Australian Government
Department of Health

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Primary Health Networks Primary Mental Health Care Funding

- **Annual Mental Health Activity Work Plan 2016-2017**
- **Annual Primary Mental Health Care Funding Budget 2016-2017**

Country WA PHN

Version 2.0

Introduction

Overview

In the 2015-16 financial year, PHNs are required (through the recent mental health Schedule which provided operational funding to PHNs this financial year) to prepare a Mental Health Activity Work Plan. This Plan is to cover activities funded under two sources:

- the Primary Mental Health Care flexible funding pool (which will provide PHNs with approximately $1.030 billion (GST exclusive) over three years commencing in 2016-17); and
- *Indigenous Australians' Health Programme* - an additional $28.25 million (GST exclusive) will be available annually under this programme and further quarantined to specifically support Objective 6 (detailed below): 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.

Activities eligible for funding

- Evidence-based clinical primary mental health care services in line with a best practice stepped care approach;
- Cost effective low intensity psychological interventions for people with mild mental illness, making optimal use of the available workforce and technology;
- Phased implementation of approaches to provide primary mental health care to people with severe and complex mental illness which offer clinical support and care coordination, including services provided by mental health nurses;
- Joined up assessment processes and referral pathways to enable people with mental illness, particularly those people with severe and complex mental illness, to receive the clinical and other related services they need. This will include provision of support to GPs in undertaking assessment to ensure people are referred to the service which best targets their need;
- Region-specific services, utilising existing providers, as necessary, to provide early intervention to support children and young people with, or at risk of, mental illness. This should include support for young people with mild to moderate forms of common mental illness as well as early intervention support for young people with moderate to severe mental illness, including emerging psychosis and severe forms of other types of mental illness;
- Strategies to target the needs of people living in rural and remote areas and other under-serviced populations; and
- Evidence based regional suicide prevention plans and commission activity consistent with the plans to facilitate a planned and agile approach to suicide prevention. This should include liaison with LHNs and other organisations to ensure arrangements are in place to provide follow-up care to people after a suicide attempt.

Each PHN must make informed choices about how best to use its resources to address the objectives of the PHN mental health funding.

This document, the Mental Health Activity Work Plan template, captures the approach to those activities outlined above.

The Mental Health Activity Work Plan will help guide activity to June 2016 and outline the planned mental health services to be commissioned for the period from 1 July 2016 to 30 June 2017, although activities can be proposed in the Plan beyond this period. The Department of Health will require an update in relation to these activities in the Annual Mental Health Activity Work Plan for 2017-18.

The Mental Health Activity Work Plan template has two connected parts:

1) The Annual Mental Health Activity Work Plan for 2016-2017, which will be linked to and consistent with the broader PHN Activity Work Plan, and provide:
   a) The Strategic Vision on the approach to addressing the mental health and suicide prevention priorities of each PHN.
   b) A description of planned activities funded under the Primary Mental Health Care Schedule which incorporates:
      i) Primary Mental Health Care funding (PHN: Mental Health and Suicide Prevention Operational and Flexible Activity); and
      ii) *Indigenous Australians' Health Programme* funding (quarantined to support Objective 6 – see pages 2-3) (PHN: Indigenous Mental Health Flexible Activity).

2) The indicative funding budget for 2016-2017 for:
   a) primary mental health care (PHN: Mental Health and Suicide Prevention Operational and Flexible Activity); and
   b) *Indigenous Australians' Health Programme* (quarantined to support Objective 6 – see pages 2-3) (PHN: Indigenous Mental Health Flexible Activity).

Mental Health Activity Work Plan 2016-2017

The template for the Plan requires PHNs to outline activities against each and every one of the six priorities for mental health and suicide prevention. The Plan should also lay the foundation for regional planning and implementation of a broader stepped care model in the PHN region. This Plan recognises that 2016-17 is a transition year and full flexibility in programme design and delivery will not occur until 2018-19.

The Plan should:

a) Outline the planned mental health services to be commissioned from 1 July 2016, consistent with the grant funding guidelines.
b) Outline the approach to be undertaken by the PHN in leading the development with regional stakeholders including LHNs of a longer term, more substantial *Regional Mental Health and Suicide Prevention plan* (which is aligned with the Australian Government Response to the Review of Mental Health Programs and Services (available on the Department's website). 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* from the relevant organisational signatories in the region, including LHNs.
c) Outline the approach to be taken to integrating and linking programs transitioning to PHNs (such as headspace, and the Mental Health Nurse Incentive Programme services) into broader primary care activities, and to supporting links between mental health and drug and alcohol service delivery.
d) Have a particular focus on the approach to new or significantly reformed areas of activity – particularly Aboriginal and Torres Strait Islander mental health, suicide prevention activity, and early activity in relation to supporting young people presenting with severe mental illness.

In addition, PHNs will be expected to provide advice in their Mental Health Activity Work Plan on how they are going to approach the following specific areas of activity in 2016-17 to support these areas of activity:

- Develop and implement clinical governance and quality assurance arrangements to guide the primary mental health care activity undertaken by the PHN, in a way which is consistent with section 1.3 of the *Primary Health Networks Grant Programme Guidelines* available on the PHN website and which is consistent with the National Standards for Mental Health Services and National Practice Standards for the Mental Health Workforce.
- Ensure appropriate data collection and reporting systems are in place for all commissioned services to inform service planning and facilitate ongoing performance monitoring and evaluation at the regional and national level, utilising existing infrastructure where possible and appropriate.
- Develop and implement systems to support sharing of consumer clinical information between service providers and consumers, with appropriate consent and building on the foundation provided by myHealth Record.
- Establish and maintain appropriate consumer feedback procedures, including complaint handling procedures, in relation to services commissioned under the activity.

Value for money in relation to the cost and outcomes of commissioned services needs to be considered within this planning process.

Activity Planning

This initial Mental Health Activity Work Plan will be informed by a specific mental health needs assessment developed by PHNs (as a complement to the broader PHN needs assessment) which should explore mental health and suicide prevention priorities against those six areas of activity which the Government has articulated for PHNs, and in consultation with key stakeholders (refer to pages 2-6, for Objectives and Activities eligible for funding, and other requirements to be reflected in the Plan).

Measuring Improvements

Each mental health priority area has one or more mandatory performance indicators. In addition to the mandatory performance indicators, PHNs may select a local performance indicator. These will be reported on in accordance with the Primary Mental Health Care Schedule.

Mental Health Activity Work Plan Reporting Period and Public Accessibility

The Mental Health Activity Work Plan will help guide activity to June 2016 and outline the planned mental health services to be commissioned for the period from 1 July 2016 to 30 June 2017.

A mental health focussed activity work plan is to be provided to the Department annually. This mental health activity plan will complement the broader PHN Activity Plan as part of the annual reporting mechanism and will build on the initial Mental Health Activity Work Plan delivered in 2016.

Once approved, the Annual Mental Health Activity Work Plan component (Section 1(b) of this document) must be made available by the PHN on their website as soon as practicable. The Annual Mental Health Activity Work Plan component will also be made available on the Department of Health's website (under the PHN website).

1 (a) Strategic Vision

The PHN will direct primary mental health care funding towards integrated models of care addressing unmet healthcare and related need in the PHN. The PHN priority is to plan and commission for the optimal mix and level of regional, community-based mental health and suicide prevention services. In 2016-17, the PHN will also ensure existing service continuity where it is clinically appropriate.

In the 12 months of this Activity Work Plan, the PHN intends to demonstrate improvement in equity, access and effectiveness of mental health and suicide prevention services, better enabling patients to stay well in the community. The founding principles of this plan include:

- Transitioning from a programmatic based approach to supporting an integrated, holistic and stepped care approach;
- Reducing fragmented care by supporting the provision of person-centred, integrated and coordinated care for vulnerable and disadvantaged people in identified geographic "hot spot" locations; and
- Place based health approach to commissioning whereby local activities are implemented to engage the community, social and mental health and health care providers, local government and other key stakeholders to knit together services to more effectively meet the needs of those people with, or at risk of, mental health issues.

The PHN will underpin all mental health activity within a stepped care approach to better target appropriate referral to mental health and related services. Mental health and suicide prevention activity of the PHN will be evidence-based, staged and comprising a hierarchy of interventions, from low to high intensity, matched to the individual's needs. The PHN's approach to stepped care will be to develop an integrated shared-care approach with the primary care sector, principally led by general practitioners allowing individuals with severe and persistent mental illness (SPMI) and with complex care needs ("severe and complex") to be managed in a coordinated way in primary care settings. The PHN implementation of a comprehensive stepped care approach is intended to ensure people get the right clinical service at the right level and at the right time, linked to other non-health supports as required.

The PHN will further invest in training of primary care practitioners in trauma informed care and practice.

The PHN will recognise the different 'needs-based groups' within the population experiencing mental health problems, disorders and conditions and those who are at risk of suicide or serious self-harm. An evidence based approach will be taken to develop co-ordinated packages or 'bundles' of care for people with mild to moderate mental disorders (defined by burden of disease) with or without complex needs.

