Australian Government
Department of Health

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An Australian Government Initiative

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

When submitting this. Mental Health Activity Work Plan (referred to as the Regional Operational Mental Health and Suicide Prevention Plan in the 2015-16 Schedule for Operational Mental Health and Suicide Prevention, and Drug and Alcohol Activities) to the Department of Health, the Primary Health Network (PHN) must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

Additional planning and reporting requirements including documentation, data collection and evaluation activities for those PHNs selected as lead sites will be managed separately.

The Activity Work Plan must be lodged to Carly Davis via email carly.davis@health.gov.au on or before 6 May 2016.

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 by May 2016. 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

- Commission evidence-based clinical primary mental health care services in line with a best practice stepped care approach;

- Develop and commission cost effective low intensity psychological interventions for people with mild mental illness, making optimal use of the available workforce and technology;

- The 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;

- 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. This will include provision of support to gps in undertaking assessment to ensure people are referred to the service which best targets their need;

- Develop and commission 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;

- Develop and commission strategies to target the needs of people living in rural and remote areas and other under-serviced populations; and

- Develop 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 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:

- Outline the planned mental health services to be commissioned from 1 July 2016, consistent with the grant funding guidelines.
- 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 Programmes 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.
- Outline the approach to be taken to integrating and linking programmes 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.
- 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 at *http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Programme Guidelines,* 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). Sensitive content identified by the PHN will be excluded, subject to the agreement of the Department.

It is important to note that while planning may continue following submission of the Mental Health Activity Work Plan, PHNs must not commit or spend any part of the funding related to this Activity Work Plan until it is approved by the Department.

Further information

The following may assist in the preparation of your Mental Health Activity Work Plan:

- The requirements detailed in the Primary Mental Health Care Schedule;
- PHN Needs Assessment Guide;
- Mental Health PHN Circulars;
- Primary Health Networks Grant Programme Guidelines – Annexure A1 – Primary Mental Health Care; and
- *Indigenous Australians' Health Programme – Programme Guidelines.*

Please contact your Grants Officer if you are having any difficulties completing this document.

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 people 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:
    - Embedding a consumer centred approach into mental health and suicide prevention planning and commissioning activities;
    - Facilitating more clearly defined pathways and alignment between general primary care, relevant social service and different disease specific health care services;
    - Supporting the provision of person-centred, integrated and coordinated care for vulnerable and disadvantaged people in identified priority locations of greatest health needs; and
    - Supporting the provision of equitable access to a broad range of connected and co-ordinated services to meet the needs of individuals with co-occurring physical and mental co-morbidities and/or problematic use of alcohol or drugs;
- Increasing the provision of timely access to mental health treatment through improving mental health screening and treatment within General Practice;
- Recognising the different 'needs-based groups' that exist within the population experiencing mental health problems, disorders and conditions and those who are at risk of suicide or serious self-harm;
- Undertaking an evidence based approach 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;
- Implementing a 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;
- Investing in training of primary care practitioners in trauma informed care and practice;
- Ensuring activities throughout the region are commissioned within an integrated systems approach for primary mental health care, the WAPHA Mental Health Primary Care model. The model incorporates the European Alliance Against Depression Multilevel Approach to the Prevention of Suicidal Behaviour in Nuremberg as detailed in Mental Health Primary Care: The WAPHA framework for Integrated Primary Mental Health Care[1] which identifies a 'whole of community' response is essential. The model confirms that four key, evidence based components of response are essential. These include Primary and mental health care services; community awareness; engagement of community facilitators and stakeholders; and targeted activities working with high-risk individuals and their families. The Nuremberg research found that not only must all components be present in a community, but they must be delivered in a 'joined-up' manner.

[1] Western Australian Primary Health Alliance, Mental Health Primary Care: The WAPHA framework for Integrated Primary Mental Health Care, October 2016

- Implementing all mental health activity within the framework of 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, which are 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) with complex care needs ("severe and complex") to be managed in a coordinated way in primary care settings. The implementation of a comprehensive stepped care approach is intended to ensure people get the right clinical service at the right level of intensity and the right time, linked to other non-health supports as required.

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 regions.

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 this group have interdisciplinary expertise relevant to mental health and suicide prevention planning.

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.

Early Psychosis Prevention & Intervention Centre – a model of care which aims to facilitate the early identification and treatment of psychosis and therefore reduce the disruption to the young person's functioning and psychosocial development.

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 - addressing issues within a defined place, community or region in a systemic way. This includes leveraging existing resources and assets to better support health and wellbeing and utilising localised models of care to realise more equitable health outcomes, better value for the community.

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 free-to-access mental health and AOD services in WA including their reach. Once completed (draft due October 2016; public release for comment December 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 can 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 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 for outcomes

To facilitate and support the move from programme funding to outcome based commissioning the WA PHNs, through the WA Primary Health Alliance (WAPHA), in collaboration with the community, providers and other stakeholders, will develop a state-wide primary care outcomes framework ("the framework").

The framework provides consistency, transparency and comparative benchmarking across funded interventions. It enables WAPHA to fully understand and measure whether the services/intervention/projects being funded and delivered are having a real and lasting impact on people's lives. In this sense, it provides public value. It also enables service providers to be clear on the types of outcome measures of interest to WAPHA. The framework will guide the selection of indicators (process, output, outcome).

The framework will not be able to assess the collective impact of providers – a shared measurement system does that. Collective impact is a set of processes set around a backbone organisation. The framework will provide guidance around a set of outcome domains such as the following:

1. Improved patient access to evidence based care
2. Improved patient outcomes
3. Improved patient experience
4. Improved care quality and safety

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 guidance 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 that a first iteration of this work will be completed by the end of November 2016.

Approach taken to prioritising activities

In March 2016, Country WA PHN undertook a baseline needs assessment of its resident population in partnership with Curtin University. A broad range of health needs were identified within the community, and 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 .

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

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/low intensity stepped care approach**
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 (see, for example http://www.ncbi.nlm.nih.gov/books/NBK83456/). The result is a disjointed mental health service system, and by extension, a disconnect between Access to Allied Psychological Services (ATAPS) and a broader low intensity approach to mental health service delivery. **ATAPs Transition** During the 9 months of service continuity the PHN will work with ATAPS providers, other service providers, consumers, carers and other stakeholders to assess the needs, scope options and support the change management across the sector towards a more integrated primary mental health system. This will be guided by a ATAPS Transition project plan, and supported by a Project Officer position from November 2016. This work will disaggregate each stream within the ATAPS program, and ensure that the replacement activities are specifically designed for that population group's needs, within a stepped care approach. **New stepped care approach** The approach will target psychological interventions to people with, or at risk of, mild to moderate mental illness at the local level, through the development and/or commissioning of low intensity mental health services. Moving to this approach will be in alignment with the WAPHA Mental Health Primary Care model and integrated with the implementation of a number of other key projects and activities by the PHN - standardised care pathways, improved shared care processes and arrangements, and a broadened range of health professionals providing services. **Telephone and eHealth** A key focus for commissioning will be procurement of telephone and e-health services enabling equitable access, regardless of geographic location. This will involve joint commissioning by the three WA PHNs, resulting in the creation of a statewide, telephone based service (supplemented by other e-strategies where relevant) available as a GP/ primary health practitioner referral option. This service will be a Monday to Friday service which provides accessible brief intervention or structured

Proposed Activities	
	psychological therapies. It is intended that this service will have eligibility similar to ATAPS to provide equitable services to financially disadvantaged and vulnerable people and will provide structured, individually tailored, low intensity therapy options delivered remotely, with capacity to provide longer term therapy where indicated. It will incorporate clear referral structures to local face-to-face services, culturally accessible services for vulnerable populations to provide equitable access, specialists and drug and alcohol treatment options for people with problematic use. These services will include those funded under the other activities within this plan and the Drug and Alcohol Treatment plan. Depending on evaluation of the service over the first 12 months, it may expand beyond clinical referral in the second year. Contracted services will be required to use integrated and collaborative pathways for GP referred entry, assessment and progress reporting, as well as standardised outcome based measurement key performance indicators (KPIs). These activities are expanded upon under the relevant activities within this Activity Work Plan. **From April 2017, the following Activities will be combined to form Regional Integrated Stepped Mental Health Services: 1. Low Intensity 2. Psychological therapies 4. Integrated services and Care coordination for severe mental illness and complex needs 7. Stepped care.** It should be noted that during the transition period services for children and young people (excluding headspace and early psychosis programs) will continue to be offered by current service providers. **Shared Resources** In addition, the WAPHA mental health program team will be employed by WAPHA to provide expert advice and guidance to the PHNs on the development of different facets of the stepped care approach and to support the management of change.
Collaboration	Country WA PHN has undertaken significant regional planning to identify under-serviced and/or hard to reach groups within each Regional area and to understand barriers to receiving appropriate services. This has involved engaging with key stakeholders, and utilising the information from the Needs Assessment, evidence based interventions and the development of the Integrated Mental Health and Other Drugs Atlas of Western Australia (the Atlas) for a comprehensive picture of mental health services, needs, gaps and opportunities. Each Region within the PHN is developing a local Mental Health and Suicide Prevention Plan (the Plan) with key stakeholders including but not limited to: WA Health; the Mental Health Commission; General Practice; WA Country Health Service (WACHS); Rural Health West; WA Association for Mental Health (WAAMH); WA Mental Health Network;

