

EMPHN needs assessment information informing this task –

- 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.
- Whittlesea is one such area of disadvantage and poor public transport in this LGA decreases access to the small number of services.
- Whittlesea has a psychological distress population rating above the Victorian average and highest rates in catchment of psychological distress.
- Whittlesea has the highest rate of Emergency Department presentations with anxiety in the catchment.
- Whittlesea is in the bottom 10 statewide of numbered services per 1000 head of population.
- Yarra Ranges has poor transport services and few service hubs.
- Services covering Manningham catchment have moved out of the municipality in recent years creating accessibility issues. There is no rail network and poor bus services, particularly in Warrandyte and North Balwyn.
- Low SES populations in Knox, Maroondah, Monash, Whittlesea, and Yarra Ranges

Aim: Commission HTR/ATAPS, Mental Health Nurses and Support Facilitators to improve access to services across the catchment to support equitable access to services. Begin collaborative process for new ways of providing counselling services to these groups. These models may include but not be specific to those identified in 1.2 and 1.3.

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.

Target population cohort: hard to reach populations across the catchment with a particular focus on Whittlesea, Yarra Ranges, Manningham, Knox, Monash and Maroondah.

3.3 Collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment. This will focus on commissioned ATAPS, Mental Health Nurse Incentive Program and Support Facilitator Programs

EMPHN needs assessment information informing this task – The lack of an equitable geographical spread of ATAPS clinicians and Mental Health Nurses across the catchment. Current existing referral pathways for Northern Mental Health Nurses which stipulate registration of a nurse to a single practice.

Aim: Improve geographical spread of the abovementioned mental health supports to improve access to services.

How the activity will address the priority: This activity will reduce service gaps by making optimal use of the available service infrastructure and workforce and also by commissioning of services to add to the current work force.

Target population cohort: Hard to reach populations outlined above

3.4 Collaborative planning for commissioning of e-health therapeutic program pilots

EMPHN needs analysis informing this task – identified access to service issues across various parts of the catchment as previously outlined.

Aim: Collaboratively implement an e-health pilot to increase access to services for hard to reach populations.

How the activity will address priority – this activity will improve access to services as the majority of access can be facilitated via computers or hand held devices.

Target population cohort: hard to access populations who have internet access and have low intensity mental health support needs.

	3.5 Collaborative planning for a strategy to increase access to services for refugees who have difficulty accessing Medicare Benefit Scheme based therapeutic services **EMPHN needs analysis informing this task** – Paucity of mental health services catering to refugee needs. **Aim:** Collaboratively develop a strategy to increase the amount of culturally appropriate mental health services. **How the activity will address the priority:** This strategy reduce an identified service gap for one hard to reach population. **Target population cohort:** Refugees residing in the EMPHN catchment.
Collaboration	Outline if the activity will be jointly implemented with any other stakeholders, including LHNs, state and territory Government, Aboriginal and Torres Strait Islander health services, consumer organisations, NGOs? If yes, provide details including the role of all parties. The PHN will aim to involve the following stakeholders in this activity **3.1 Identification of hard to reach populations and needs analysis of services available to hard to reach populations** The PHN will look to engage with the following stakeholders during this activity; LHNs – Adjacent PHNs State Government - statistics/ information/ resources that may identify at risk populations Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Healesville Indigenous community Services (HICSA), Victorian Aboriginal Health Service (VAHS), Victorian Aboriginal Child Care Agency (VACCA), Mullum Mullum Indigenous gathering Place and Wadamba Wilam Consumer representatives – to be identified through Community Advisory Committee Carer representatives – to be to be identified through Community Advisory Committee