The PHN will aim to facilitate an integrated primary mental health care system that is based on the identified and agreed needs of the local population. This will be guided by the PHN's comprehensive needs assessment, detailed services mapping and reference to evidence-based practice. These processes are critical in the PHN's identification of gaps, duplication and opportunities that will inform the regional planning and integration of mental health and suicide prevention services, to align service provision (capability and capacity) with local need.

Regionally co-designed and implemented responses will be enabled by the ongoing cultivation of sustainable partnerships with the WA Mental Health Commission, WA Country Health Service, Aboriginal Health organisations, National Disability Insurance Scheme (NDIS) providers, community based primary health care, mental health and social care organisations, consumer groups and other service providers. These responses will make the best use of available workforce and services and will include a strong commitment to capacity building within the region.

The PHN will embed a consumer centred approach in its mental health and suicide prevention planning and commissioning activities, facilitating more clearly defined pathways and alignment between general

and mental health. There will be a focus on enabling easier access to a broad range of connected and co-ordinated services to meet the needs of individuals.

A collaborative and culturally appropriate Indigenous specific response is integrated throughout the PHN Primary Mental Health Activity Plan to better support Aboriginal people.

Regional mental health and suicide prevention planning undertaken by the PHN will leverage the expertise and local knowledge of members of the Regional Clinical Commissioning Committees, their mental health working groups and the Mental Health Expert Advisory Group. Members of these groups have interdisciplinary expertise relevant to mental health and suicide prevention planning.

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Definitions applied

Canterbury Health System Outcomes Framework - an outcome measurement approach utilised within the Canterbury Health Network in New Zealand. The framework identifies the key outcomes sought at a population level and tracks performance using an evolving set of indicators, moving the health system away from tracking of inputs and aligning resource of the wider system to patient rather than provider outcomes.

Clinical governance - the systems and processes that organisations use to audit care, train staff, obtain feedback from clients and manage clinical risk to ensure that the services provided are safe and good quality.

Co-design - where service users, providers and commissioners are equal partners in the design of systems and services that affect them.

Co-production - In practice, involves people who use services being consulted, included and working together from the start to the end of any things that affect them. (*Often used as the operational description of how co-design is achieved, but also gets used interchangeably).*

Collective impact - an approach that brings a range of organisations together to focus on an agreed common change agenda that results in long-lasting benefits.

CREMs – clinician reported experience measures.

Evidence based care - care that research has shown is effective in providing the desired result.

HealthPathways - an online management tool to assist general practitioners (GPs) provide consistent conditions-specific care and referrals. Each pathway provides GP's with up to date information about local referral pathways.

Multidisciplinary team - A term used to describe a variety of different health professionals working together. (Also called inter-professional or interdisciplinary team).

Outcome based commissioning - planning and purchasing services based on **what** positive differences are made, over **how** they are done. This is a key concept in reforming our health services.

An example would be where a government replaces a block contract to buy 2000 hip replacements a year, with a contract to deliver an agreed level of hip mobility for a group of people in a region, ensuring people are mobile and not in pain. Hip replacements might be the right answer in some cases, but probably in fewer cases than before, and most importantly that decision is directed much more by the outcomes that the patient wants.

Person centred care - when decisions about the way health care is designed and delivered puts the needs and interests of the person receiving the care first. (Also called Consumer Centric Care).

Place based approach - a way of addressing issues within a defined place, community or region in a systemic way.

PREMs - Patient reported experience measures.

Primary care - the first point of contact with health care provided in the community most commonly with a GP. Does not require and external referral at point of entry.

PROMs - Patient reported outcome measures.

Quadruple aim - is widely accepted as a compass to optimise health system performance. The Quadruple aim includes – enhancing patient experience, improving population health, reducing costs and improving healthcare provider experience and satisfaction.

Secondary care - care provided by a specialist often in a clinic or hospital requiring an external referral.

Shared care - care provided by a team of people in a coordinated way.

An example would be arrangements between a local hospital and GP for pregnancy care where some appointments are with the GP, and some are at the hospital.

Stepped care - A key concept in mental health. In this model the care is "stepped" up or down in intensity and scope, depending on the severity and complexity of the patient's needs, rather than care "dosing" according to diagnosis and service specification.

For example, someone suffering depression related to a specific incident in their life such as sickness or job loss, will require a different level of care to a person with long-term chronic depression or psychiatric conditions. With a stepped care approach, all patients with depression start with low intensity intervention, usually 'watchful waiting', as around half will recover spontaneously within 3 months. Progress is monitored by a mental health professional and only those who don't recover sufficiently move up to higher intensity intervention – which might involve guided self-help. There are two more levels or steps: brief one-on-one therapy; and then for those still badly impacted by depression, longer-term psychotherapy and antidepressant medication.

Systems approach - a way of tackling issues by looking at all the services that exist and the connections between them and making changes that can affect the whole system rather than just individual parts within it.

Social determinants of health - the conditions within which people are born, develop, grow and age – they include social, economic, cultural and material factors surrounding people's lives, such as housing, education, availability of nutritional food, employment, social support, health care systems and secure early life.

Tertiary care - specialised care usually provided in hospital that usually requires referral from a primary or secondary care provider.

Wrap around care - this is a key concept within person centred care. The patient and their family form a partnership with their primary care provider team and other services "wrap around" this partnership as required.

Key Projects underpinning proposed activities

Mental Health Atlas project -The project maps by primary function, all of the free to access mental health and AOD services in WA including their reach. Once completed (due September 2016) the project will provide a planning tool that helps health commissioning organisations to understand current service availability by locality.

My Health Record project - My Health Record is a secure online summary of a person's health information, provided to all Australians by the Commonwealth Department of Health. The individual can control what goes into the record and who can access it. The My Health Record makes it possible for an individual to share their health information with a variety of healthcare services and providers such as GP's, hospitals and specialists. Everyone granted access to the record is able to see information about an individual's health condition, allergies, test results or medications depending on what the individual elects to share, and with whom. The benefits are significant – the electronic record is a convenient way for people to store all of their health information and also in reducing duplication and potential errors through health professionals having access to the right information all in one place.

A note on Country WA PHN's commissioning approach and performance management

To facilitate and support the move from single service/programme funding to outcome based commissioning the WA PHNs, supported by WAPHA and in collaboration with the community, providers and other stakeholders, will develop a state-wide primary care outcomes framework ('the framework').

This framework will include a suite of indicators (process, output and outcome). It will also be available for use by other stakeholders in the primary care sector. Wherever possible it will draw on and align with existing work at a national and State level (for example, the National Primary Health Care Strategic Framework, WA Department of Health's Aboriginal Health and Wellbeing Framework 2015-2030, and the Partnering in Procurement Guidelines produced by the WA Council of Social Services and the WA Department of Health).

In line with the Department of Health's guidance documents on designing and contracting services the framework will be developed with the following principles:

- Indicators will be developed in collaboration with the community, providers and other stakeholders;
- Duplication in data collection and reporting for providers will be minimised wherever possible – for example, by collaborating with other funders to agree shared performance measures;
- Timely and responsive feedback on performance will be provided to service providers;
- Measurement will be at patient-level (de-identified) wherever possible;
- Providers will be supported to develop their capacity to identify and report appropriate outcomes and indicators; and
- Annual changes to local indicators will be minimised.

It is intended to complete a first iteration of this work by the end of October 2016.

Approach taken to prioritising activities

During 2016, Country WA PHN undertook a baseline needs assessment of its resident population in partnership with Curtin University. While a broad range of health needs were identified within the community, key stakeholders were involved in a prioritisation process to agree high level priority needs. The following needs were determined:

- Keeping people well in the community;
- People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs;
- Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage;
- System navigation and integration to help people get the right services, at the right time and in the right place; and/or
- Capable workforce tailored to these priorities.

These priority needs will guide resource allocation in the commissioning process.

Proposed Activities	
Priority Area 1: Low intensity mental health services	This activity aligns with the following priorities in the PHN Needs Assessment: • Priority 1: Keeping people well in the community.
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**MH 1.1 - ATAPS and MHSRRA transition to low intensity stepped care approach (new)**
Description of Activity(ies) and rationale (needs assessment)	The PHN's Needs Assessment identified significant gaps in early intervention strategies for people with or at risk of mental health problems including shortcomings in the current service mix and a lack of comprehensive planning for low intensity early interventions to support a stepped care approach. The result is a disjointed mental health service system, and by extension, a disconnect between ATAPS and a broader approach to mental health service delivery. To address this the PHN will transition the existing ATAPS and MHSRRA programs for people with or at risk of mild to moderate mental illness to a new stepped care approach that integrates suicide prevention and alcohol and other drug services with low intensity mental health services to minimise duplication and maximise resources. The PHN recognises that this is a significant change requiring close working with existing suppliers and service providers to assess needs and explore options to achieve comprehensive regional planning and a smooth transition. A continuation of the current ATAPS and MHSRRA services for 9 months will be contracted to ensure continuity of service for people with, or at risk of, a mild to moderate mental illness. During the transition phase providers will be required to deliver the original programme outcomes. In addition to the 9 months contract extensions a further 3 months transitional period has been included in the PHN Flexible Funding Activity Plan. This additional period will be negotiated with existing providers as required to ensure all clients currently enrolled in a cycle of care will be able to complete this care. Moving to a more integrated stepped care approach will also require the implementation of a number of other key projects and activities by Country WA PHN and WAPHA - standardised care pathways, improved shared care processes and arrangements, a single point of entry with choice based triage, and a broadened range of health professionals providing services and tele-health services, linked with the resources available through the national digital gateway. With the exception of headspace and youth early psychosis programs, services for children and young people will continue to be offered by service providers during the transition period.