Proposed Activities	
	WA Network of Alcohol and other Drug Agencies (WANADA); Aboriginal[2] Medical Services and Regional Aboriginal Health Planning Forums; Aboriginal Health Council of WA (AHCWA); Mental Health consumer and carer groups including Consumers of Mental Health WA (CoMHWA), Health Consumers Council WA, Helping Minds (Mental health carers organisation) and Carers WA. Each Regional Plan will be informed by the Needs Assessment and the Atlas and includes the following: • Identification by condition, need, and burden of disease target population groups; • Development of appropriate low intensity mental health service models; • Planning of a decision support framework to support GPs in their shared care lead; and • Education and orientation of consumers and providers on the availability of low intensity services, self-help and self-management initiatives and integrated referral pathways. In developing plans specifically relating to low intensity mental health services, the PHN will engage with GPs and other health professionals, recognising their lead role. **Governance Structures** Within each of the seven Regions a mental health working group advises the Regional Clinical Commissioning Committee (RCCC) about appropriate models, approaches and geographical coverage. All RCCC recommendations are submitted for endorsement to the Country WA PHN Council which reports to the WAPHA Board. The PHN is also informed by the Mental Health Expert Advisory Group (MHEAG) established by WAPHA to guide the development of needs-based models of care. Integral to this will be continued development of e-mental health initiatives including localised pathways in HealthPathways; and a point of entry, choice-based triage and referral for definitive care approach, which supports right care, in the right place and at the right time and use of digital self-management programmes.
Duration	ATAPS/MHSRRA transition 2 May 2016 - 31 March 2017. 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, Southwest and Great Southern.
Commissioning approach	**Existing providers** Contracts for ATAPS and MHSRRA are extended until 31 March 2017.

[2] Within Western Australia, in line with the WA Department of Health policy, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

Proposed Activities	
	Service providers funded to continue to deliver ATAPS/MHSRRA services during 2016/17 are Anglicare, Boab Health, Pilbara Health Network, 360 Health + Community, Wheatbelt GP Network and GP Down South. **New stepped care approach** Each region will have an integrated Regional Stepped Mental Health Care approach which is commissioned to the following principles: • Access to comprehensive PHN-wide structured brief intervention and psychological services delivered through telephone, video conferencing and e-mental health mechanisms to provide base line, equity of access to people in country WA; • Accessible low intensity services; • Links with GP will be integral to the model; • Care coordination for severe conditions; • Face to face and group sessions in accessible centres for more intensive work; and • A commissioning approach which aligns the WA Mental Health Commission and other bodies commissioning suicide prevention, mental health and AOD services and with WA Country Mental Health Service as the provider of acute and continuing care across all regions. Using a standardised decision tool it has been identified in most Country WA Regions that Expressions of interest from collaborations or consortia will be the most appropriate mechanisms for regional services. **Telephone and eHealth** The PHN in partnership with key stakeholders will identify and prioritise low intensity mental health service gaps within primary care and apply a stepped care approach as part of the development of the comprehensive regional mental health plan. The PHN has determined that the essential criteria for the commissioned services are the ability to: 1. Provide telephone based expert-led intake assessment (Monday-Friday, 8:30am-5pm AWST, Monday-Friday, excluding WA public holidays) and high volume low intensity evidence-based structured psychological therapy (SPT) courses for individuals 16 years and older with common mental disorders (mild to moderate anxiety and depression) across WA including rural and remote (high access). 2. Take intake referrals from General Practice and equivalent and provide regular structured feedback on clinical progress using standardised assessments including PROMs

Proposed Activities	
	3. Direct referrals to local face-to-face services as indicated 4. Provide therapeutic support for problematic alcohol and other drug use 5. Deliver components of care across a range of low-bandwidth e-health modalities (apps, e-mail, moderated internet groups etc.) with demonstrated effectiveness 6. Escalate cases to local and national urgent and emergency care services in response to rising risk and expert clinical judgement based on agreed protocols 7. Have an existing stable client interface that has the capability to incorporate new therapeutic courses/pathways as they are developed (for example, problematic eating, problematic sleep etc.) 8. A commitment to evidence based service development 9. Provide therapy that aligns with the WAPHA framework for Integrated Primary Mental Health Care 10. Commence service operations by March 2017, and be fully operational by July 2017 Whilst there are an increasing number of providers entering the Australasian e-health market, most provide single modality options with the majority being on-line, which is a significant limitation in terms of the integrated approach WAPHA wishes to commission. Moreover, whilst there are several telephone-based services, nearly are helplines, or crisis lines, offering counselling of various forms, support or advice, these do not provide access to a program of structured psychological therapy. In contrast, the WAPHA approach is predicated on GP referral to a single point-of entry, predominantly telephone-based, expert-led therapeutic intake assessment with allocation, as necessary, to well-specified and evidence-based courses of structured psychological therapy, supplemented were possible with a range of integrated on-line supports. Moreover, the commissioned services need to be able to provide progress reports back to general practice that support on-going clinical decision making. It is intended that WAPHA will co-design this service across the three WA PHN boundaries with key stakeholders. It has been determined that there is significant benefit to be had from this collaborative co-creation with a consortium who currently deliver services that align with the essential criteria of the service model outlined above therefore WAPHA will undertake a direct approach to procurement. A market analysis identified two providers with an established track record and peer reviewed evidence which supports the efficacy of the on-line interventions they offer. In addition they have the capacity and capability to offer the integration of the online/offline modalities which support equity of access for vulnerable populations across Western Australia. One organisation in particular has secured a position in the market which gives consumers confidence that their information is confidential and secure within a therapeutic environment and can be shared easily with their GP or other healthcare professionals. This type of on-line platform which utilises telephony provides the opportunity to integrate and provide accessibility to mental health services locally.

Proposed Activities		
	Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice and will form part of the evaluation plan within the service agreements. Refer also to Activity MH 3.1 **Psychological therapies for under-serviced and/or hard to reach groups**	
Performance Indicator **Local Performance Indicator target (where possible)**	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 WACHS *Public and Primary Health Directions Strategy 2015 – 2018.* 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)	$2,586,348	Commonwealth funding (40% ATAPS/MHSRRA for nine months' transition & three months low intensity component of stepped care) 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**
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 model 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 broader primary mental health care services; physical and sexual health services; drug and alcohol services; social and vocational support services. headspace is yet to integrate fully into a stepped care approach and the PHN will focus on working with them to further develop their model to support region-specific cross sectoral approaches to early intervention for children and young people. headspace centres will be included within WAPHA's development of child and family, and youth specific integrated care pathways and services and are in the project scope of the WA Mental Health Atlas currently under development. WAPHA is also invested in the development of children, adolescent, and youth specific integrated care pathways and services built upon a whole-of-system whole-of-State approach to coordinated planning and co-commissioning with the WA Mental Health Commission and WA Department of Health, working together with the sector, including FAMHSS funded providers. WAPHA has localised more than a dozen child mental health pathways for use by General Practitioners, with others, notably FASD, ASD, and ADHD, in development. In addition, two mental health program leads are employed utilising funds from the combined WA PHN operational budgets 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

Proposed Activities	
	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 CCCs and CECs; headspace national and WA headspace providers (including centre staff); WA Health, including WACHS, the MHC, Aboriginal Health organisations and Aboriginal Health Planning Forums, youth service providers, community based primary health care, peak organisations such as WAAMH and WANADA, mental health and social care organisations, consumer and carer 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. Advice will also be sought from Headspace centres, Youth Advisory Committees where appropriate.
Duration	2 May 2016 – 31 March 2018.
Coverage	The PHN will be commissioning headspace services in the Midwest (Geraldton); Goldfields (Kalgoorlie), Great Southern (Albany), Southwest (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.