	Consumer organisations – Headspace, Migrant Information Centre, others to be identified
	NGOs – Connections UnitingCare, Anglicare, EACH, others to be determined
	Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Monashlink, others to be identified– to partner in low intensity mental health service innovation.
	The PHN will aim to liaise with the abovementioned stakeholders in a collaborative process of scoping for rural and remote populations, other under-serviced and/or hard to reach populations.
	3.2 Improve access to services and/or service usage across the PHN with particular focus on the LGA's of Whittlesea, Yarra Ranges, Manningham, Knox, Monash and Maroondah
	The PHN will look to engage with the following stakeholders during this activity;
	LHNs – Adjacent PHNs.
	State Government - statistics/ information/ resources that may identify at risk populations.
	Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Healesville Indigenous community Services (HICSA), Victorian Aboriginal Health Service (VAHS), Victorian Aboriginal Child Care Agency (VACCA), Mullum Mullum Indigenous gathering Place and Wadamba Wilam
	Consumer representatives – to be identified through Community Advisory Committee
	Carer representatives – to be to be identified through Community Advisory Committee
	Consumer organisations – Headspace, Migrant Information Centre, others to be identified
	NGOs – Connections UnitingCare, Anglicare, EACH, others to be determined
	CHS – Carrington Health, Camcare, Doncare, Monashlink, others to be identified– to partner in low intensity mental health service innovation.
	The PHN will aim to involve the abovementioned stakeholders in a commissioning strategy for equitable service access across the PHN.

3.3 Collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment. This will focus on commissioned ATAPS, Mental Health Nurse Incentive Program and Support Facilitator Programs.

LHNs – Adjacent PHNs

State Government - statistics/ information/ resources that may identify at risk populations

Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Healesville Indigenous community Services (HICSA), Victorian Aboriginal Health Service (VAHS), Victorian Aboriginal Child Care Agency (VACCA), Mullum Mullum Indigenous gathering Place and Wadamba Wilam

Consumer representatives – to be identified through Community Advisory Committee

Carer representatives – to be to be identified through Community Advisory Committee

Consumer organisations – Headspace, Migrant Information Centre, others to be identified

NGOs – Connections UnitingCare, Anglicare, EACH, others to be determined

Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Monashlink, others to be identified– to partner in low intensity mental health service innovation.

The PHN will aim to liaise with the abovementioned stakeholders in developing a commissioning strategy to increase equitable access to ATAPS, MHNIP and support facilitators to identified hard to reach populations.

3.4 Collaborative planning for commissioning of e-health therapeutic program pilots

The PHN will look to engage with the following stakeholders during this activity;

LHNs – Adjacent PHNs

State Government - statistics/ information/ resources that may identify at risk populations

Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Healesville Indigenous community Services (HICSA), Victorian Aboriginal Health Service (VAHS), Victorian

	Aboriginal Child Care Agency (VACCA), Mullum Mullum Indigenous gathering Place and Wadamba Wilam
	Consumer representatives – to be identified through Community Advisory Committee
	Carer representatives – to be to be identified through Community Advisory Committee
	Consumer organisations – Headspace, others to be identified
	NGOs – Connections UnitingCare, Anglicare, EACH, others to be determined
	Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Monashlink, others to be identified– to partner in low intensity mental health service innovation.
	The PHN will aim to liaise with the abovementioned stakeholders in a developing a commissioning strategy to pilot an e-health therapeutic service.
	3.5 Collaborative planning for a strategy to increase access to services for refugees who are not eligible for Medicare Benefit Scheme based therapeutic services
	The PHN will look to engage with the following stakeholders during this activity;
	LHNs – Adjacent PHNs
	State Government - statistics/ information/ resources that may identify at risk populations
	Aboriginal and Torres Strait Islander Services – Yarra Valley Aboriginal Health (YVAH), Healesville Indigenous community Services (HICSA), Victorian Aboriginal Health Service (VAHS), Victorian Aboriginal Child Care Agency (VACCA), Mullum Mullum Indigenous gathering Place and Wadamba Wilam
	Consumer representatives – to be identified through Community Advisory Committee
	Carer representatives – to be to be identified through Community Advisory Committee
	Consumer organisations – Headspace, Migrant Information Centre, others to be identified
	NGOs – Connections UnitingCare, Anglicare, EACH, others to be determined