Proposed Activities	
Description of Activity(ies) and rationale (needs assessment)	It is proposed the combined budget for Activity 1 and Activity 3 for the period 1 July 2016 – 31 March 2017 will be equivalent to 75% of the ATAPS and MHSRRA annual allocation for 2015-16 enabling nine months of flexible service delivery (refer comment in budget section below). It is anticipated the split between Activity 1 and Activity 3 will be approximately 40% to Low Intensity services and 60% to Psychological Therapies but this split will not be mandated during the nine-month transition period.
Collaboration	The PHN is informed by the Mental Health Expert Advisory Group (MHEAG) established by WAPHA to guide the development of needs-based models of care. Over the coming months the PHN will develop its longer term regional Mental Health and Suicide Prevention Plan ("the Plan" - refer MH 8.1) with key stakeholders including but not limited to: the PHN's Clinical Commissioning Committee (CCC) and Clinical Engagement Committee (CEC), the WA Mental Health Commission, WA Health, Aboriginal Health organisations, NDIS providers, community based primary health care, mental health and social care organisations, WANADA, consumer groups and other service providers. In developing plans specifically relating to low intensity mental health services, the PHN will engage with GPs, in particular, and other health professionals, recognising their lead role.
Duration	ATAPS transition 2 May 2016 - 31 March 2017. Additional transitional period to be negotiated with 'transition out plans' – April – June 2017 (see Flexible Funding Activity Plan). The Country WA PHN proposes to commission new models of care from 1 April 2017. These programs will be contracted until 30 June 2018 with the option of extending the contracts for an additional period of 12 or 24 months.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Commissioning approach	**Existing providers** Contracts for ATAPS and MHSRRA will be extended until 31 March 2017. **New stepped care approach** The PHN in partnership with key stakeholders will identify and prioritise primary low intensity mental health service gaps within the stepped care approach as part of the development of the comprehensive regional mental health plan. The PHN will work with partners to identify the most appropriate commissioning approach in each case.

Proposed Activities		
Commissioning approach	It is intended that co-commissioning the entry point to care will be in partnership with the other WA PHNs, the Mental Health Commission and other key stakeholders. Utilising the following procurement strategies as the preferred approach: • Market testing through expression of interests and/or requests for proposals; • Co-production and co-design processes to ensure place and consumer centric approaches to new models of care; and • Competitive dialogue with the mental health provider sector, to seek requests for proposals for consortia models. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements.	
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 and variation per PHN-commissioned mental health service – low intensity services; and • Clinical outcomes for people receiving PHN-commissioned low intensity mental health service. In addition to the mandatory performance indicators, the PHN will work with our stakeholders to identify local performance indicators, if relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$5,546,655	Commonwealth funding (75% indicative funding levels for ATAPS/MHSRRA & Suicide Prev general as per advice 8/4/16. Note this funding also includes 3.1 – Psychological Therapies and 5.1 Suicide Prevention during the nine month transition period)**.** **A revised budget will be submitted once the mental health plan has been completed and the new models commissioned. This budget will be for the periods 1 April 2017 – 30 June 2017 and 1 July 2017 – 30 June 2018.**
	$0	

Proposed Activities	
Priority Area 2: Youth mental health services	This activity aligns with the following priorities identified in the PHN Needs Assessment: • Priority 1: Keeping people well in the community. • Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. • Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity(ies) / Reference (e.g. Activity 2.1, 2.2, etc)	**MH 2.1 - headspace (existing)**
Description of Activity(ies) and rationale (needs assessment)	The PHN will work with existing service providers to maintain service delivery within headspace centres, in line with the existing headspace service delivery mode and supporting them to further develop their model to integrate fully into a stepped care approach. The PHN will also work with other health providers to improve the integration of headspace centres into the broader primary mental health care services; physical health services; drug and alcohol services; social and vocational support services. headspace centres will be included within WAPHA's development of child, adolescent, and youth specific integrated care pathways and services and are in the project scope of the WA Mental Health Atlas currently under development. In addition, two mental health program leads will be employed by WAPHA to provide expert advice and guidance to the PHNs on the development of child, adolescent and youth services, as well as working collaboratively with the sector as funding moves from program based to flexible.
Collaboration	The PHN is informed by the Mental Health Expert Advisory Group (MHEAG), established by WAPHA, to guide the development of a robust stepped care approach to mental health services which also include a focus on the mental health needs of children and young people. The MHEAG includes representation from Child and CAMHS and headspace National. Within this activity, the PHN plans to work collaboratively with key stakeholders from other WA PHN's and their CCC and CEC's, headspace national and WA headspace providers; WA Health, the MHC, Aboriginal Health organisations, Youth Service providers, community based primary health care, mental health and social care organisations, WANADA, consumer groups and other service providers The PHN also recognises the importance of involving young people in the development of service models and will therefore ensure that headspace's National Youth Reference Group, which will remain in place over the next two years, is an integral partner in providing support and advice to the PHN through local headspace centres.
Duration	2 May 2016 – 31 March 2018.

Proposed Activities		
Coverage	The PHN will be commissioning headspace services in the Midwest (Geraldton); Goldfields (Kalgoorlie), Great Southern (Albany), South West (Bunbury) and Kimberley (Broome).	
Commissioning approach	The commissioning approach is to contract existing headspace service providers under the same or similar conditions until 30 June 2018. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements.	
Performance Indicator	The mandatory performance indicator for this priority is: • Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services. In addition to the mandatory performance indicator the PHN will work with both the National headspace and headspace centres, to identify local performance indicators that reflect regional priorities. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets. headspace centres will be required to continue to collect data on the client minimum data sets on headspace Application Platform Interface (HAPI) to headspace National Office. The data collected through HAPI supports reporting, monitoring, quality improvement and evidence-building requirements of the programme. The PHN will support headspace centres to continue to collect data on centre services and client data.	
Planned Expenditure 2016-2017 (GST exc)	$3,827,682	Commonwealth funding.
	$0	Funding from other sources (eg. private organisations, State and territory governments).

Proposed Activities	
Priority Area 2: Youth mental health services:	This activity aligns with the following priorities identified in the PHN Needs Assessment: • Priority 1: Keeping people well in the community. • Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. • Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. • Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity(ies) / Reference (e.g. Activity 2.1, 2.2, etc)	**MH 2.2 - Severe mental illness and first episode of psychosis for young people (new)**
Description of Activity(ies) and rationale (needs assessment)	The Needs Assessment identified limited service availability for children and young people with, or at risk of, severe mental illness in regional areas and limited access to mental health professionals offering services to vulnerable young people, especially those experiencing early psychosis. The PHN in partnership with key stakeholders will identify primary mental health service gaps for the treatment of severe mental illness and first episode of psychosis for young people and commission services for these within the stepped care approach as part of the comprehensive regional mental health plan. Planned activities will include regional planning utilising information from the needs assessment and the Atlas. The PHN will work with key youth and local stakeholders to develop cross-sectoral approaches and to promote the use of localised youth mental health pathways with the addition of FASD, ASD, and ADHD when these are completed. Two mental health programme leads will be employed by the PHN to provide expert advice and guidance on the development of child and youth mental health services.
Collaboration	The PHN is informed by the Mental Health Expert Advisory Group (MHEAG) established by WAPHA to guide the development of a robust stepped care approach to mental health services which also include a focus on the mental health needs of children and young people. The MHEAG includes representation from CAMHS, headspace National. Within this activity, the PHN plans to work collaboratively with key stakeholders from other WA PHN's and their CCC and CEC's, headspace national and WA hYEPP providers; WA Health, the MHC, Aboriginal Health organisations, Education, Youth Service providers, community based primary health care, mental health and social care organisations, WANADA, consumer groups and other service providers.
Collaboration	The PHN also recognise the importance of involving young people in the development of service models and will therefore ensure that strategies are implemented to ensure that young people and service users are meaningfully engaged.