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. 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 and mental health conditions; • Priority 3: Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage; and • 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**
Description of Activity(ies) and rationale (needs assessment)	Currently service availability for children and young people with, or at risk of, severe mental illness is very limited in most areas within the PHN and in some areas services for this group of young people are non-existent, as highlighted in the Needs Assessment and the Atlas of Mental Health and Alcohol and Drug Services. There is also a lack of mental health professionals offering services to vulnerable young people, especially those exhibiting self-harming behaviours or suicidality. Planned activities: • Regional planning will be a primary activity in the first six months of 2016 -17 with the PHN utilising the information from the Needs Assessment, evidence based interventions and the Integrated Mental Health and Other Drugs Atlas of Western Australia (the Atlas) to inform service development and promote evidence-based innovation. • In collaboration with the Mental Health Commission, WACHS, CAMHS and other key stakeholders, the PHN will liaise with relevant local stakeholders to commission an effective cross-sectoral approach including: general practice; early childhood services; schools and tertiary and vocational providers; drug and alcohol services; and social support services to develop early intervention for children and young people within primary care. This development will be informed by the body of evidence supporting the effectiveness of models of comprehensive care in facilitating early identification and intervention for the first-episode psychosis in improving both functional and clinical outcomes. • In line with the WAPHA Mental Health Framework[1] is proposed that this activity will be integrated with comprehensive primary care so that General Practice is supported in providing timely assessment, referral and liaison to facilitate early identification and intervention of psychosis in young people. The activity model will reflect elements of the Early Psychosis Prevention & Intervention Centre (EPICC) approach, providing 'whole of

Proposed Activities	
	person' support in a stepped care environment (noting lower volume, higher intensity interventions are indicated for this group). • In addition, the Country WA PHN will support GPs through the promotion of localised child mental HealthPathways for use by General Practitioners, with the addition of FASD, ASD, and ADHD when these are completed. • The PHN will be supported through the employment of mental health program leads to provide expert advice and guidance to the PHNs on the development of child and family, adolescent and youth early psychosis services. • The WA PHNs will promote the resources for clinical and non-clinical professionals available under the National Centre of Excellence for Youth Mental Health. The Needs Assessment highlighted the importance of timely intervention for young people with mental health problems and concerns, particularly if accompanied by the use of drugs and alcohol. Early intervention is particularly problematic in the PHN due to the disconnection between the identification of need and limited access to service across most of the PHN. In taking a place based approach, the PHN will work with local clinical services to commence the development of pathways which build on any existing services and infrastructure and explore the utilisation of e-mental health services to supplement face to face services where these are unavailable.
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 PHNs and their CCC and CEC's, headspace national and WA headspace Youth Early Psychosis Program (hYEPP) providers; WA Department of Health including WACHS, the MHC, Aboriginal Health organisations, youth service providers, community based primary health care, peaks such as WAAMH and WANADA, mental health and social care organisations, consumer and carer 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	1 July 2016 – 30 June 2018.

Proposed Activities		
	The PHN proposes to commission new models of care by 1 April 2017. These programmes will be contracted until 30 June 2018 with the option of extending these contracts for an additional 12 or 24 months.	
Coverage	The PHN will be commissioning services across Country WA with the regional areas still to be determined. The location of services will also be informed through the Atlas and discussions with existing providers, GPs and other stakeholders to identify service gaps and areas of significant need – focusing on under-serviced groups.	
Commissioning approach	It is intended that WAPHA will co-commission some services across the three PHN boundaries in partnership with 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; and • Co-design processes to ensure that commissioned models of care are place and consumer centric. Regional service provision will complement the combined service with regional approaches to commissioning being developed in collaboration with the Regional Clinical Commissioning Committees. Areas of significant need will be prioritised and the PHN will collaborate with partners to identify the most appropriate commissioning approach in each case. 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 Psychological therapies for under-serviced and/or hard to reach groups including ATAPS transition**
Description of Activity(ies) and rationale (needs assessment)	As noted in Activity 1, funding for this activity will be provided on a transitional basis to existing providers of ATAPS/MHSRRA services for a period of nine months. Country WA PHN covers over 2.5 million square kilometres. Most 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 highlighted the lack of primary care access and accessibility for some disadvantaged and hard to reach groups. The Needs Assessment brought to the forefront a lack of comprehensive planning and the absence of a stepped care approach to mental health which has led to a disjointed mental health service system, and by extension, a disconnect between ATAPS/MHSRRA and a wider approach to mental health service delivery. Country WA PHN has undertaken significant regional planning identify under-serviced and/or hard to reach groups within each Region and better understand barriers to them receiving appropriate services. This has involved engaging with key stakeholders, and utilising the information from the Needs Assessment, evidence based interventions and the Atlas for a comprehensive picture of mental health services, needs, gaps and opportunities. **Stream 1. Accessible e-Counselling/Therapy service** The Structured Psychological Therapies will be provided in the first instance through GP referral to access comprehensive structured psychological services delivered through telephone and video conferencing to provide base line, equity of access to people in country WA. This will be supplemented by face to face and group sessions in accessible centres for more intensive work.

Proposed Activities	
	Stream 2. Face to face clinical services/at risk groups While the telephone based structured psychological therapies service will provide remotely delivered individually tailored therapy options activity this stream will ensure locally based 'face to face' services will also be made available when required. This forms part of the Regional Integrated Mental Health service that will provide clinical services for people at risk of self-harm or suicide. 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. Service continuity for existing ATAPS users will be maintained by extending existing contracts for 9 months. **Demand Management** Demand management will be the responsibility of the Service Providers; however advice will be provided by the PHN regarding expectations and criteria for admission to the program. For structured psychological therapies delivered as either e-counselling or face to face, a deliberate GP information and decision making engagement strategy will be employed so that referrals are appropriate and very targeted to the people who will gain most from the service. Referrals from GPs are targeted to those who are least able to pay. Previous access criteria used for ATAPS will be employed. Sessions are not capped but are expected to be between 1 and 4 on previous ATAPS data. Co-payment strategies may be adopted by service providers within their proposed models. **Access to mainstream services** Streams 1 and 2 have capacity to refer clients who are using the service to appropriate mainstream services as an adjunct to or instead of the e-counselling or face to face counselling service. Service providers will have responsibility to design a model that links people back to the referring GP as standard procedure as well as the use of MyHR as a shared record of treatment. **Access and linkages to mainstream service for Indigenous clients and cultural competency training** All providers who respond to Regional calls for Expression of Interest for the new Mental Health Integrated Stepped care model will be required to articulate their demand management, mainstream access approaches and co-payment policies. There will be a requirement within the call for Expression of Interest to demonstrate and measure processes that link Aboriginal people to mainstream services that are cultural competent.

Proposed Activities	
	Stream 3. Workforce development to support shared care and patient transitions The need for workforce development for staff working with under-serviced/hard to reach groups has been identified to support the safe transition of patients with a range of mental health issues between primary care and hospital care. This is particularly problematic in regional areas where people are often dispersed across vast geographic areas. For example, when a patient is referred by a GP for admission to hospital this may mean the patient is required to be transferred to a regional or metropolitan hospital away from their local community. Upon discharge the patient is not necessarily transferred back to their local community and the patient can "fall through the gap". Shared care allows General Practitioners to retain responsibility for the day-to-day care of people with moderate to severe mental disorders living in the community whilst being supported by a specialist. It increases the availability of evidence based interventions, provides regular and timely access to specialist expertise through partnerships with other primary care programs as well as community mental health teams including real-time access to community psychiatrists and other mental health specialists. Critically, it treats GP-managed primary care as the norm, supports general practitioners to confidently manage levels of complexity and risk they could not otherwise, and provides a smooth "gateway" transition to secondary care should this be required. In this way, it is a key enabler of stepped care. In addition to clarifying and promoting standardised clinical pathways through HealthPathways, there is an opportunity to improve shared care and improve "gateway" transitions – when a patient's care is transferred between one level of clinical care and another and back again. The PHN will work with GPs, specialists, other health professionals, consumers and carers to identify these "gateways" in the patient's journey as they traverse the mental health sector and key factors to reducing the chances of a patient "falling through the gaps". Through that process, the PHN will explore the use of telehealth and other e-health options to support the development of the clinical workforce and leverage the capability of specialists to build capacity in the system. For example: • Dialectic behavioural therapy (DBT) has been demonstrated to be effective in treating patients with personality disorders. DBT can also be adapted for people with a range of therapy needs, as well as being able to be adapted for delivery by a range of health professionals. Increased access to DBT in the primary care setting could reduce the number of patients with personality disorders who are admitted to hospital; and • There is an opportunity to broaden the range of health professionals involved in the treatment of people with eating disorders which would help to alleviate the long waiting times for access to these services. The PHN will explore options to use specialists to build capacity amongst health professionals including GPs, psychologists and other allied health professionals, nurse practitioners in the country and pharmacists.

Proposed Activities	
	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 allocation of these funds will be informed by ongoing consultation, leading to the finalisation of the both the Atlas and the regional mental health plans. This stream also links with activity 4.1 – Severe and Complex Mental Illness A stepped care model with the following principles is in the pilot phase in the South West and is informing design. To date the indications are that: 1. Skilled triage and short term therapeutic interventions at the Regional level are providing a good quality service for most of the referred service recipients; 2. A small number of people are referred for more intensive work with an average of 3-4 sessions; 3. The addition of the state-wide service for structured psychological therapies will provide a demand management strategy for GP referrals and other referral sources; 4. Specialised suicide prevention and services for children will take a higher profile as short term interventions and access to telephone and digital therapies provide services to more people at a lower cost; and 5. GPs will use a service that is easy to refer to and is perceived to be tailored to their patients' needs These approaches will inform service development and promote evidence-based innovation to increase access to psychological therapies for underserviced and hard to reach groups. PHN staff will also work with existing providers and other related service providers on the change management activities required to transition from the existing arrangements to the new environment. Where appropriate, innovative approaches to reach these groups may be tested using the 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*.