	Community Health Services (CHS) – Carrington Health, Camcare, Doncare, Monashlink, others to be identified– to partner in low intensity mental health service innovation.
	The PHN will aim to liaise with the abovementioned stakeholders in developing a proposal for service delivery alternatives for refugees who are not eligible for Medicare Benefit Scheme Services (MBS).
Duration	Anticipated activity start and completion dates (excluding the planning and procurement cycle).
	3.1 Identification of hard to reach populations and commissioning and needs analysis of services available to hard to reach populations
	Start: July 2016
	Completion: August 2016
	3.2 Improve access to services and/or service usage across the PHN with particular focus on the LGA's of Whittlesea, Yarra Ranges, Manningham, Knox, Monash and Maroondah
	Start: July 2016
	Completion: June 2017
	3.3 Collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment. This will focus on commissioned ATAPS, Mental Health Nurse Incentive Program and Support Facilitator Programs
	Start: July 2016
	Completion: June 2017
	3.4 Collaborative planning for commissioning of e-health therapeutic program pilots
	Start: June 2016
	Completion: June 2017
	3.5 Collaborative planning for a strategy to increase access to services for refugees who find it difficult to access Medicare Benefit Scheme based therapeutic services
	Start: July 2016

	Completion: December 2016
Coverage	Outline geographic coverage of the activity. i.e. entire PHN region, or area within the PHN catchment. (Provide the statistical area as defined in the Australian Bureau of Statistics (ABS).
	All activities will focus on the entire PHN catchment at this stage. Although there are some activities that may focus on particular geographical locations within the PHN, current needs analysis data, stakeholder liaison and collaboration are not sufficient to exclude any particular geographical location in the PHN.
Commissioning approach	Briefly outline the planned commissioning method and if the process will involve an approach to market, direct engagement or other approach for the activity. E.g. purchased, commissioner, direct delivery.
	Include a description of how contracted services will be monitored and evaluated.
	All activities will follow the EMPHN commissioning framework.
	3.1 Identification of hard to reach populations and needs analysis and commissioning of services available to hard to reach populations – this task will be performed by executive, management and appropriate EMPHN staff (population health team for example) in consultation with the external stakeholders previously outlined.
	3.2 Improve access to services and/or service usage across the PHN with particular focus on the LGA's of Whittlesea, Yarra Ranges, Manningham, Knox, Monash and Maroondah - This task will be performed by executive, management and appropriate EMPHN staff (population health team for example) in consultation with the external stakeholders previously outlined. Clinical services will be purchased by EMPHN from suitable NGOs, CHSs and individual private contractors.
	3.3 Collaborative planning and commissioning of services that are better placed to equitably meet the needs of hard to reach populations in the catchment. This will focus on commissioned ATAPS, Mental Health Nurse Incentive Program and Support Facilitator Programs - This task will be performed by executive, management and appropriate EMPHN staff (population health team for example) in consultation with the external stakeholders previously outlined. Clinical services will be contracted by EMPHN from suitable NGOs, CHSs and individual private contractors.

	3.4 Collaborative planning for commissioning of e-health therapeutic program pilots - This task will be performed by executive, management and appropriate EMPHN staff (population health team for example) in consultation with the external stakeholders previously outlined. Clinical services will be purchased by EMPHN from suitable NGOs, CHSs and individual private contractors. **3.5 Collaborative planning for a strategy to increase access to services for refugees who have difficulty accessing Medicare Benefit Scheme based therapeutic services -** This task will be performed by executive, management and appropriate EMPHN staff (population health team for example) in consultation with the external stakeholders previously outlined. Contracted services will be monitored by establishment of program specific Key Performance Indicators. These will include but may not 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 • Delivery of services across identified target groups
Performance Indicator	The mandatory performance indicators for this priority are: • 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 PHN-commissioned Psychological therapies delivered by mental health professionals.