Proposed Activities		
Duration	Planning Phase – 1 July 2016 – 30 September 2016. Procurement – 1 October – 31 December 2016. Service delivery – commencing 1 Jan 2017.	
Coverage	The PHN will be commissioning services across Country WA with the regional areas still to be determined.	
Commissioning approach	The PHN will work with partners to prioritise gaps and identify the most appropriate commissioning approach in each case. It is intended that co-commissioning the entry point to care will be in partnership with the other WA PHNs, Mental Health Commission and other key stakeholders. Utilising the following procurement strategies as the preferred approach: • Market testing through expression of interests and/or requests for proposals; • Co-production and co-design processes to ensure place and consumer centric approaches to new models of care; and • Competitive dialogue with the mental health provider sector, to seek requests for proposals for consortia models. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements.	
Performance Indicator	The mandatory performance indicator for this priority is: • Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services. The PHN will work with key stakeholders to identify local performance indicators, if relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be done in conjunction with Area Health Services and the WA Mental Health Commission and used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$782,548	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed Activities	
Priority Area 3: Psychological therapies for rural and remote, under-serviced and /or hard to reach groups	This activity aligns with the following priorities identified in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity(ies) / Reference (e.g. Activity 3.1, 3.2, etc)	**MH 3.1 – ATAPS and MHSRRA Transition to Psychological therapies for under-serviced and/or hard to reach groups (new)**
Description of Activity(ies) and rationale (needs assessment)	Country WA PHN covers over 2.5 million square kilometres. The majority of this vast geographic area is rural, remote and under-serviced. All mental health services within the Country WA PHN focus on increasing the services to people in hard-to reach groups and on improving the availability of and access to services. The PHN's Needs Assessment identified a lack of primary care access and accessibility for some disadvantaged and hard to reach groups. Reduced access is also due to significant gaps in early intervention strategies for people with or at risk of mental health problems including shortcomings in the current service mix and a lack of comprehensive planning for low intensity early interventions to support a stepped care approach. The result is a disjointed mental health service system, and by extension, a disconnect between ATAPS and MHSRRA services and a broader approach to mental health service delivery. To address the existing gaps for under-serviced and hard to reach groups the PHN will transition the existing ATAPS and MHSRRA programs to a new stepped care approach that integrates suicide prevention and alcohol and other drug services with low intensity mental health services to minimise duplication and maximise resources. The PHN recognises that this is a significant change that will require working closely with existing suppliers and service providers to understand levers and barriers to people receiving services and to achieve comprehensive regional planning and a smooth transition to making the ATAPS and MHSRRA models more flexible. Service continuity for existing ATAPS users will be maintained by extending existing contracts for 9 months. As mentioned at MH 1.1 above, a further 3 month transitional period will be funded through the PHN Flexible Funding. Moving to this approach will also require the implementation of a number of other key projects and activities by WA Country PHN and WAPHA - standardised care pathways, improved shared care processes and arrangements, a single point of entry with choice based triage, and a broadened range of health professionals providing services and tele health services. The provision of psychological therapies will be a critical part of the integrated mental health services and where possible will draw on the existing workforce in regions and be supplemented by the use of digital technologies, including the national digital gateway.

Proposed Activities	
Description of Activity(ies) and rationale (needs assessment)	The capacity to test other innovative approaches will be met by utilising the proposed Innovation and Evidence Fund (activity NP8 outlined in the Flexible Funding activity work plan).
Collaboration	The PHN is informed by the Mental Health Expert Advisory Group (MHEAG) established by WAPHA to guide the development of needs-based models of care. Within this activity, the Country WA PHN will work collaboratively with key stakeholders to scope, plan and potentially co-commission tailored primary care mental health services for hard to reach and under-serviced groups and ensure the PHN's plans align with the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*. Key Stakeholders include but are not limited to other WA PHN's and their CCC and CEC's, the WA MHC, WA Health, Aboriginal Health organisations, NDIS providers, community based primary health care, mental health, justice, social and welfare agencies, local government, WANADA, consumer groups and other service providers dealing with hard to reach groups.
Duration	1 July 2016 – 31 March 2017 – Contract continuation. Additional transitional period to be negotiated with 'transition out plans' – April – June 2017 (see Flexible Funding Activity Plan). 1 July 2016 – 30 June 2018 – planning and commissioning of psychological therapy services as part of the stepped care approach. The PHN proposes to commission new models of care by 1 April 2017. The programs will be contracted until 30 June 2018 with the option of extending the contracts for an additional 12 or 24 months.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Commissioning approach	Contracts for ATAPS and MHSRRA will be extended until 31 March 2017. During this period of extension it is anticipated that where possible the preferred approach will be to commence competitive dialogue with the mental health provider sector to seek requests for proposals for consortia models to provide integrated mental health stepped care approaches. The aim is to commission new models of care by 1 April 2017. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements.

Proposed Activities		
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; and • Clinical outcomes for people receiving PHN-commissioned Psychological therapies delivered by mental health professionals. Performance indicators for the contract extension will remain as currently contracted. Additional process or outcome indicators such as Patient Reported Experience Measures or Patient Reported Outcome Measures to be negotiated. During this time, we will work in partnership with providers and other stakeholders to identify and agree future local performance indicators. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the WACHS *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$see budget for Activity 1	The funding for this activity is reflected in planned expenditure for activity 1.1 during the first 9 months of the 2016 -17 year. A revised budget will be submitted once the mental health plan has been completed and the new models commissioned. This budget will be for the periods 1 April 2017 – 30 June 2017 and 1 July 2017 – 30 June 2018.
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed Activities	
Priority Area 4: Mental health services for people with severe and complex mental illness including care packages	This activity aligns with the following priorities identified in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity(ies) / Reference (e.g. Activity 4.1, 4.2)	**MH 4.1 - Integrated Primary Health Care for people with severe and complex mental illness (existing)**
Description of Activity(ies) and rationale (needs assessment)	The Needs Assessment identified the following mental health issues in country WA that are directly related to the needs of people with a serious and complex mental illness: • High percentage of people with a serious mental illness not accessing GPs; • Lack of timely and responsive care coordination; • Lack of best practice interventions when comorbidities are present; and • Lack of understanding of the complexity and episodic nature of mental illness. In order to keep people with complex mental health conditions well in the community and to effectively manage co-morbidities often present with people with severe and persistent mental illness, the PHN will re-contract the current service providers of the Mental Health Nurse Incentive Programme (MHNIP) for 12 months, ensuring continuity of care for MHNIP recipients and work through the Regional Clinical Commissioning Committees (RCCCs) (to extend mental health nursing within primary care settings. This will involve: • Working with stakeholders to develop a full suite of activities to respond to the needs of people with severe and complex mental illness and to facilitate increased management of the physical and mental health of this patient group within primary care. This will include using the Atlas to identify the most appropriate models of care for the region, taking into account both the needs of the community and the availability of workforce and infrastructure, including linkages with the public mental health services and community based psychiatry services; • Promoting better management of the physical health of individuals with severe mental illness and the use of single multiagency care plans to help link providers;

Proposed Activities	
Description of Activity(ies) and rationale (needs assessment)	• Continuing to develop online and telehealth options, including, localised pathways in HealthPathways; and a point of entry, choice-based triage and referral for a definitive care approach with the use of digital self-management program; and • Evaluating innovations to implement stepped care. This could include trialling co-locating general practice and community mental health providers, developing health precincts, exploring models which incorporate peer-workers, investing in training of primary care practitioners regarding trauma informed care and practice, testing the concept of the Mental Health Care Home – where wrap around GP-led care coordination is delivered to patients with severe and complex mental illness and using telehealth in rural and remote areas.
Collaboration	The PHN will work closely with WACHS and the Mental Health Commission to establish a planned approach to address service gaps and build on existing workforce and infrastructure to utilise the Comprehensive Primary Care (CPC) approach in a mental health context. This will also require engagement with general practice at the local level and with GP representative bodies. Engagement with Regional Aboriginal Health Planning Forums will also ensure culturally appropriate clinical services are available for Aboriginal people with complex mental illness, especially those in remote communities where current access is problematic. Flexible funding will be used alongside Aboriginal mental health funding and suicide prevention allocations to develop Aboriginal specific services that reflect local identified needs and realistic objectives. The PHN will work with WACHS and service providers to explore opportunities to link with Primary Health Nurse Practitioner models in the Southern Inland area of Country WA and to further the links with general practice. The PHN will also collaborate with the community mental health NGO sector, Partners in Recovery, NDIS and My Way providers to effect integration in team care arrangements.
Duration	Anticipated activity start and completion dates (excluding the planning and procurement cycle) include: • Existing MHNIP – 1 July 2016 – 30 June 2017. • New services – Planning and Procurement Phase – 1 July 2016 – 31 December 2016. • New services – Delivery Phase – 1 January 2017 – 30 June 2018. The PHN proposes to commission new models of care by 1 April 2017. The programs will be contracted until 30 June 2018 with the option of extending the contracts for an additional 12 or 24 months.
Coverage	The PHN will be commissioning MHNIP practices to receive continuation funding are located in: • South West – Busselton • Great Southern – Denmark The planning and procurement of services will see services in the future delivered throughout the PHN. The exact locations within each of the regions will be determined by the planning process, the Atlas and the Regional Clinical Commissioning Committees. At a minimum there will be one mental health nursing service located in each of the seven regions, being: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.