Proposed Activities	
	These stakeholders include but are not limited to Perth South PHN and Perth North PHN, the PHN's Regional Clinical Commissioning Committees; WA Health including the OMH, WACHS; the MHC; General Practice; WAAMH; WA Mental Health Network; WANADA; Aboriginal Medical Services; AHCWA; Department of Corrective Services; WA Police; Department of Child Protection and Family Support; Local Government Authorities; Social and welfare agencies, homeless agencies and other groups dealing with hard to reach groups; and Mental Health consumer and carer groups including CoMHWA, Health Consumers Council WA, Aboriginal Health Action Groups, Helping Minds (Mental health carers organisation) and Carers WA.
Duration	1 July 2016 – 31 March 2017 – Contract continuation. (Service Continuity) 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, Southwest and Great Southern.
Commissioning approach	**Existing providers** Contracts for ATAPS will be extended until 31 March 2017. **Regional Integrated Mental Health Stepped Care** All Regions have developed Region Specific Integrated Stepped Care Frameworks for commissioning. Each Region will call for Expressions of Interest in the first 2 weeks of November. Approaches have been developed using established governance mechanisms. The PHN is working closely with the WA Mental Health to ensure that programs complement and enhance existing and planned services. This is in line with the *Better Choices Better Lives – Western Australian Mental Health, Alcohol and other Drug Services Plan 2015 – 2025 and with the Commonwealth Guidelines.* Regional models developed in each region through consultation and through expert working groups, are endorsed by the Country WA PHN Regional Clinical Commissioning Committees and recommended to the Country WA PHN Council for final approval and presentation to the WAPHA Board. **Telephone and eHealth** The PHN in partnership with key stakeholders will identify and prioritise low intensity and structured psychological services within primary care and apply a stepped care approach as part of the development of the comprehensive regional mental health plan. The PHN has determined that the essential criteria for the commissioned services are the ability to:

Proposed Activities	
	1. Provide telephone based expert-led intake assessment (Monday-Friday, 8:30am-5pm AWST, Monday-Friday, excluding WA public holidays) and high volume low intensity evidence-based structured psychological therapy (SPT) courses for individuals 16 years and older with common mental disorders (mild to moderate anxiety and depression) across WA including rural and remote (high access). 2. Take intake referrals from General Practice and equivalent and provide regular structured feedback on clinical progress using standardised assessments including PROMs 3. Direct referrals to local face-to-face services as indicated 4. Provide therapeutic support for problematic alcohol and other drug use 5. Deliver components of care across a range of low-bandwidth e-health modalities (apps, e-mail, moderated internet groups etc.) with demonstrated effectiveness 6. Escalate cases to local and national urgent and emergency care services in response to rising risk and expert clinical judgement based on agreed protocols 7. Have an existing stable client interface that has the capability to incorporate new therapeutic courses/pathways as they are developed (for example, problematic eating, problematic sleep etc.) 8. A commitment to evidence based service development 9. Provide therapy that aligns with the WAPHA framework for Integrated Primary Mental Health Care 10. Commence service operations by March 2017, and be fully operational by July 2017 It is intended that WAPHA will co-design this service across the three WA PHN boundaries with key stakeholders. Based on market research, it has been determined that there is significant benefit to be had from this collaborative co-creation including only consortium which currently delivers the service model that aligns with the essential criteria of the service model that WACHA wants to commission. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice and will form part of the evaluation plan within the service agreements. See Activity 1 **MH 1.1 ATAPS and MHSRRA transition/low intensity stepped care approach** for a full articulation of the commissioning approach for telephone and e-Health.
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

Proposed Activities		
	• 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)	$4,116,870	Commonwealth funding – 60% of current ATAPS/MHSRRA allocations ($3,087,653 for nine months ATAPS/MHSRRA transition activity; $1,029,217 for stepped care April – June 2017). Please refer to 7.1 Stepped Care for funding relevant to the new stepped care approach. **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 in the PHN Needs Assessment: • Priority 1: Keeping people well in the community • Priority 2: People with multiple morbidities especially chronic co-occurring physical and mental health conditions • 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**
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. The Needs Assessment highlighted the lack of system responsiveness to people with a severe and complex mental illness or disorder and the uncoordinated and inadequate coverage of services in and between regions. As with other areas within the mental health service continuum the lack of a stepped care approach to mental health has led to disjointed mental health service provision. 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 implement a number of activities: **Mental Health Nurse Incentive Program** • Re-contract the current service providers of the Mental Health Nurse Incentive Programme (MHNIP) for 12 months, ensuring continuity of care for MHNIP recipients. **Mental Health Care Managers**

Proposed Activities	
	• Develop and introduce an enhanced care coordination package to complement the MHNIP from 1 April 2017, utilising available funds. This program will be progressively scaled up from 1 July 2016, and targets service provision in areas of identified need, not covered by current programs. This model will expand the important role of mental health nurses as care coordinators through engagement of peer support workers, Aboriginal Health workers and others working under expert supervision. The model aims to provide a greater level and spread of support to GPs/ primary health practitioners in responding to patient mental health needs, to underline a mainstreame reform objective. It is expected commissioned activities will be aligned with the WAPHA Mental Health Primary Care model and the Comprehensive Primary Care program where appropriate. **Stepped Care Approach** • Work 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 work locally with general practice and other stakeholders to identify the most appropriate models of care for the region, considering both the needs of the community and the availability of workforce and infrastructure, including linkages with the public mental health services and between primary care and community based psychiatry services; and • Evaluate innovations to implement stepped care. This could include trialling co-locating general practice and community mental health providers, exploring models which incorporate peer-workers, investing in training of primary care practitioners regarding trauma informed care and practice and testing the concept of the Comprehensive Primary Care (as outlined in the PHN Core and Flexible Activity Plan – where wrap around GP-led care coordination is delivered to patients with severe and complex mental illness. **HealthPathways** The PHN will continue to develop localised pathways in HealthPathways, the provision of a clear point of entry, referral for a definitive care approach with the use of supported self-management programs. In line with the expectations of the *PHN Mental Health and Suicide Prevention Implementation Guidance – 2016* document the services to young people with severe mental illness are described in activity 2.2.
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 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 Health Care Home approach in a mental

Proposed Activities	
	health context. This will also require engagement with general practice at the local level and with GP representative bodies including the RACGP and ACCRM. 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 allocation of these funds will be informed by ongoing consultation, leading to the finalisation of the both the Atlas and the regional mental health plans. 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 (through the WA Association of Mental Health and others) to effect integration in team care arrangements. Linkages with Partners in Recovery, National Disability Insurance Scheme (NDIS) and My Way programme will also be facilitated where applicable.
Duration	**Mental Health Nurse Incentive Programme (MHNIP)** MHNIP transition – 1 July 2016 – 30 June 2017. **Mental Health Care Management** The PHN proposes to commission new models of care by 1 April 2017. These programmes will be contracted until 30 June 2018 with the option of extending these contracts for an additional 12 or 24 months. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice and will form part of the evaluation plan within the service agreements.
Coverage	The PHN will be commissioning MHNIP practices to receive continuation funding are in: • South West – Busselton • Great Southern – Denmark The planning and commissioning 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 care coordination management service located in each of the seven regions, being: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, South West and Great

Proposed Activities	
	Southern. Care management will also be available through a WA wide service which will provide accessible base line support where face to face services are not accessible.
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. In addition, the information from the Atlas and the Needs Assessment will be utilised by RCCCs to determine the: • Model of service delivery, including the opportunities for a co-design approach involving consumers and service providers. Local innovation hubs will play an integral part in the co-design. The innovation hub to inform service design has been utilised by the WA PHNs to develop the Health Care Home model; and • Commissioning approach, for example, the use of a 'competitive dialogue' approach, expression of interest, select tender, open tender or preferred service provider approach. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice alongside the commissioned service agreements. **Mental Health Care Management** The PHN intends to commission using the following procurement strategies as the preferred approach: • Market testing through expression of interests and/or requests for proposals; and • Co-design processes to ensure that commissioned models of care are place and consumer centric. Monitoring and evaluation methods will be developed in consultation with service providers, consumers and general practice and will form part of the evaluation plan within the 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. In addition to the mandatory performance indicators, the PHN will work with our stakeholders to identify local performance indicators, if relevant.