	In addition to the mandatory performance indicator, you may select a local performance indicator. What local performance indicator will measure the outcome of this activity? Is this a process, output or outcome indicator? **3.1** Outcome – comprehensive document with list of agreed upon hard to reach populations. **3.2** Outcome – Data supporting increase in number of hard to reach populations accessing PHN mental health services. **3.3** Outcome – Data supporting increase in number of hard to reach populations accessing PHN mental health services. Also data supporting increased geographical spread of PHN mental health services across the catchment. **3.4** Outcome – Data demonstrating use of e-health initiatives across the catchment. Equity of use/access will be an important performance indicator. **3.5** Outcome – A project proposal for this strategy.
Local Performance Indicator target (where possible)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). What is the baseline for this indicator target and what is the effective date of this baseline? What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age) **3.1** Performance target - document **3.2** Performance target – An increase in people from identified hard to reach populations accessing PHN mental health services from 2016 baseline data. Baseline: 2015 – 2016 MDS data for ATAPS and PIR in addition to internal population health MHNIP data. Effective Date: June 30 2016

	3.3 Performance target – An increase in people from identified hard to reach populations accessing PHN mental health services from 2016 baseline data.
	Baseline: 2015 – 2016 MDS data for ATAPS and PIR in addition to internal population health MHNIP data.
	Effective Date: June 30 2016
	3.4 Performance target – Use of PHN e-health initiative by hard to reach populations in the catchment.
	Baseline: No baseline data is applicable to this activity given its pilot status within the PHN.
	Effective Date: N/A
	3.5 Performance Target – A project proposal for this strategy along with a trial outline
Local Performance Indicator Data source	Provide details on the data source that will be used to monitor progress against this indicator.
	Is this indicator sourced from a national data set? If so, what national data set?
	Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection?
	The data sources are stated in the above section. The PHN will plan to collect data through the above-mentioned methods from July 2016. 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	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)
	Since inception of the Partners in Recovery program in July 2013 the combined services have supported 2,212 registered consumers. Currently there are 1061 active consumers across the Eastern PHN and also including the LGAs of Darebin and Hume. A further 972 consumers have received or been offered a facilitated referral to other service options.
	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.
	Desired State:
	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. The majority of people with severe and enduring mental health need in the region should 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.
Activity Reference	**4.1: Timely access to Mental Health Services across the Eastern Melbourne catchment**

	4.2: Cultural competency of EMPHN mental health services in working with people from Aboriginal and Torres Strait Islander Communities. Report on impacts and access issues. **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. **4.5:** Reduction of avoidable deaths due to overdose. **4.6:** A focus on co-occurring ongoing physical illness and severe enduring mental health needs.
Description of Activity and rationale	**4.1: Access to Mental Health Services:** 4.1.1. Monitor wait list times for people seeking psycho-social support. *(EMPHN Needs Analysis pp: 56)* *4.1.2. Monitor wait list times for people seeking mental health services. (EMPHN Needs Analysis pp: 56)* 4.1.3. Investigation of After Hours Service Availability and Need for people seeking mental health support/ advice/ treatment *Mental health issues one of top two issues in the after hours reported by Ambulance Victoria. (EMPHN Needs analysis, pp 45)* Limited community-based services for people with mental health needs after hours. Lack of capacity to provide onsite psychological support as a optional response to mental health intervention during the after hours period. 4.1.4. **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. EMPHN Mental Health Intake system includes roles of intake processing, and cross-sector relationship building to facilitate care for clients who have difficulty contacting mainstream mental health service system access points. The EMPHN Intake system will include facilitating referrals to the Mental Health Nursing program, ATAPS, PiR and Suicide Prevention.**

	4.2: Better awareness and cultural understanding of Aboriginal and Torres Strait Islander Communities. 4.2.1 How to assist MH consumers and carers within these communities. 4.2.3 Better access to appropriate MH support services. *(EMPHN Needs Analysis pp: 55)* *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. 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.* *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: 56)* **4.4: Suicide Prevention strategies.** Coordinate with all other SPS approaches in the region- ATAPS (Community Health)/ DHHS / PACERs & ED /Acute and sub-acute services/ AMHS/ MHCSS/ AoD services. Link up these efforts into a coordinated plan for people with severe and enduring MI & CN. *(EMPHN Needs Analysis pp: 57)* **4.5: Reduction of avoidable deaths due to overdose.** *(EMPHN Needs Analysis pp: 58)* 4.5.1. Commission a report to look at comorbidity and prevalence of adverse drug interactions related to MH medications and other prescription medications and illicit drugs. 4.5.2. Look at hot spot areas (including Banyule) where higher than average numbers of incidence have occurred (recent data). 4.5.3. Research focus- looking at other national and international studies in this area. **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: Provision of flexible treatment and support models to people experiencing severe and enduring mental health conditions. 4.7.1. Consolidation 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 'step up' to higher levels of care as needed, and 'step down' as mental health treatment needs reduce.
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 accordion to various timelines over the 2016/17 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. Focusses 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 virtually not present in other areas). Each project/ initiative should clearly set out any such coverage limitations if relevant.