Proposed Activities	
Commissioning approach	**Mental Health Nurse Incentive Programme (MHNIP)** The services currently provided under the MHNIP programme will be commissioned through a continuation of the current contract, during which time local PHN staff will work with the mental health nurses and general practices involved to assess the reach and effectiveness of the programme utilising the same assessment process as used for services funded under the general flexible funding pool in 2015 -16. **New stepped care approach** The PHN in partnership with key stakeholders will identify primary mental health service gaps within the stepped care approach as part of the comprehensive regional mental health plan. The PHN will work with partners to prioritise primary mental health service gaps and identify the most appropriate commissioning approach for people with severe and complex mental illness in each case. It is intended that co-commissioning the entry point to care will be in partnership with other WA PHNs, the Mental Health Commission and other key stakeholders utilising the following procurement strategies as the preferred approach: • Co-production and co-design processes to ensure place and consumer centric approaches to new models of care; and • Competitive dialogue with the mental health provider sector, to seek requests for proposals for consortia models. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements.
Performance Indicator	The mandatory performance indicators for this priority are: • Proportion of regional population receiving PHN-commissioned mental health services – Clinical care coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses); and • Average cost per PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.
Performance Indicator	In addition to the mandatory performance indicators, the PHN will work with our stakeholders to identify local performance indicators, if relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State - wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.

Proposed Activities		
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$1,135,955	Commonwealth funding
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed Activities	
Priority Area 5: Community based suicide prevention activities	This activity aligns with the following priorities in the PHN Needs Assessment: • Priority 1: Keeping people well in the community. • Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. • Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity(ies) / Reference (e.g. Activity 5.1, 5.2, etc)	**MH 5.1.1 – ATAPS/MHSRRA Suicide prevention transition to Community based suicide prevention - (existing)**
Description of Activity(ies) and rationale (needs assessment)	The Needs Assessment identified issues of workforce and community capacity when identifying and responding to suicide, non-suicidal self-harm and suicidal ideation, particularly in rural and remote locations. Current suicide prevention services for people in Country WA are limited to the suicide prevention component of ATAPS and MHSRRA within their limitations being to provide support for people and increased but not at acute risk of suicide or self-harm. During the transition period until March 2017 community based suicide prevention will continue to be commissioned through the existing ATAPS/MHSRRA programs to allow for the development of collaborative planning for integrated mental health and suicide prevention services in the seven regions which constitute the Country WA PHN. The PHN will work with stakeholders to assess the needs, scope options and support the change management across the sector towards a more integrated system. While this could include commissioning new services it is anticipated that a key role for the PHN will be to coordinate services across existing providers and support the more effective management of transition points. Activities 1.1 and 3.1 above provide a description of the activities to be funded.
Collaboration	During the ATAPS/MHSRRA continuation and transition period the PHN will work with other WA PHN's their CCC and CEC's, State government, WA Health, the MHC; general practice at the local level and GP representative bodies WANADA, Mental Health Professionals' Network; Aboriginal Health Council of WA and consumer and carer groups.
Duration	1 July 2016 – 31 March 2017. The PHN proposes to commission new models of care by 1 April 2017. The programs will be contracted until 30 June 2018 with the option of extending the contracts for an additional 12 or 24 months.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.

Proposed Activities		
Coverage	As per previous years services through ATAPS will be delivered face to face and where appropriate telephone based in the following regional centres. MHSRRA services will continued to be delivered from community centres, clients' homes and Aboriginal Medical Service clinics.	
Commissioning approach	Contracts for ATAPS and MHSRRA will be extended until 31 March 2017. The PHN will work with partners to prioritise primary community based suicide prevention service gaps and to identify the most appropriate commissioning approach for people at risk of suicide and self-harm utilising the following procurement strategies as the preferred approach; • Co-production and co-design processes to ensure place and consumer centric approaches to a stepped care approach; and • Competitive dialogue with the mental health provider sector, to seek requests for proposals for consortia models. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements.	
Performance Indicator	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, Country WA PHN will work with stakeholders, to identify local performance indicators if relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$0	Commonwealth funding The funding for this activity is reflected in planned expenditure for activity 1.1 during the first 9 months of the 2016 -17 year. A revised budget will be submitted once the mental health plan has been completed and the new models commissioned. This budget will be for the periods 1 April 2017 – 30 June 2017 and 1 July 2017 – 30 June 2018.
	$0	Funding from other sources (e.g. private organisations, State and territory governments).

Proposed Activities	
Priority Area 5: Community based suicide prevention activities	This activity aligns with the following priorities identified in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity(ies) / Reference (e.g. Activity 5.1, 5.2, etc)	**MH 5.1.2 - Aboriginal suicide prevention services transition to Community based suicide prevention services (existing)**
Description of Activity(ies) and rationale (needs assessment)	Two Aboriginal suicide prevention services are currently funded under the Commonwealth's Community Suicide Prevention Programme in Country WA. • Kimberley Aboriginal Law and Culture Centre – Yiriman Project; and • Goomburrup Aboriginal Corporation – Banang Project in the South West. The aim of these projects is to assist local at risk young people and families in the Fitzroy Valley (Yiriman) and South West (Banang). The projects seek to develop culturally appropriate strategies to address issues of self-harm and suicide. Due to the nature of the services and the vulnerability of the communities serviced, a 12 month extension has been granted to enable the PHN to develop an understanding of the services, their effectiveness and how they integrate with other services in the regions and to develop a collaborative plan for integrated mental health and suicide prevention services in the seven (7) PHN regions.
Collaboration	During the 12 month continuation, the PHN will be developing its longer term regional Mental Health and Suicide Prevention Plan (the Plan) utilising the Atlas to guide the development and location of suicide prevention activities. Flexible funding for Aboriginal Suicide Prevention will be used alongside the Aboriginal Mental Health funding allocation to develop Aboriginal specific services that reflect local identified needs and realistic objectives. Key stakeholders will include but are not limited to other WA PHN's and their CCC and CEC's, the WA MHC, WA Health, Aboriginal Health and regional planning organisations, NDIS providers, community based primary health care, mental health, social and welfare agencies, local government, WANADA, consumer groups and other service providers dealing with Aboriginal people at risk of suicide and self-harm. In areas where the National Suicide Prevention Program funds the United Synergies *Stand By* service into Aboriginal Communities the service sub-contractor will also be involved in the development of the new models of service provision to ensure linkage at a local level.

Proposed Activities		
Duration	1 July 2016 – 30 June 2017. The PHN proposes to commission new models of care by 1 April 2017. The programs will be contracted until 30 June 2018 with the option of extending the contracts for an additional 12 or 24 months.	
Coverage	Country WA regions in the Kimberley and South West.	
Commissioning approach	Contracts for the Yiriman and Banang Projects will be extended until 30 June 2017. During this period of extension tenders will be called for Consortia approaches to integrated mental health and suicide prevention services using the Stepped Care guidelines provided by the Commonwealth with a view to having new contracts operational by 1 April 2017. During this review and planning period opportunities to commission additional Aboriginal suicide prevention programs will be explored in consultation with the Regional Clinical Commissioning Committees, Aboriginal Medical Services and the Regional Aboriginal Health Planning Forums. Areas of significant need identified through the Atlas mapping will be considered as locations for services and localised models developed with communities.	
Performance Indicator	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, we will work with our stakeholders, to identify local performance indicators if relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$363,115	Commonwealth (this includes Yiriman and Banang continuation)
	$0	

Proposed Activities	
Priority Area 5: Community based suicide prevention activities	This activity aligns with the following priorities identified in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity(ies) / Reference (e.g. Activity 5.1, 5.2, etc)	**MH 5.2.1 - Community based suicide prevention - integrated local suicide prevention approaches (new)**
Description of Activity(ies) and rationale (needs assessment)	The Needs Assessment highlighted gaps in the primary health care system with regard to systematic, organised and graduated suicide prevention services tailored to Regions or, in some cases of high prevalence, to local areas. The distribution and focus of services with a role in suicide prevention across the PHN is uneven and lacks joint planning and service delivery commitment from both funders and service providers. The Needs Assessment articulated the need for a comprehensive range of integrated suicide prevention strategies across all regions. This was particularly pertinent to Country WA where access to means, economic and financial hardship and patchy non-responsive services contribute to rising suicide rates and suicide attempts higher than the WA and national averages. The PHN acknowledges that all pieces of the puzzle that effect successful suicide prevention, follow-up and support do not lie within the PHN's commissioning scope. Nonetheless leadership in creating service linkages including the development of a localised pathways and a point of entry choice based triage and building a common agenda between service providers are well within the PHN's purview. The PHN will therefore take a lead role in the development of Regional and local plans that are person-centred, funded on the basis of need, take an evidence based regional approach to service planning and integration and provide effective early intervention across the lifespan. The planning process will take into account those existing State (hospitals, ED's and first responders) commonwealth health (GP's and community care workers) and other funded services in the social care sector that contribute to the stepped care approaches that a suicide prevention system requires to be effective.