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	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)	$1,135,955	Commonwealth funding – this includes funds committed to MHNIP transition. A more detailed 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 (eg. 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 Community based suicide prevention - transition services – suicide prevention delivered under the continuation of ATAPS/MHSRRA.**
Description of Activity(ies) and rationale (needs assessment)	It is recognised that suicide prevention is a complex issue and causes of suicide and/or suicidal ideation can stem from a complex mix of factors such as adverse life events, social and geographical isolation, socio-economic disadvantage, mental and physical health, lack of support structures and individual levels of resilience. The Needs Assessment identified issues of workforce and community capacity when identifying and responding to suicide, non-suicidal self-harm and suicide ideation, particularly in rural and remote locations. Current suicide prevention services for people in Country WA are limited to the suicide prevention component of the former Allied Psychological Services (ATAPS) and the Mental Health Services for Rural and Remote Areas (MHSRRA) within their limitations as outlined above in Activity 1.1 and other funded community suicide prevention programmes as described in 5.1.2 below. Whilst some suicide prevention programs funded under the National Suicide Prevention Program and Community Suicide Prevention Program are available in Country WA their reach is limited. For example: • ARBOR – which aims for early engagement of those bereaved by suicide with support services, resources and assistance. The ARBOR programme accepts referrals from agencies in the Perth area and has an established referral relationship with the Coronial Counselling Service. The programme offers in-home visits in the metropolitan area and telephone counselling in regional and remote WA. The data from 2014 15 shows that only 4% of clients were from Country WA. During the transition period mainstream community based suicide prevention will continue to be commissioned through ATAPS/MHSRRA for nine (9) months 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.

Proposed Activities	
	Existing service providers will follow the original guideline: *the ATAPS Suicide Prevention Service is designed to provide support to people in the community who are at increased risk of suicide or self-harm. However, this Service is not designed to support people who are at acute and immediate risk of suicide or self-harm.*
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. During the ATAPS/MHSRRA continuation and transition period the PHN will work with Perth North and Perth South PHNs, funded providers, General Practice, the Mental Health Commission, WACHS, WAAMH, WANADA, Mental Health consumer and carer groups including Consumers of Mental Health WA (CoMHWA), Health Consumers Council WA, Helping Minds (Mental health carers organisation), and Carers WA. The PHN will work with stakeholders to assess the needs, scope options and support the change management across the sector towards 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.
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, Southwest and Great Southern. 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. 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 integrated mental

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	health stepped care approaches, as informed by the *Stepped Care* guidelines provided by the Commonwealth. 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.	
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)	$400,567	Commonwealth funding **– this funding is for 9 months to support the transition from ATAPS**
	$0	Funding from other sources (eg. 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 5.1.2 Community based suicide prevention - transition services – Aboriginal suicide prevention services transition of services**
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 • 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. The Yiriman project appears to be well connected with the local Aboriginal community and has the involvement of traditional Elders, seeking a whole of community response to issues associated with young people harming themselves and being involved in high risk alcohol and drug taking behaviours. The Banang project is more recently established and was not included in the Australian Healthcare Associates *Evaluation of Suicide Prevention Activities*. Less information is available on the Banang project and during the transition period the PHN will work with the provider to determine the objectives and linkages. 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. Note: This activity is linked with activity 6. Aboriginal Mental Health.
Collaboration	During the 12 month continuation, the PHN will be developing its longer term regional Mental Health and Suicide Prevention Plan (the Plan) with key stakeholders including but not limited to: funded providers: WA

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	Health; the Mental Health Commission; General Practice; WA Country Health Service (WACHS); Rural Health West; WA Association for Mental Health (WAAMH); WA Network of Alcohol and other Drug Agencies (WANADA); Aboriginal Medical Services and Regional Aboriginal Health Planning Forums; Aboriginal Health Council of WA (AHCWA); Mental Health consumer and carer groups including Consumers of Mental Health WA (CoMHWA), Health Consumers Council WA, Helping Minds (Mental health carers organisation), and Carers WA. 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. Engagement with Regional Aboriginal Health Planning Forums and Aboriginal people in communities is critical to ensure culturally appropriate suicide prevention services continue to be available for Aboriginal people in the areas currently served. This consultation and involvement will provide insight into future provision in remote communities where current access is problematic. Aboriginal Suicide Prevention services will be supported by Flexible mental health funding alongside the Aboriginal Mental Health funding allocation to develop culturally relevant services that reflect local identified needs and realistic objectives. The allocation of these funds will be informed by ongoing consultation, leading to the finalisation of the both the Atlas and the Regional mental health plans.
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. Future commissioning will be linked to Activity 6 Aboriginal Mental Health Services. During this review and planning period opportunities to commission additional Aboriginal suicide prevention programmes will be explored in consultation with the Regional Clinical Commissioning Committees, Aboriginal Medical Services and the Regional Aboriginal Health Planning Forums.

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	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 (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)	$300,000	Commonwealth (this includes $109,115 for Yiriman and $190,000,000 for Banang continuation)
	$0	

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 2: People with multiple morbidities especially chronic co-occurring physical and mental health conditions. • 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 Community based suicide prevention - integrated local suicide prevention approaches**
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 PHN acknowledges that all pieces of the puzzle leading to successful suicide prevention, follow-up and support, do not lie within the PHN's commissioning scope. Nonetheless leadership in developing a collaborative and joined up approach between services and service providers including the development of localised pathways, a point of entry, choice based triage and the building of a common agenda are well within the PHN's purview. The PHN will therefore take a lead role in the development of a whole of community focussed regional and local suicide prevention plan which will embed a consumer centred approach, be funded based on need, take an evidence based regional approach to service planning and integration and provide effective early intervention across the lifespan, built on the European Alliance Against Depression framework[3]. Building on the evidence and experience, activities throughout the region will utilise the European Alliance Against Depression (Nuremberg Approach) methodology which identifies a 'whole of community' response is essential. The model confirms that four key, evidence based components of response are essential. These include Primary and mental health care services; community awareness; engagement of community facilitators and stakeholders; and targeted activities working with high-risk individuals and their families.

[3] http://www.eaad.net/mainmenu/eaad-project/4-level-approach/

Proposed Activities	
	The Nuremberg research found that not only must all components be present in a community, but they must be delivered in a 'joined-up' manner. Accordingly, the PHN will look to conduct localised needs assessments and to commission a mix of services across the continuum, targeted to gaps. This process will consider existing the roles hospitals, particularly emergency departments, first responders, front line health workers, GPs and other community based health workers play in timely intervention with people at serious risk of suicide is well documented. This is essentially a whole of community-focussed approach to suicide prevention. 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. The PHN will collaborate and develop partnerships with key stakeholders to assess the needs, scope options and support the change management across the sector towards more community based integrated suicide prevention approaches and ensure the PHN's plans align with the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025. These stakeholders include but are not limited to other WA PHNs and their CCC and CECs, the WA MHC, WA Department of Health including WACHS, Aboriginal Health organisations, NDIS providers, community based primary health care, mental health, justice, social and welfare agencies, local government, peak bodies including WAAMH and WANADA, consumer and carer groups and other service providers dealing with people at risk of suicide and self-harm.
Duration	1 July 2016 – 30 June 2018.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, Southwest 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. Country WA PHN will utilise this information to plan and commission services which meet the needs of people with co-occurring mental health and alcohol and drug misuse and those at risk of suicide. The first draft of the Atlas is due for completion in October 2016. It is estimated a further three to six months will then be required to explore local options with communities to determine service models most suited to community needs. **New stepped care approach**

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	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. It is intended that co-commissioning the entry point to care will be in partnership with the other WA PHN's, 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. • Competitive dialogue with the mental health provider sector, to seek requests for proposals for consortia models. 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. Where appropriate the PHN may seek to directly negotiate 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, especially 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.

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	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)	$133,522	Commonwealth funds – the funding for these activities is for three months, April – June 2017 (Activity 5.1 refers to activities between July 16 – March 17. A Revised budget will be submitted following the completion of the Regional Mental Health and Suicide Prevention Plan.
	$0	

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 2: People with multiple morbidities especially chronic co-occurring physical and mental health conditions • 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 5.3 Community based suicide prevention - integrated place based suicide prevention approaches for Aboriginal and Torres Strait Islander Peoples** This activity links closely with **Activity 5.1.2 Community based suicide prevention – transition Aboriginal and Torres Strait Islander Peoples, Activity 5.2 Integrated Local Suicide Prevention;** and **Activity 6 Aboriginal and Torres Strait Islander mental health services.**
Description of Activity(ies) and rationale (needs assessment)	In the Australian Government 2015 response to the National Mental Health Commission Review of Mental Health Programs and Services, a renewed approach to suicide prevention was signalled, which included refocused effort to prevent suicide in Indigenous communities. And further, PHNs were given a key role in the planning and commissioning of community-based mental health and suicide prevention activity. PHNs have been tasked with identifying Indigenous communities within their region that may be at high risk of suicide, and to liaise with local Indigenous specific organisations, as well as mainstream service providers at a regional level, to help plan, integrate and target local mental health and suicide prevention activities. It is also expected that PHNs will support the implementation of culturally appropriate activity, guided by the goals and actions identified with the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.[4] 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. In addition, the PHN will look to the Aboriginal and Torres Strait

[4] Aboriginal and Torres Strait Islander Suicide Prevention (ATSIPEP) Evaluation Project Report, 2016