Commissioning approach	Details YTBD for each of the above priority areas, however the principles of commissioning will be adhered to. The EMPHN commissioning cycle dictates the following processes: Further scope of data, both currently available and data gaps to explore, to assist clear problem definition. Scoping activities to be done in collaboration with stakeholders. 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 range 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.
Performance Indicator	**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):** **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 **4.2: Cultural competency of EMPHN mental health services in working with people from Aboriginal and Torres Strait Islander Communities. Report on impacts and access issues.** **a** Increased uptake by Aboriginal people of health services. **b** Better outcomes reported by Aboriginal participants *c* Greater cultural awareness among EMPHN staff and practitioner's in partner agencies.

	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. **4.5: Reduction of avoidable deaths due to overdose.** **a** All region report with recommendations for coordinated drug and MH approaches and hot spot focused proposals. **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 – Eds/ PACERS/ AMHS (where possible) ATSI data through DHHS and VAHS. MHNIP availability relative to service need (geographically)
Local Performance Indicator Data source	To be considered as above

Proposed Activities	
Priority Area 5: Community based suicide prevention activities	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • 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 Reference	5.1 Localised data collation and analysis. Community engagement, and 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 nation data inform 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. 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.
Description of Activity and rationale	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. • Liaising with local hospitals, and births, deaths and marriages to obtain local, up to data relevant data. • Needing further data analysis- i.e Is there a trend, or a pattern in the data for those who completed suicide. 5.2 From the data available, more men will complete suicide at a rate of approximately 3:1 Scoping of current situation • 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 early intervention programs, and health promotion which promotes resilience, and community cohesiveness. 5.3 People of Aboriginal descent are 2 times more likely to complete suicide in comparison to non-aboriginal people (proportional to population) • Engaging indigenous community leaders to establish the needs, and best strategies, tools to work with their community. Discussion with Aboriginal and Torres Strait Islander community members and service stakeholders to review current strengths and barriers to access within the

service system. Links with Activity Plan for MH Priority Area 6; further exploration of service provision and access, culturally safe services.

•   Targeted cultural education to key stakeholders as needed, including GPs and services targeting those at risk of suicide or providing services to high risk populations.

•   Scope what programs have been available in the past, and identify the aspect of these that made them effective, and any learning from these.

•   Reviewing service mapping data and reviewing what service outcome/evaluation data is available to guide process of targeting service gaps to align with population need.

•   Collaborate with the Aboriginal and Torres Strait Islander community in order to co-design and commission a mental health service to target at risk groups and better identify early warning signs, and establish pathways to supports and care that is culturally safe.

5.4 From the 2013 data, Within the male population, the most at risk age groups 85 + years (38.3 in 100,000).

Closely followed by

45-49 (23.9 in 100,000)

50-54 (23.9 in 100,000)

 and 80-84 (22.2 in 100,000)

• 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/personality integrity, increasing vulnerability and loss or bereavement.

•   Scope potential programs/ social inclusiveness programs currently available.

•   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.

	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 Sane Australia, Incolink and Jesuit Social Services to be confirmed with plan for consistent reporting and quality indicators. • 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.
Collaboration	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 ATAPS- SPS service providers (EMPHN) Current service providers with a suicide prevention scope- currently working within the catchment G.P's Area Mental Health Services (Northern, Austin, Eastern and Monash) 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.
Coverage	Activities involving mental health care service delivery will involve all people residing within the EMPHN catchment. The planned health promotion, and specific services delivered will target specific populations within the catchment, that are at higher risk of suicide- male, aged, indigenous and those with a mental illness, or following a recent episode of care.