Proposed Activities	
Description of Activity(ies) and rationale (needs assessment)	The major outcome of the first phase of this activity will be *Regional Mental Health and Suicide Prevention Plan* which will be to be developed in consultation with WACHS, refer to Activity 8.
Collaboration	The PHN is informed by the Mental Health Expert Advisory Group (MHEAG) established by WAPHA to guide the development of needs-based models of care. The PHN will collaborate and develop partnerships with key stakeholders including but not limited to: other WA PHN's and their CCC and CEC's, the WA MHC, WA Health, Aboriginal Health organisations, NDIS providers, community based primary health care, mental health, social and welfare agencies, local government, WANADA, consumer groups and other service providers dealing with people at risk of suicide and self-harm.
Duration	1 July 2016 – 30 June 2017 (Aboriginal Suicide Prevention through current contracts). 1 July 2016 – 30 June 2018 new services (from unallocated Aboriginal Suicide Prevention funds). 31 March 2017 – 30 June 2018 (on release of ATAPS and MHSRRA funds). The PHN proposes to commission new models of care by 1 April 2017. The programs will be contracted until 30 June 2018 with the option of extending the contracts for an additional 12 or 24 months.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Commissioning approach	The Commissioning of integrated local suicide prevention approaches will be carefully phased based on the understanding of regional and local community needs and using the mapping undertaken by the Atlas project. **New stepped care approach** The PHN in partnership with key stakeholders will identify primary community based suicide prevention gaps within the stepped care approach as part of the comprehensive regional mental health plan. These gaps will be prioritised and the PHN will collaborate with partners to identify the most appropriate commissioning approach in each case. The Commissioning approaches may vary as regions complete their own analyses and assess their service provider strength and capacities however, it is intended that co-commissioning the entry point to care will be in partnership with other WA PHNs, the Mental Health Commission and other key stakeholders utilising the following procurement strategies as preferred approaches; • Co-production and co-design processes to ensure place and consumer centric approaches to new models of care; • Competitive dialogue with the mental health provider sector, to seek requests for proposals for consortia models; and

Proposed Activities		
Commissioning approach	• Direct negotiation with individual agencies within remote areas where these agencies have the capacity and cultural authority to effectively support Aboriginal people who are at risk of suicide. The PHN will explore opportunities for taking a family and community centred approach to suicide prevention and to integrating the suicide prevention program with other social and community wellbeing programs within remote communities. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements.	
Performance Indicator	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, we will work with our stakeholders, to identify local performance indicators if relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$0	Commonwealth funds – the funding for these activities will be released through the cessation of the ATAPS/MHSRRA suicide prevention activity
	$0	

Proposed Activities	
Priority Area 5: Community based suicide prevention activities	This activity aligns with the following priorities identified in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place.
Activity(ies) / Reference (e.g. Activity 5.1, 5.2, etc)	**MH 5.2.2 - Community based suicide prevention - integrated place based suicide prevention approaches for Aboriginal and Torres Strait Islander peoples (new)** This activity links closely with **Activity 5.2 Integrated Local Suicide Prevention Programs;** and **Activity 6 Aboriginal and Torres Strait Islander mental health services.**
Description of Activity(ies) and rationale (needs assessment)	The Needs Assessment, and National, State and Regional data provide a compelling rationale to work with Aboriginal people to design and develop responsive and relevant suicide prevention approaches with and for those people made especially vulnerable by domestic violence, remoteness and alcohol and substance use, often in combination. The PHN will: • Commission trusted, safe and nuanced services, delivered through developed relationships with local service providers, hospitals and general practice; • Acknowledge and use any existing interagency and community suicide prevention groups within the PHN as a springboard for further planning and development work. Flexible funding released by the discontinuation of ATAPS and MHSRRA as prescribed programs can be used alongside Aboriginal Mental Health funding and suicide prevention allocations to develop services that reflect local identified needs and are also considered culturally safe by Aboriginal people; • Undertake planning and commissioning of community-based suicide prevention activities for Aboriginal people that are integrated with drug and alcohol services, mental health services and social and emotional wellbeing services (in line with PHN Mental Health and Suicide Prevention Implementation Guidance). Such planning will also recognise the integral role that hospitals, particularly emergency departments, first responders, front line health workers, GPs and other community based health workers play in timely intervention with people at acute risk of suicide;

Proposed Activities	
Description of Activity(ies) and rationale (needs assessment)	• Ensure that the integration of trauma informed approaches and an exploration of the linkages between disorders such as Foetal Alcohol Syndrome Disorder (FASD) and suicide and self-harm is included in the regional approaches to Aboriginal and Torres Strait Islander suicide prevention activities; and • Ensure that there will be a key focus on people aged 15 – 34 years within Aboriginal Suicide prevention planning. The major outcome of the first phase of this activity will be *Regional Mental Health and Suicide Prevention Plan* which will be to be developed in consultation with WACHS (refer to Activity 8).
Collaboration	The PHN will collaborate and develop partnerships with key stakeholders including but not limited to: other WA PHN's and their CCC and CEC's, the WA MHC, WA Health, Aboriginal Health, Medical, Planning & Policy organisations, community based primary health care, mental health, social and welfare agencies, local government, WANADA, consumer groups and other service providers dealing with people at risk of suicide and self-harm and hard to reach groups. As previously mentioned, consultations will be held in each region to inform the development of the Atlas. Opportunities for co-commissioning of services will be explored.
Duration	1 July 2016 – 30 June 2017 (Aboriginal Suicide Prevention through current contracts). 1 July 2016 – 30 June 2018 new services (from unallocated Aboriginal Suicide Prevention funds) 31 March 2017 – 30 June 2018 (on release of ATAPS and MHSRRA funds). The PHN proposes to commission new models of care by 1 April 2017. The programs will be contracted until 30 June 2018 with the option of extending the contracts for an additional 12 or 24 months.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Commissioning approach	The Commissioning of integrated local suicide prevention approaches for Aboriginal and Torres Strait Islander peoples will be carefully phased based on the understanding of regional and local community needs and using the mapping undertaken by the Atlas project. The PHN in partnership with key stakeholders will identify primary community based suicide prevention gaps within the stepped care approach as part of the comprehensive regional mental health plan. These gaps will be prioritised and the PHN will collaborate with partners to identify the most appropriate commissioning approach in each case.

Proposed Activities		
Commissioning approach	The Commissioning approaches may vary as regions complete their own analyses and assess their service provider strength and capacities however, it is intended that co-commissioning the entry point to care will be in partnership with other WA PHNs, the Mental Health Commission and other key stakeholders utilising the following procurement strategies as preferred approaches; • Co-production and co-design processes to ensure place and consumer centric approaches to new models of care; • Competitive dialogue with the mental health provider sector, to seek requests for proposals for consortia models; and • Direct negotiation with individual agencies within remote areas where these agencies have the capacity and cultural authority to effectively support Aboriginal people who are at risk of suicide. The PHN will explore opportunities for taking a family and community centred approach to suicide prevention and to integrating the suicide prevention program with other social and community wellbeing programs within remote communities. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements.	
Performance Indicator	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, we will work with our stakeholders, to identify local performance indicators if relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$239,300	Commonwealth funds – some additional funds for this activity will be released through the cessation of the ATAPS/MHSRRA Programs. A revised budget will be submitted once the mental health plan has been completed and the new models commissioned.
	$0	

Proposed Activities	
Priority Area 5: Community based suicide prevention activities	This activity aligns with the following priorities identified in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity/Reference	**MH 5.3 - Capacity Building in remote communities (new)**
Description of Activity(ies) and rationale (needs assessment)	Building capacity within communities, agencies and individual providers to respond to local needs in an integrated manner has been highlighted as a key mental health strategy for remote areas by recent national and international initiatives especially within the areas of suicide prevention and bereavement. The Country WA PHN is largely comprised of areas considered to be remote or very remote with limited dedicated suicide prevention programs and coordinated responses to suicide that are at best, ad hoc, but mostly non-existent. WA Country PHN has a key role to play in bringing stakeholders together to develop a system wide co-ordinated response and to build their capacity to ensure that the needs of families and communities affected by suicide in the region are met. The PHN will work with communities to develop and disseminate local client pathways and to establish community responses dedicated to delivering a comprehensive service for the local community, and building strong relationships with other service providers for referral services. The community response will necessarily be broad with a long-term focus especially for remote communities with a disproportionate number of people variously and continuously affected. Ensuring that the most appropriate services and individuals can assist on a case-by-case basis will also be imperative in terms of culture and gender in the context of remote communities, particularly those which a predominance of Aboriginal people. The provision of education initiatives and workshops about suicide intervention for other health and social service providers and for community members will also raise awareness and increase help seeking and community self-responsibility.
Collaboration	The WA Mental Health Commission will be a key collaborator as the PHN and the MHC work to align their approaches to suicide prevention in remote areas, particularly with a view to increasing local capacity. As previously mentioned PHN will collaborate and develop partnerships with other key stakeholders including but not limited to: funded providers, General Practice, WACHS, WANADA, Mental Health consumer and carer groups, local government, justice, social and welfare agencies and Aboriginal health, Medical and Policy organisations.