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	Islander Suicide Prevention Evaluation Project (ATSISPEP) – Final Report recommendations and tools to support Indigenous Suicide Prevention Activity to ensure reference to the evidence base of what works in Indigenous community led suicide prevention. Suicide is a complex behaviour with many causes. For Aboriginal and Torres Strait Islander peoples, there are specific cultural, historical and political considerations to contribute to the high prevalence, requiring the rethinking of conventional models and assumptions. The PHN will: • Commission trusted, safe and nuanced services, delivered through developed relationships with local service providers, hospitals and general practice after consultation with local Interagency Suicide Prevention Groups; Aboriginal planning and service delivery groups; and the carers and consumers of services; • Acknowledge and use any existing interagency and community suicide prevention groups within the PHN as a springboard for further planning and development work. The allocation of these funds will be informed by ongoing consultation, the finalisation of both the Atlas and the regional mental health plans; • Recognise the importance of providing on-country activities, mentoring and leadership; and • Undertake planning and commissioning of community-based suicide prevention activities with Aboriginal people, Elders and communities that recognise the impact of social determinants, 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). This is essentially a whole of community-focussed approach to suicide prevention. 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. Elements of the Integrated place-based approach for Aboriginal and Torres Strait Islander Suicide Prevention in Country WA will have particular areas of focus: **Integrated Place-based mental health, suicide prevention and alcohol and other drug services** Outlined in Activity 6 and include Meekatharra and Carnarvon. **Capacity Building in Remote Communities** The Country WA PHN is largely comprised of areas considered to be remote or very remote. The importance of building capacity within communities, agencies and individual providers to respond to local needs in an

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	integrated manner has been highlighted by recent national and international initiatives in these areas, especially within the area of suicide prevention and bereavement. The establishment of community responses, dedicated to delivering a comprehensive service for the local community, and building strong relationships with other service providers for referral services will contribute to improved system wide outcomes. 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 community self-responsibility. Building sustainable capacity with communities to respond to and support those affected by suicide is long-term work especially in remote communities with a disproportionate number of people variously and continuously affected. Multidimensional approaches are required to: • Provide immediate, comprehensive and sustained care and lessen the likelihood of longer term mental health impacts; • Lessen the reliance on unhealthy coping strategies such as excessive consumption of alcohol and other drugs; • Provide referral pathways to culturally appropriate treatment services for short-term support if required, this may include linkages with hospital services; and • Support the development of Aboriginal-led Community and family centred programs. An example of an existing program funded through MHSRRA is considered to have capacity building elements supporting remote communities on the Dampier Peninsula. Regionally based PHN staff and the WAPHA suicide prevention program lead will continue to identify and support local capacity building activities through a small grants program funded from the carry-forward of unexpended Flexible funding from 2015-16. **Community-based Suicide Prevention – demonstration projects in high risk areas** 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 include: • 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 community member's

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	journey through the service system and to promote a way of thinking about suicide that builds trust and makes people want to seek help; • 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 project will also support a "Grow Local" strategy which aims to assist local people to gain skills and qualifications in mental health and Aboriginal health. Further projects will be identified in other regions.
Collaboration	Each of the seven Regional Clinical Commissioning Committees has representation from the Aboriginal Health Sector and in most regions, significant engagement has been undertaken with Aboriginal service providers and the Aboriginal communities. For example, the development of the demonstration projects outlined above has been in direct collaboration with the relevant communities. In other regions the PHN has commissioned regional Aboriginal consultations to inform service development. The development of projects is also informed by the ATSISPEP with the PHN being represented on the ATSISPEP Critical Response Governance Committee. The PHN will collaborate and develop partnerships with key stakeholders including but not limited to: Perth North and Perth South PHNs, funded providers, General Practice, the Mental Health Commission, WACHS, WAAMH, WANADA, AHCWA and its member agencies, Regional Aboriginal Health Planning Forums and their subcommittees; Aboriginal cultural organisations; Mental Health consumer and carer groups including Consumers of Mental Health WA (CoMHWA), Health Consumers Council WA, Helping Minds (Mental health carers organisation), Aboriginal Mental Health Reference Group and Carers WA. 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).

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	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, Southwest 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 Atlas (draft) is due for completion in October 2016. It is estimated a further three to six months will then be required to explore local options with communities to determine service models most suited to community needs. The Commissioning approaches may vary as regions complete their own analyses and assess their service provider strength and capacities. Where appropriate the PHN may seek to directly negotiate 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, especially 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.*

Proposed Activities		
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)	$460,647	Commonwealth funds – includes commitment of $158,232 from MHSRRA. **A revised budget will be submitted once the mental health plan has been completed and the new models commissioned.**
	$0	

Proposed Activities	
Priority Area 6: Aboriginal and Torres Strait Islander mental health services	This activity aligns with the following priorities in the PHN Needs Assessment: • Priority 1: Keeping people well in the community. • Priority 2: People with multiple morbidities especially chronic co-occurring physical and mental health conditions. • 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**
Description of Activity(ies) and rationale (needs assessment)	The planning phase of this activity is an integral component of the commissioning cycle. Significant engagement with Aboriginal communities across Country WA is occurring prior to the establishment of services. Country WA PHN has undertaken this component in conjunction with key stakeholders to ensure maximum alignment with the services already available. An integrated model of service delivery is being developed in each region to ensure Aboriginal people have access to a suite of mental health, social and emotional wellbeing, suicide prevention and alcohol and other drug services where they are most needed. The developed services will link closely to the *WA Mental Health and Alcohol and Other Drug Services Plan 2015 – 2025 (the WA Plan*) and the *Mental Health and Alcohol and other Drugs Atlas (the Atlas);* will be tailored to specific mental health needs of local Aboriginal people; and will improve access to drug and alcohol services, social and emotional wellbeing services and mainstream services. In developing a comprehensive and integrated approach to Aboriginal mental health and wellbeing the PHN has undertaken a range of activities including: **Understanding community need** • Utilise the PHN needs assessment and other tools such as the ATSISPEP Report, to identify current geographical locations that require focus; • Engage with local Aboriginal communities, Aboriginal Controlled Community Health Services (ACCHOs), mainstream services and other stakeholders such as the MHC to inform the commissioning activity being undertaken by the PHN; and • Utilising the Atlas to provide a comprehensive picture of Mental Health services across the state to inform the PHN's commissioning activities in this area. **Understanding the system**

Proposed Activities	
	• 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 to meet the needs of Aboriginal people with co-occurring mental health and alcohol and drug misuse, and those at risk of suicide. A draft of the Atlas is due for completion in October 2016. It is estimated a further three to six months will then be required to explore local options with communities 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; • Engage with local Aboriginal communities and consult, in collaboration with the MHC, 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; • Country WA PHN will utilise the MHC Agency Plan and the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) Final Report to identify evidence-based preventions, interventions and activities. The PHN will take a place-based approach to identifying and addressing hotspots of mental health inequality[5] The PHN will continue to work with WAPHA's research partner Curtin University to conduct data analysis to build on the PHN's Needs Assessment, and utilise ATSIPEP tools demonstrating Indigenous suicides by postcodes to inform the location of commissioned Aboriginal mental health services; and • Build on existing HealthPathways to develop specific Aboriginal and Torres Strait Islander mental health pathways for health providers to better support Aboriginal people in accessing and utilising Aboriginal services that are culturally appropriate, safe and secure. **General Practice and Aboriginal Medical Services Clinicians** • PHN practice support activity will identify opportunities to improve linkages with GPs and Aboriginal Medical Services Clinicians and improve the uptake of appropriate MBS items including GP Mental Health Treatment Plans for Aboriginal people; • Utilise PHN existing communication tools (Primary Health Exchange, GP Connect and Practice Connect) as mechanisms to improve and strengthen practice knowledge of services, information and Aboriginal health issues including mental health; • Develop a community of practice of health providers with an interest in Aboriginal Health, to provide an opportunity for tailoring and improving responses and practice support in the area of Aboriginal physical and mental health; • The PHN will work collaboratively and meaningfully with consumers, carers, health care providers (primary, secondary and tertiary), social services and a range of civic stakeholders to understand complexities and gaps, and identify what is needed to develop seamless pathways. Key partnerships include the Mental Health Commission,

[5] Perils of Place, Identifying hotspots of health inequality, Stephen Duckett, Grattan Institute, July 2016

Proposed Activities	
	WA Association of Mental Health, WA Network of Alcohol and Drug Agencies, general practice and WA Area Health Services;[6] and • Support mental health education and training for GPs and other general practice staff as a part of the workforce capacity building activity being undertaken as a part of the ITC and Comprehensive Primary Care programs across the in conjunction with Perth metro PHNs. **Integrated Team Care (ITC)** • Promote mental health in general practice as an eligible chronic condition for those registered with the ITC program; • Support the provision of general practice to deliver culturally competent and safe mental health services as a part of increasing the cultural safety of general practice and primary care activity being undertaken as a part of the ITC program across the Country WA PHN; • Support the ITC workforce which includes Indigenous Health Project Officers, Care Coordinators and Indigenous Outreach Workers with appropriate training to advocate and act as a conduit to other supports for those ITC patients with mental health conditions; and • Provide guidance to ITC commissioned services on provision of both culturally and mentally safe workplace for their ITC workforce including opportunities to promote mental health and wellbeing of the ITC workforce through a variety of activity e.g. peer networking; NAIDOC Week and other days of significance to the Aboriginal community activity across agencies; staff cultural mentoring activity, etc. **Social and Emotional Wellbeing Teams Care Model** Using the allocated commissioning funds, release an Expression of Interest (EOI) to commission a trial of the Social and Emotional Wellbeing Teams[7] care model and an evaluation of the trial. Potential services for consideration in the EOI scope include: ○ place based targeted low intensity mental health Aboriginal services; ○ targeted suicide prevention programs and services for Aboriginal people; ○ culturally appropriate mental health first aid training options; ○ traditional Aboriginal healing activity; and ○ targeted approach in the delivery of mental health services to young Aboriginal people.