Commissioning approach	Commissioning to 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.
	Co-design of interventions to meet identified need will occur in collaboration with key stakeholders, including those currently delivering service.
	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.
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 to the mandatory performance indicator, you may select a local performance indicator. • 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.

Local Performance Indicator target (where possible)	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 Data source	Commissioned services- minimum data-set and internal population data Local Health Network – Emergency Departments Births/ death/ marriages.

Proposed Activities	
Priority Area 6: Aboriginal and Torres Strait Islander mental health services *Note – Further detail is to be added in October 2016 following further planning*	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. For this Objective, both the *Primary Health Networks Grant Programme Guidelines - Annexure A1 - Primary Mental Health Care* and the *Indigenous Australians' Health Programme – Programme Guidelines* apply.
Activity Reference	6.1 Further scoping of data relevant to the Aboriginal and Torres Strait Islander community with respect to data considerations such as community members identifying cultural membership. Particular emphasis regarding concurrent psychosocial and health factors associated with problematic levels of alcohol consumption. 6.2 Development of relationships with key stakeholders for the purposes of sharing knowledge and data 6.3 Development of a collaborative approach to increasing awareness and communication of the need for services specific to the Aboriginal and Torres Strait Islander communities, and the provision of services within a culturally safe environment. 6.4 Service mapping currently underway by Yarra Ranges Shire Council; share information and knowledge with this process. Consideration particularly to not repeating surveys or questions to a community group who identify as experiencing fatigue with survey processes. Exploration of ways

	to access data and knowledge with respect to the experience of the Aboriginal and Torres Strait Islander community experience. 6.5 Service mapping activities regarding health care delivery and costs associated with access, transport. 6.6 Consultation with key stakeholders regarding meeting service gaps/challenges. 6.7 Development of a commissioning plan to address service gaps/challenges in partnership with key stakeholders. 6.8 Implementation of the above commissioning plan. 6.9 Further develop partnership with LHNs and share data regarding admission rates. In consultation with LHNs and key stakeholders, review reasons for admission and review strategies that assist early intervention, care in the community and recovery-oriented practice in a culturally safe/appropriate process. 6.10 Problem definition; scope nature of issue; in consultation with the Aboriginal and Torres Strait Islander community 6.11 Generate commissioning processes to work with accessible and safe services, and perception/awareness of community regarding safety and practice of these services.
Description of Activity and rationale	Needs Assessment findings: 6a Aboriginal and Torres Strait Islander community members may not identify when accessing healthcare or mental health supports. Links to activities: 6.1, 6.2, 6.3 6b Aboriginal and Torres Strait Islander communities have higher numbers in Whittlesea and Yarra Ranges (Healesville) in areas of high socioeconomic disadvantage. Links to activities: 6.4 6c There is a higher proportion of alcohol use identified as problematic in comparison to the non-indigenous population (ie fewer drinkers however more of those who drink experience difficulties with their alcohol consumption). Links to activities: 6.1, 6.2, 6.3 6d Noted difficulties in accessing healthcare due to affordability (e.g. bulk billing) Links to activities: 6.5, 6.6, 6.7, 6.8

	6e Rates of admission were higher at all ages across presenting issues of schizophrenia, mood disorders, AOD and neurotic disorders. Rates of admission, except those for mood disorders, were proportionately twice that of non-Indigenous Australians. Links to activities: 6.9 6f There is an absence of services perceived as culturally safe/appropriate local to Aboriginal and Torres Strait Islander communities. Links to activities: 6.10, 6.11
Collaboration	Key stakeholders include: Aboriginal and/or Torres Strait Islanders living in the Eastern Melbourne PHN catchment. Local Aboriginal and Torres Strait Islander community and health service groups State Department of Health and Human Services – Eastern Region General Practices Local community health services Local Hospital Networks Primary Care Partnerships
Duration	3 months: establishment of collaborative relationships; further data scoping and problem definition followed by commissioning and service evaluation from late October 2016
Coverage	Targeted areas of the catchment where there are higher populations of aboriginal and Torres strait Islanders such as Yarra Ranges, Bangyle and Whittlesea LGAs.
Commissioning approach	All activities will follow the EMPHN Commissioning Framework It is agreed that updated plans following the 3 month planning process will be provided to the Department by 1st October 2016. Planning is being undertaken by human resource allocation within operational funds as per guideline requirement. Further scope of data, both currently available and data gaps to explore, to assist clear problem definition. Scoping activities to be done in collaboration with stakeholders. 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 range 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.
Performance Indicator	The mandatory performance indicator for this priority is: • Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate.
Local Performance Indicator target (where possible)	To be further defined
Local Performance Indicator Data source	To be further defined