Proposed Activities		
Duration	2 May 2016 – 30 June 2016 – planning phase. 1 July 2016 – 30 June 2018 – Service delivery in pilot areas. 31 March 2017 – 30 June 2018 – extended service delivery (on release of ATAPS and MHSRRA funds). The PHN proposes to commission new models of care by 1 April 2017. The programs will be contracted until 30 June 2018 with the option of extending the contracts for an additional 12 or 24 months.	
Coverage	Country WA PHN. Regions to be included in the pilot will be identified in collaboration with MHC in the planning phase. Further areas will be introduced 1 April 2017.	
Commissioning approach	As previously mentioned, opportunities for co-commissioning of services will be explored. The prime co-commissioning agency will be the WA Mental Health Commission. The MHC will work with the Country WA PHN to improve suicide prevention coordination and capacity building in rural and remote areas. This work will commence in May 2016 with a view to having a joint approach in place for commencement on 1 July 2016.	
Performance Indicator	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, we will work with our stakeholders, to identify local performance indicators if relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$	Commonwealth funds. Refer to Commonwealth Funding 7.1 Stepped care.
		Funds provided by MHC for Suicide prevention coordination and capacity building

Proposed Activities	
Priority Area 5: Community based suicide prevention activities	This activity aligns with the following priorities identified in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity(ies) / Reference (e.g. Activity 5.1, 5.2, etc)	**MH 5.4 - Community based suicide prevention - demonstration projects in high-risk areas (new)**
Description of Activity(ies) and rationale (needs assessment)	The aim of this activity is to commission a small number of services in identified high-risk areas where the community has identified coordinated community approaches to suicide prevention. The identified communities are: • Halls Creek - an identified hot-spot in the Needs Assessment is beginning a community planning process to address suicide and suicide attempts. The approach will be to engage the whole community in a process to identify what raises risk for people, to track a hypothetical patients' journey through the service system and to promote a way of thinking about suicide that builds trust and makes people want to seek help; and • Leonora – the local Suicide Prevention Action Group is a collaboration of local government, Aboriginal organisations and other service providers. The plan is to develop a suite of approaches that include counselling face to face and by phone, safe, timeout places, young people-friendly people and places to avert self-harm and suicide attempts and post attempt follow up and support. The plan also includes liaison from the main hospital in Kalgoorlie to community.
Collaboration	These demonstration projects require considerable collaboration with WA Country Health Service, WA Mental Health Commission and local Aboriginal organisations and suicide prevention groups.
Duration	1 July 2016 – 30 June 2018. This will include an extensive planning and capacity building phase which is likely to take approximately six months. The PHN proposes to commission new models of care by 1 April 2017. The programs will be contracted until 30 June 2018 with the option of extending the contracts for an additional 12 or 24 months.
Coverage	Country WA PHN region covering Halls Creek in the Kimberley and Leonora in Goldfields. Other locations are likely to be identified through the Atlas.

Proposed Activities		
Commissioning approach	It is anticipated that where possible, the preferred approach will be to seek requests for proposals for local consortia models.	
Performance Indicator	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, we will work with our stakeholders, to identify local performance indicators if relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$	Commonwealth funds – this will be funded through Carry Forward Operational Funding.

Proposed Activities	
Priority Area 6: Aboriginal and Torres Strait Islander mental health services	This activity aligns with the following priorities identified in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity(ies) / Reference (e.g. Activity 6.1, 6.2, etc)	**MH 6.1 - Integrated Aboriginal and Torres Strait Islander Mental Health Services (new)**
Description of Activity(ies) and rationale (needs assessment)	The PHN's Needs Assessment identified a significant gap in culturally secure services for Aboriginal people and it is acknowledged that significant engagement with the Aboriginal communities across the PHN will be required prior to the establishment of any new services. To establish improved integrated services WA Country PHN will: • Engage with local Aboriginal communities and consult with key Aboriginal and mainstream primary health care organisations to design and commission culturally appropriate, evidence based mental health services to holistically meet the needs of Aboriginal people across the region; • Develop an integrated model of service delivery to ensure Aboriginal people have access not only to mainstream health and mental health services but also to social and emotional wellbeing, suicide prevention and alcohol and other drug services; • Utilise the Atlas to identify gaps and opportunities for improved service delivery in mental health, suicide prevention and drug and alcohol treatment and to plan and commission services that meet the needs of Aboriginal people with co-occurring mental health and alcohol and drug misuse, and those at risk of suicide. The Atlas is due for completion in September 2016. It is estimated a further three to six months will then be required to explore local options with communities in order to determine service models most suited to community needs. The Atlas will also highlight opportunities to build on existing services, making best possible use of existing workforce and infrastructure; • Explore opportunities to improve linkages with GPs and improve the uptake of appropriate MBS items; • Explore the use of telephone/technology to facilitate early intervention services; • Consider the needs of Aboriginal people with a mental health condition in the planning of the extended primary care trial (referred to in the PHN's Flexible Funding Activity Work Plan) and the associated After Hours activity; • Review workforce capacity including the use of Health Pathways in primary care health services to provide culturally secure mental health care to Aboriginal people;

Proposed Activities	
Description of Activity(ies) and rationale (needs assessment)	• Explore the concept of Social and Emotional Wellbeing Teams[1] in service design; • Ensure Trauma Informed Care and Practice (TICP) is a feature of the Aboriginal and Torres Strait Islander mental health program; • Ensure the needs of Aboriginal people with a mental health condition will also be considered in the planning of the Extended Primary Care trial (referred to in the PHN's Flexible Funding Activity Workplan) and the associated After Hours activity; • Review workforce capacity in primary care health services to provide culturally secure mental health care to Aboriginal people, including the use of Health Pathways to ensure people are referred to culturally appropriate services. This will include an emphasis on building the capacity of local people to lead the development and delivery of services within their communities; and • Seek to collaborate with drug and alcohol services, wellbeing services, headspace and State bordering PHN's, to facilitate the linkage of mental health, suicide prevention and alcohol and other drug services to minimise duplication and maximise resources. This activity meets the mental health funding objectives by: • Enhancing access to and better integrated Aboriginal mental health services at a local level; and • Facilitating a joined up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services.
Collaboration	The PHN will work collaboratively with key stakeholders including but not limited to: other WA and bordering PHN's and their CCC and CEC's, WAPHA Mental health Advisory Group, the WA MHC, WA Health, Aboriginal Health, Medical, Planning & Policy organisations and Aboriginal Community Controlled Health Organisations, mental health providers, justice, social and welfare agencies, local government, WANADA, consumer groups, headspace and other service providers dealing with aboriginal people with mental health issues, at risk of suicide and self-harm and hard to reach groups. As outlined elsewhere the PHN will also establish Aboriginal Mental Health and AOD Advisory Groups to bring together experts with clinical and community perspectives to advise on priorities and plans for Aboriginal mental health and suicide prevention services.

[1] Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services, http://www.health.gov.au/internet/main/publishing.nsf/Content/0DBEF2D78F7CB9E7CA257F07001ACC6D/$File/response.pdf last accessed 27/04/16

Proposed Activities	
Duration	Planning and Procurement Phase – 1 July 2016 – 31 December 2016. This will include: • Regional consultations with Aboriginal medical services and other relevant organisations to inform the Atlas – ongoing from 2015 – 16 to August 2016; • Delivery of the Atlas – September 2016; • Working with Aboriginal Health Planning Forums and other relevant stakeholders to inform models of service delivery – July – October 2016; • Regional Clinical Commissioning Committees work on finalising service models for each region and determining commissioning/procurement approach – September – October; and • Tenders called – November 2016. Service delivery – phased commencement from 1 January 2017. The PHN proposes to commission new models of care in all regions across Country WA by 1 April 2017. The programs will be contracted until 30 June 2018 with the option of extending the contracts for an additional 12 or 24 months.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern. The most appropriate locations will be determined on the basis of the Atlas and consultations with existing providers and key stakeholders to highlight areas of significant unmet need.
Commissioning approach	The services currently provided under the ATAPS and MHSRRA programme providing mental health counselling for Aboriginal people will be commissioned through a continuation of the current contracts as outlined elsewhere in this document. Flexible funding released by the discontinuation of ATAPS as prescribed programs will be used alongside Aboriginal mental health funding and suicide prevention allocations to develop new Aboriginal specific services that reflect local identified needs and realistic objectives. Information from the Atlas and the needs assessment will be used by RCCCs to determine: • the location of new services within the region; • the model of service delivery, including the opportunities for a co-design approach involving consumers and service providers; and • the commissioning approach, for example, the use of a competitive dialogue approach, use of a local innovation hub, expression of interest, select tender, open tender or preferred service provider approach.