[6] Mental Health Primary Care: The WAPHA Framework for Integrated Primary Mental Health Care, WA Primary Health Alliance (Oct 2016)

[7] Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services, Commonwealth of Australia (2015)

Proposed Activities	
	Workforce • Review health workforce capacity across the PHN regions including training requirements to ensure culturally appropriate service delivery for Aboriginal people with mild to moderate problematic mental health; and • Finalise development of local HealthPathways that support general practice and other clinician knowledge and access to culturally secure mental health care referral pathways for Aboriginal people. **Regional Aboriginal Mental Health Plans** The overall Country WA PHN Aboriginal Mental Health budget is $2.145 million. A further $602,000 is allocated to specific Aboriginal Suicide Prevention activities and mainstream service provision must also be culturally appropriate for Aboriginal people. Within the Aboriginal Mental Health budget notional regional allocations have been made based on the number of Aboriginal people in the Region; the remoteness of communities within the Region; health status as reported through usage and demand data. Services are being developed using with Aboriginal Community Controlled Health Services working with mainstream public mental health services and non-government service providers. Services will operate in accordance with the Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan* and the *WA Department of Health Aboriginal Health and Wellbeing Framework*. Through the co-design process services are being developed to ensure increased community ownership and awareness of factors that contribute to mental illness, drug/alcohol use and suicidal behaviours. **Goldfields** The Goldfields Aboriginal Mental Health budget is $325,000. The Goldfields Regional Aboriginal Health Planning Forum, the Regional Clinical Commissioning Committee and consultation with local Aboriginal leaders have identified Leonora and surrounding communities within the Goldfields Region as an area of significant need for an integrated mental health, suicide prevention and alcohol and drug response. The Ngaanyatjarra Lands in central Australia is also considered an area of significant need with the PHN taking a joint approach, with the WA Mental Health Commission and the Department of Prime Minister and Cabinet, to commissioning of integrated mental health, suicide prevention and alcohol and drug treatment services. **Great Southern** The Great Southern Aboriginal Mental Health budget is $215,000. The main area of focus of services in this region will be Katanning and surrounding communities where co-morbid mental health and alcohol and drug use has been identified as a priority.

Proposed Activities	
	There is no Aboriginal Community Controlled Health Organisation in the Wheatbelt, with WACHS providing the Aboriginal Health Services in this region. **Kimberley** The Kimberley Aboriginal Mental Health budget is $450,000. In addition to this funds have also been allocated to Suicide Prevention activities (see Activity 5.1.2 & 5.3) in Fitzroy Crossing, Halls Creek and the Dampier Peninsular. It should also be noted that the Kimberley has been identified as a Trial Site for an Aboriginal Suicide Prevention Project however details of this project are unknown at this time. The current Sexual Assault/Trauma Counselling and Support service provided by Anglicare (through flexible funding) is likely to be transitioned to the Mental Health funding stream from July 2017. Further engagement with Anglicare and the Aboriginal communities will be required to determine the future provision of this service. A key focus in this region will be ensuring Aboriginal people are engaged to work alongside any mainstream providers and have the opportunity to develop skills and gain employment in the mental health sector. The design principles agreed by the Kimberley RCCC to support the development of Aboriginal mental health and social and emotional wellbeing services include: • New services models will take family and community focused approach; • Early intervention; • Services need to be considered culturally appropriate and of value to the local community with an emphasis on community healing; • Support for models based on community development principles; • Build community capacity with cultural carers and health care navigators; • Wrap around models of social and health care; and • Strong care coordination/management. Input will be sought from the Kimberley Aboriginal Health Planning Forum, Mental Health Subcommittee in the development of these initiatives. **Midwest** The Midwest Aboriginal Mental Health budget is $325,000. In response to areas of need identified in the Needs Assessment and following community and service provider consultation in Meekatharra and Carnarvon the Midwest RCCC recommended:

Proposed Activities	
	• Meekatharra – to work collaboratively with the Mental Health Commission and WACHS to support commissioning of services for an integrated mental health and alcohol and drug counselling/capacity building service. • Carnarvon – a consortium approach between Carnarvon Aboriginal Medical Service, WACHS and the Carnarvon Medical Service to facilitate the employment of a mental health social worker to support Aboriginal people with mild to moderate mental health problems. **These services will be commissioned to commence 1 January 2017.** **Pilbara** The Pilbara Aboriginal Mental Health budget is $355,000. Community consultation undertaken by a local Aboriginal consultant has guided the Pilbara mental health working group and the RCCC in determining the service development and commissioning approach. Changes to the delivery of the ITC program in the Pilbara, with the development of a collaborative approach between the three AMSs and the Pilbara Health Network has provided an opportunity for a collaborative approach to the provision of Integrated Aboriginal Mental Health Services across the region. Some work is still required to develop the model but it is anticipated it will build on the ITC program and provide significant benefits to Aboriginal people with co-occuring mental and physical health problems. It is anticipated these services will be commissioned to commence 1 January 2016 in conjunction with the changes to the ITC contract. **South West** The South West Aboriginal Mental Health budget is $235,000. Following extensive consultation with the local communities and service providers the South West RCCC endorsed the direct commissioning of the South West Aboriginal Medical Service to provide the Social and Emotional Wellbeing care in collaboration with a contracted NGO with experience in the provision of mental health services. This service will provide • Culturally appropriate place based targeted low intensity Aboriginal mental health services; • targeted suicide prevention and support; • linkages for people with co-occuring mental health and drug and alcohol use; • linkages with other mental health services as part of the stepped care approach; and • opportunities for shared care where appropriate. **This service commenced operation in September 2016.** **Wheatbelt** The Wheatbelt Aboriginal Mental Health budget is $240,000. Opportunities have been identified to link with KAATA a local Aboriginal health and wellbeing organisation who will be collaborating with ITC service providers in the Wheatbelt (Wheatbelt General Practice Network) and the Southern Wheatbelt (Amity Health) to provide additional support to Aboriginal people with co-occurring mental health and physical health problems.

Proposed Activities	
	There is no Aboriginal Community Controlled Health Organisation in the Wheatbelt, with WACHS providing the Aboriginal Health Services in this region. The PHNs Aboriginal mental health services will be commissioned to enhance access to integrated Aboriginal 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. It will be important to work with other funding providers and commissioners of services to avoid duplication.
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 explore the establishment of Aboriginal mental health and AOD advisory groups, as outlined in activity MH 8.1, although the major advisory mechanisms will be regionally based and will include Regional Aboriginal Health Planning Forums and their mental health sub-committees. Where necessary, PHN will seek to bring together experts with clinical and community perspectives to advise on priorities and plans for Aboriginal mental health and suicide prevention services. The Country WA PHN have an in principal agreement with WA based ATSIPEP membership to represent and inform the PHN mental health commissioning and the PHN is a member of the ATSISPEP Critical Response Governance Committee. The PHN will collaborate and develop partnerships with key stakeholders to assess the needs, scope options and support the change management for the development of tailored place-based Aboriginal mental health and suicide prevention strategies and ensure the PHN's plans align with the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025. These stakeholders include but are not limited to other WA and bordering PHNs and their CCCs and CECs, the WA MHC, WA Health including WACHS, Aboriginal Health, Medical & Policy organisations, community based primary health care and Aboriginal Community Controlled Health Organisations, mental health, justice, social and welfare agencies, local government, WAAMH, WANADA, consumer and carer groups, headspace and other service providers dealing with Aboriginal people at risk of suicide and self-harm.