Proposed Activities	
Priority Area 7: Stepped care approach	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • 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 Reference	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
Description of Activity and rationale	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 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 funded services into flexible funded services under the stepped care model along with commissioning new services as required to fill identified gaps. 7.1.2 A key component of establishing a stopped care model of care is the implementation of the central intake point to the system allowing consumer to be directed to the right services. If a consumer need their care to step up or down this can be coordinated by the central Intake team to reduce the need for multiple assessments and ensure continuity of care and smooth transition. 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 will commission 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 has explored multiple models and platforms that may offer clinically significant interventions and 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.
- Evaluation of efficacy including:
    retention data
    symptom improvement
    user-experience
    GP feedback

    Financial reporting

Collaboration	Outline if the activity will be jointly implemented with any other stakeholders, including LHNs, state and territory Government, Aboriginal and Torres Strait Islander health services, consumer organisations, NGOs? If yes, provide details including the role of all parties. The PHN will look to engage with the following stakeholders during this activity; LHNs – 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 aim to liaise with the above mentioned stakeholders in a collaborative process of scoping current service system gaps and barriers and requirements for commissioning approach for a stepped care model.
Duration	July 2016 (preparation and literature review) – June 2017
Coverage	Entire PHN region
Commissioning approach (If applicable)	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 with the up to 20% of current ATAPS and MHNIP funded services with specified performance, reporting and evaluation requirements in line with the stepped care model.
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)	What performance target will be used (including justification) noting that performance target reporting will cover the 12 month reporting period (eg. from activity commencement for 12 months for reporting in September 2017). What is the baseline for this indicator target and what is the effective date of this baseline? What level of disaggregation will apply to this target and be reported to the Department? (eg. target group, gender, age) 7.1.1 A review of services by consumers and stakeholders identifies as 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. 7.1.2 90% of referred clients are able to access services within set threshold of time (thresholds to be defined during planning in Quarter 1 per step of the model) 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	Provide details on the data source that will be used to monitor progress against this indicator. Is this indicator sourced from a national data set? If so, what national data set? Where possible, data collection should cover the activity duration period. What is the commencement date of the data collection? 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. 7.1.2 Clinical intake data. Complaints/Feedback mechanism data, stakeholder consultations including GP's. 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 Reference	8.1 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.
Description of Activity and rationale	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 interim 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 the establishment of a Mental Health Reference Group 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 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. |
| Collaboration | Outline the approach to be undertaken by the PHN in leading the development with regional stakeholders including LHNs, state and territory Governments, Aboriginal and Torres Strait Islander |

	health services, consumer organisations, and NGOs, of a longer term, more substantial *regional mental health and suicide prevention plan*. This will include an outline of the approach to be undertaken by the PHN to seek agreement to the longer term *regional mental health and suicide prevention plan* (see Mental Health Plan Circular 2/2016) Provide details including the role of all parties. In recognition of the significant catchment planning underway in the region regarding state funded mental health and AOD services, it is proposed that EMPHN will work 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, 3 PIR consortiums and 3 headspace consortium to garner their knowledge and experience of the service system and to collaborate with local service providers. In addition, 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.
Duration	Anticipated activity start and completion dates. July 2016- ongoing plan development and refinement
Coverage	Entire PHN region
Commissioning approach (If applicable)	This activity will be undertaken by Mental Health Team staff to inform commissioning activity
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 Mental Health Reference Group to inform planning and commissioning • 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 Mental Health Reference group is 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 at risks 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) Mental Health Reference Group membership Evidence of input by Mental Health Reference Group in development of commissioning specifications and service model design Commissioned services- minimum data-set and internal population data Local Health Network – Emergency Departments