Proposed Activities		
Commissioning Approach	Proposals for innovative approaches to Aboriginal mental health and suicide prevention services could also be considered for funding through the PHN's Innovation and Evidence Fund (as outlined in the PHN Flexible Funding Activity Work Plan). Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements.	
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. In addition to the mandatory performance indicator, we will work with our stakeholders to identify local performance indicators if relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$2,145,941	Commonwealth funding – note this funding will not be expended on the planning component but will be used to commission services once the planning phase is complete. Services will commence at various times across the 2016-17 year.
	$0	Funding from other sources (e.g. private organisations, State and territory governments)

Proposed Activities	
Priority Area 7: Stepped care approach	This activity aligns with the following priorities identified in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity(ies) / Reference (e.g. Activity 7.1, 7.2, etc)	**MH 7.1 - Stepped Care (new)**
Description of Activity(ies) and rationale (needs assessment)	The PHN's approach to stepped care will be to develop an integrated shared-care approach with the primary care sector, principally led by general practitioners. This activity underpins all of the mental health funding objectives. To support better integrated care and the establishment of effective care pathways the PHN will: • Establish relationships and agree to terms of reference, including where appropriate memorandums of understanding and service level agreements; • Understand comprehensive regional mental health planning and identify primary mental health service gaps within a stepped care approach; • Review the linkages with, and between relevant services and supports; • Establish joined up assessment processes and referral pathways to enable people with mental illness, particularly those people with severe and complex mental illness, to receive the clinical and other related services they need; • Develop new approaches to broaden the service mix and improve access, with a focus on hard to reach groups; • Build workforce capacity for a stepped care approach and target referral to 'soft' entry points; • Establish mental health specific clinical governance arrangements; • Promote and integrate a single point of entry and online / telehealth services as core elements of the stepped care approach; and • Build general practice capacity to screen, treat and monitor at risk and co-morbid individuals and population groups. All activities undertaken by the PHN through its stepped care approach will be: • Recovery oriented and client focused – operating under a recovery framework using a personalised approach, tailored to meet the specific support needs of individuals; • Flexible in rollout and complementary to existing services – with scope to build on system strengths, address gaps and meet specific local area service delivery needs. New services will support system navigation, integration and coordination;

Proposed Activities	
Description of Activity(ies) and rationale (needs assessment)	• Focused on integrating mental health, suicide prevention and alcohol and other drugs services where possible to minimise duplication and maximise the use of available resources. This will include developing linkages between Commonwealth and State government initiatives; and • Designed with continuity of care in mind, ensuring appropriate care is available on a 24/7 basis in key regional areas through linking mental health activities to the After Hours funding as outlined in the Country WA PHN Annual Activity Plan Flexible and Operational Funding 2016 – 17.
Collaboration	The PHN is informed by the Mental Health Expert Advisory Group (MHEAG) established by WAPHA to guide the development of models of care to meet the mental health needs. Models of care that will be explored and developed include the mental health care home and local integrated team care within a stepped care approach. Integral to this will be continued development of digital health including localised pathways in HealthPathways, and a point of entry, choice based triage and referral for definite care approach and use of digital and self-management programs. In establishing a continuum of primary mental health services the PHN will work collaboratively with key stakeholders including but not limited to: WACHS, WA Mental Health Commission, AHCWA and Aboriginal health services, local Aboriginal Health Planning Forums, Professional Colleges and Associations, headspace, mental health consumer and carer groups and mainstream health and service providers specific to disadvantaged and hard to reach groups.
Duration	2 May 2016 to 30 June 2018. The PHN proposes to commission new models of care by 1 April 2017. The programs will contracted until 30 June 2018 with the option of extending these contracts for additional 12 or 24 months.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.
Commissioning approach (If applicable)	**New Stepped Care Approach** The PHN in partnership with key stakeholders will identify primary mental health service gaps within the stepped care approach as part of the comprehensive regional mental health plan. These gaps will be prioritised and the PHN will collaborate with partners to identify the most appropriate commissioning approach in each case. It is intended that co-commissioning the entry point to care will be in partnership with other WA PHNs, the Mental Health Commission and other key stakeholders utilising the following procurement strategies as the preferred approaches; • co-production and co-design processes to ensure place and consumer centric approaches to new models of care; and • competitive dialogue with the mental health provider sector, to seek requests for proposals for consortia models.

Proposed Activities		
Commissioning approach (If applicable)	Where appropriate the new stepped care approach will also link with services provided under the National Disability Insurance Scheme to reduce the likelihood of service duplication. This will be especially relevant for people with severe and complex mental illness. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements.	
Performance Indicator	The mandatory performance indicator for this priority is: • 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. In addition to the mandatory performance indicator, we will work with our stakeholders, to identify local performance indicators. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$1,848,885	Commonwealth funding (ATAPS/MHSRRA 25%)
	$0	Funding from other sources (eg. private organisations, State and territory governments)

Proposed Activities	
Priority Area 8: Regional mental health and suicide prevention plan	This activity aligns with the following priorities identified in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. Priority 4: System navigation and integration to help people get the right services, at the right time and in the right place. Priority 5: Capable workforce tailored to these priorities.
Activity(ies) / Reference (e.g. Activity 8.1, 8.2, etc)	**MH 8.1 - Regional mental health and suicide prevention plan (new)**
Description of Activity(ies) and rationale (needs assessment)	In Western Australia there is a need for a comprehensive review of primary care mental health activity, and to transition to new models of stepped care to address a lack of comprehensive mental health planning for targeted interventions tailored specifically for the needs of different groups, and a disjointed mental health service system that is unable to respond to local needs and local priorities. During 2015 -2016 WAPHA commenced the foundation work for system reform. Activities in 2016-2017 and beyond will focus on increased integration and coordination of existing services (across sectors and across funders) to improve the timeliness, access and quality of mental health services in the region. Where appropriate new models will be tested using the Innovation and Evidence Fund (activity NP8 outlined in the Flexible Funding activity work plan) before commissioning new services during the latter part of 2016-2017. **2016-2017 activities** • Establishing contracts within a clinical governance framework; • Developing and implementing a project management framework to oversee the PHN's activities; • Ensuring appropriate data collection and reporting systems are in place for all commissioned services, to inform service planning and facilitate ongoing performance monitoring and evaluation; • Developing and implementing systems to support sharing of consumer clinical information between service providers and consumers; • Establishing and maintaining appropriate consumer feedback procedures including complaint management; • Implementing a comprehensive *Mental Health and Suicide Prevention Needs Assessment* and development of *Mental Health Activity Work Plan;* • Developing a *Regional Mental Health and Suicide Prevention Plan;*

Proposed Activities	
Description of Activity(ies) and rationale (needs assessment)	• Scoping, planning and implementing a commissioning trial of the Extended Primary Care model – to provide wrap around primary care for people who have complex mental health care needs; and • Reviewing the evaluation of the Extended Primary Care trial and the Local Integrated Team Care model to identify opportunities for better integrated and co-ordinated mental health services for people with complex, chronic conditions and vulnerable people without consistent access to primary health care. The PHN is aware the DoH mental health branch are commissioning a PHN specific National Mental Health Services Planning Framework-based decision support tool (DST) to assist with planning. This PHN tool will include the capability to adjust for rurality and ATSI populations. Access to a PHN-DST provides the facility to align WAPHA planning with the WA Mental Health Commission Mental Health, Alcohol and Other Drug Services plan as this was also developed using the NMHSPF DST planning methodology. Thus commonwealth and State -based service planning in WA will share the same fundamental approach to resource allocation within a co-commissioning framework, demarcating more keenly the separate commonwealth and State responsibilities that if not addressed can lead to duplication of services and cost shifting to the detriment of patient care and community health. The development of a regional mental health and suicide prevention plan will underpin all six of the mental health funding objectives across all seven regions with the Country WA PHN.
Collaboration	During the nine month ATAPS/MHSRRA continuation the PHN will work collaboratively with key stakeholders whose roles will be based on the IAP2 participation spectrum[2] and the RACI (responsible, accountable, consulted, informed) matrix. Stakeholders include but are not limited to WAPHA Board, PHN Council CCC and CEC's. WAPHA Mental Health Advisory Group, WA MHC, WA Health, Aboriginal Health organisations and councils, HaDSCO, Consumer and carer groups, patients their families and carers. Agreement for the *Regional Mental Health and Suicide Prevention Plan* will be sought from key partners through WAPHA's Mental Health Expert Advisory Group.
Duration	See above for a breakdown of the work that is planned in 2015-2016 and 2016-2017. The *Mental Health Activity Work Plan* will be submitted in May 2017. • It is anticipated that new models of primary care mental health services could be tested using the Innovation and Evidence Fund during 2016-2017 before moving to a full commissioning cycle in 2016-2017/2017-2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great Southern.

[2] International Association for Public Participation Spectrum (inform, consult, involve, collaborate, empower), http://www.iap2.org.au/documents/item/84, last accessed 27/04/16

Proposed Activities		
Commissioning approach (If applicable)	As outlined above, a comprehensive mental health needs assessment will be undertaken by March 2017. Discussions will also take place with providers and other funders/purchasers of services to inform the commissioning approach. The PHN will also undertake a co-production approach with mental health consumers to address identified needs as appropriate.	
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. The PHN will work with key stakeholders to identify local performance indicators where relevant. Furthermore, as outlined in the PHN's Flexible Funding Annual Activity Work Plans, it is planned to scope, plan and develop a State -wide primary care outcomes framework. This will be used to identify local performance indicators for the PHN and for commissioned services. This framework in Country WA will also reference the *Public and Primary Health Directions Strategy 2015 – 2018.*	
Local Performance Indicator target (where possible)	As outlined above, local performance indicators will be agreed in partnership with providers and stakeholders. Targets will be identified and agreed as part of the commissioning process.	
Local Performance Indicator Data source	To be agreed. Potential sources include provider patient-level (de-identified) data; State -wide data sets; national data sets.	
Planned Expenditure 2016-2017 (GST exc)	$0	Commonwealth funding – operational funding for mental health and Carry Forward Operational Core Funding
	$0	Funding from other sources (eg. private organisations, State and territory governments)