Proposed Activities	
	An important feature of Aboriginal mental health services will be the integration with suicide prevention/post-vention services and alcohol and other drug treatment services and emphasis on building the capacity of local people to lead the development and delivery of services within their communities.
Duration	Planning and Procurement Phase – 1 July 2016 – 31 March 2017, this will include: • Regional consultations with Aboriginal medical services and other relevant organisations to inform the Atlas – ongoing from 2015–16 to September 2016 • Delivery of the Atlas – draft October 2016 • Working with Aboriginal Health Planning Forums and other relevant stakeholders to inform models of service delivery – July 2016 – March 2017 • Regional Clinical Commissioning Committees work on finalising service models for each region and determining commissioning/procurement approach – August 2016 – January 2017 • Approach to market, staged approach based on readiness in each region – August 2016 – March 2017 Service delivery – phased commencement from September 2016 – April 2017 as regions complete planning. The PHN proposes to commission new models of care in the PHN by 1 April 2017. The programs will be contracted until 30 June 2018 with the option of extending the contracts. This approach will include a mix of Primary Health Care Practitioner care coordination support; new phone based counselling services of particular benefit to regional and remote communities; face to face provision of place-based services and direct community service procurement at the local level, targeted to need. The Aboriginal Mental Health Services program stream will be commissioned alongside the new model of care, with contractual reporting requirements in all components reflecting proportionate services to Aboriginal people. In addition to this general stepped care approach, regionally focused Aboriginal mental health services will be commissioned using a staged approach across all regions with the first services commencing September 2016 and all regions being covered by 1 April 2017. All programs will be contracted until 30 June 2018 with the option of contract extensions for either 12 or 24 months.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, Southwest and Great Southern. Areas of particular focus have been identified in each region. The most appropriate locations have been determined based on the Atlas and consultations with Aboriginal people, existing providers and key stakeholders to highlight areas of significant unmet need.

Proposed Activities	
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. Given the diversity of regions with Country WA, commissioning approaches will vary across the PHN. Commissioning will be informed by the ATSISPEP recommendations for suicide prevention services and programs for integrated solutions regarding contemporary challenges experienced by regional and remote Aboriginal communities.[8] A co-design process using information from the PHN Needs Assessment, the Atlas, ATSIPEP Indigenous Suicide postal code interactive map, and community and service provider consultation in collaboration with the MHC will determine the location of new services, model of service delivery and commissioning approach. Considerable work has been undertaken in regions to identify the preferred commissioning approach and in most instances, it is anticipated services will be developed using a consortia approach which will aim to support Aboriginal Community Controlled Health Services working with mainstream public mental health services and non-government service providers for better outcomes for Aboriginal people with mental health problems. Services will take into consideration the social determinants of health and will operate in accordance with the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan[9] and the WA Department of Health Aboriginal Health and Wellbeing Framework[10]. As outlined the RCCCs have made (or will make) recommendations based on local input 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 direct negotiation approach. 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.

[8] Final Report, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project, Part Two A: Tools to Support Indigenous Suicide Prevention Activity (June 2016)
[9] Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023, Commonwealth of Australia (2015)
[10] WA Aboriginal Health and Wellbeing Framework 2015 – 2030, Government of Western Australia, Department of Health (2015)

Proposed Activities		
	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, which will be funded through the operational funds. Commissioning of services will be staged as regional planning is complete and Services will commence at various times across the 2016-17 year.
	$0	Funding from other sources (eg. private organisations, state and territory governments)

Proposed Activities	
Priority Area 7: Stepped care approach	This activity aligns with the following priorities in the PHN Needs Assessment: Priority 1: Keeping people well in the community Priority 2: People with multiple morbidities especially chronic co-occurring physical and mental health conditions 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**
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 as part of the WAPHA Comprehensive Primary Care Approach and the Mental Health Primary Care Model. This activity underpins all 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 as identified in the PHN's Needs Assessment; • 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 the national digital mental health gateway as a core element of the stepped care approach; and • Build general practice capacity to screen, treat and monitor at risk and co-morbid individuals and population groups. The Stepped Care commissioning activity will be undertaken using a placed based approach, integrated with Comprehensive Primary Care and focused on targeting of areas of particular need with the aim of addressing health inequalities in a systemic way within defined areas identified as having persistent but reducible health inequalities.

Proposed Activities	
	Place based interventions will be developed with local communities to leverage the existing resources and assets to better support the wider determinants of health and wellbeing, realise more equitable health outcomes and provide better services at better value for the community. Commissioned activities could include community support services such as local specialist counselling, peer workers, service navigation and coordination. 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; and • Designed with continuity of care in mind, ensuring appropriate care is available across 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 definitive care approach which supports right care, in the right place and at the right time and use of digital, e-health and self-management programmes. In establishing a continuum of primary mental health services and ensuring the PHN's plan aligns with the WA Mental Health Plan, the PHN will work collaboratively with key stakeholders including but not limited to other WA PHNs and their CCC and CECs, the WA MHC, WA Department of Health including WACHS, Aboriginal Health organisations, Health Professionals' Colleges and Associations, community based primary health care, mental health, justice, social and welfare agencies, local government, WAAMH, WANADA, consumer and carer groups, headspace and other service providers dealing with people with mental health issues The PHN will also seek to collaborate with existing services and facilitate the linkage of mental health, suicide prevention and alcohol and other drug services to minimise duplication and maximise resources.
Duration	1 July 2016 to 30 June 2018.

Proposed Activities	
	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 these contracts for additional 12 or 24 months.
Coverage	Country WA PHN region covering the following geographical regions: Kimberley, Pilbara, Midwest, Goldfields, Wheatbelt, Southwest and Great Southern.
Commissioning approach (If applicable)	**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. 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 commissioning 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 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.

Proposed Activities		
Planned Expenditure 2016-2017 (GST exc)	$0	Commonwealth funding – the budget for the stepped care approach is referenced at 1.1,3.1 & 4.1 as per the mandatory performance indictor which requires low intensity, psychological therapies and clinical care coordinator for severe and complex mental illness. A revised budget will be submitted for 2017-18 which will show expenditure for stepped care.
	$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 in the PHN Needs Assessment: Priority 1: Keeping people well in the community. Priority 2: People with multiple morbidities especially chronic co-occurring physical and mental health conditions. 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 Integrated mental health and suicide prevention plan**
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 needs which have been identified through the initial Needs Assessment and the WA Mental Health Commission Mental Health Plan 2015-2025. The Needs Assessment brought to the forefront a lack of comprehensive mental health planning for targeted interventions tailored specifically for the needs of different groups. The lack of a stepped care approach to mental health has resulted in a disjointed mental health service system that is unable to respond to local needs and local priorities. The first step in the development of the regional mental health and suicide prevention plan is the WA Mental Health and Drug and Alcohol Atlas. This Atlas, jointly commissioned by the WA PHNs, WA Mental Health Commission and area health services will provide the foundation for effective planning across the state. The PHN contribution to the Atlas funding has been through operational and MH establishment funding rather than through the 2016-17 mental health flexible funding. During 2015-2016 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. **2015-2016 activity** • Working with other WA PHNs to establish of a small team of mental health specialists with a focus on child and adolescent; severe and persistent; AOD; Aboriginal Mental Health and suicide prevention and primary mental health care to work across all 3 WA PHNs; • Development of a comprehensive mental health and drug and alcohol Atlas, as a planning tool to inform commissioning of stepped care models of service in 2017/18. The Atlas will map all the services currently available to people experiencing mental health problems and disorders and compare this to the needs and

Proposed Activities	
	demographics of each Region. It will be used to identify gaps in services and commission/co-commission a more collaborative, coordinated and integrated mental health service system; • Development of several locally tailored clinical pathways for mental health; • Confirmation of PHN priorities against new funding streams; • Engagement of PHN stakeholders through existing governance and committee structures including the WAPHA Mental Health Expert Advisory Group and Regional Clinical Commissioning Committees and Mental Health working groups; • Development of a comprehensive State-wide primary care outcomes framework (as referred to in the broader PHN Activity Work Plan) to support the planning, procurement and monitoring/evaluation of primary care mental health services; • Identification of specific mental health issues in the CPC activity; and • Alignment of the mental health nurse program with the integrated team care approach associated with the CPC to provide wrap around care for people with complex chronic conditions, with a focus on improved care coordination; **2016-2017 activity** • 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;* • Identifying 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; and • Working with Regional Clinical Commissioning Committees, mental health working groups and other relevant stakeholders to identify and priorities areas within Regions. The PHN is aware the DoH mental health branch are commissioning a PHN specific National Mental Health Services Planning Framework (NMHSPF)-based decision support tool (DST) to assist with planning. This PHN tool will include the

Proposed Activities	
	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.
Collaboration	The PHN will work collaboratively with key stakeholders whose roles will be based on the IAP2 participation spectrum[11] and the RACI (responsible, accountable, consulted, informed) matrix. Stakeholders include but are not limited to WAPHA Board, PHN Council and RCCCs, WAPHA Mental Health Advisory Group, WA MHC, WA Health, Aboriginal Health organisations and councils, 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 Workplan* 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, Southwest and Great Southern.
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

[11] International Association for Public Participation Spectrum (inform, consult, involve, collaborate, empower), http://www.iap2.org.au/documents/item/84.

Proposed Activities		
	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)

2. Indicative funding budget for 2016-17:

Part A: Primary mental health care

(PHN: Mental Health and Suicide Prevention Operational and Flexible Activity); and

Part B: Indigenous Australians' Health Programme funding (quarantined funds)

(PHN: Indigenous Mental Health Flexible Activity).

Indicative Funding Budget for 2016-17 - Part A

Please see attached the PHN's indicative 2016-17 fund budget in an excel file.

Indicative Funding Budget for 2016-17 - Part B

Please see attached the PHN's indicative 2016-17 fund budget in an excel file.