

Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services

A Guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs)



Integrated Regional Planning Working Group

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GLOSSARY 55

About this guide

This document provides guidance to both Local Health Networks (LHNs) and Primary Health Networks (PHNs) on the expectations of Commonwealth, state and territory governments and the opportunities associated with the joint development of Integrated Regional Mental Health and Suicide Prevention Plans. The guide explains the intent and role of joint regional planning as a key priority in the Fifth National Mental Health and Suicide Prevention Plan¹ (the Fifth Plan). It also provides advice on best practice in regional mental health and suicide prevention planning and the tools and resources which are available to support this.

The guide has been prepared by the Integrated Regional Planning Working Group which was established by the Mental Health Principal Committee. The Guide should be read in conjunction with existing service agreements, funding agreements or protocols which may operate in individual jurisdictions. It is intended to provide advice to PHNs and LHNs for development of joint regional plans over the period from 2018 – 2020.

The guide is an updated version of *Regional Planning for Mental Health and Suicide Prevention – a Guide for Primary Health Networks (PHNs)*, provided by the Commonwealth Government to PHNs in August 2017)². It differs from the original guide in that it supports a **joint** role between LHNs and PHNs in regional planning, and incorporates other agreed priorities for mental health and suicide prevention emerging from the Fifth Plan.

This guide is broken into four sections.

- **Section 1** - Government requirements and expectations arising from the Fifth National Mental Health and Suicide Prevention Plan, and the parameters within which PHNs and LHNs should develop joint regional plans;
- **Section 2** - The process of developing a joint regional plan and the considerations and steps which may be taken into account;
- **Section 3** - Focus areas which could be expected to form part of the content of joint regional plans, and
- **Section 4** - Planning for integration.

It is supported by a compendium which details resources, data and tools currently available to support regional planning, and provides jurisdiction specific information in relation to regional mental health and suicide prevention policy and planning issues.

The Guide uses the term Local Hospital Networks (LHNs) to refer to local entities funded by State Governments to manage hospital and other community health services, although these entities maybe known under different names such as Hospital and Health Services or Local Hospital Districts.

It uses the term ‘people with lived experience’ in some parts of the Guide to encompass consumers of mental health services, their family and carers, and people with lived

¹ The Fifth National Mental Health and Suicide Prevention Plan, National Mental Health Strategy, 2017

² Regional Planning for Mental Health and Suicide Prevention – a Guide for Primary Health Networks, Department of Health, 2017

experience of suicidal thoughts or behaviour. More information on terms is available in the glossary included in the compendium to the Guide.

Executive Summary

Commonwealth, State and Territory Governments are committed to supporting joint regional planning for integrated mental health and suicide prevention services as the first action from the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan). Governments require Local Hospital Networks (LHNs) and Primary Health Networks (PHNs) to jointly develop and publicly release joint regional mental health and suicide prevention plans by mid-2020.

These joint plans will provide a regional platform for addressing many problems which people with lived experience of mental illness or suicide and their carers and families currently face. This includes fragmentation of services and pathways, gaps, duplication and inefficiencies in service provision, and a lack of person-centred care. The key objectives of joint regional mental health and suicide prevention planning are as follows:

- **Objective 1:** Joint regional plans should embed **integration** of mental health and suicide prevention services and pathways for people with or at risk of mental illness or suicide through a whole of system approach.
- **Objective 2:** Joint regional plans should drive and inform **evidence-based service development** to address identified gaps and deliver on regional priorities.

Joint regional mental health and suicide prevention plans will inform the coordinated commissioning of services across the stepped care spectrum of need for services and across the lifespan. They will also support opportunity for coordinated regional implementation of national priority areas which were agreed through the Fifth Plan. These areas include better coordination of services for people with severe and complex mental illness, a systems-based approach to suicide prevention, improving Aboriginal and Torres Strait Islander mental health and suicide prevention and improving the physical health of people living with mental illness.

Joint regional planning is challenging new territory for LHNs and PHNs, which will require collaboration, resources, evidence, and a whole of system approach. A region for the purpose of planning will usually be defined at the PHN level. In some cases there may be multiple LHNs aligning with a single PHN.

This guide recommends that some regions may choose to commence their joint regional planning with a **foundation plan** which focuses on working together to identify service gaps, shared priorities and make better use available resources to meet regional needs in the short term. Foundation plans will be expected to be publicly released by mid-2020 and commit to completing more comprehensive service development and detailed planning by mid-2022. Other LHNs and PHNs may already have the capacity and partnerships in place to commit at the outset to developing a **comprehensive service development plan** by mid-2020, informed by evidence based service planning tools and detailed service and workforce mapping. Governments will support the further development and promotion of the National Mental Health Service Planning Framework to inform regional planning and to address challenges of planning in geographically diverse areas.

The process of joint regional planning will need to be supported by strong governance arrangements, clear parameters and the allocation of appropriate resources for coordination, technical support, plan preparation, consultation and evaluation. Genuine inclusion of consumers, carers and people with lived experience of suicide, at all stages of planning is essential to deliver patient-centred care that is needed. Other stakeholders who need to be consulted include, but are not limited to, Aboriginal and Torres Strait Islander people, National Disability Insurance Scheme (NDIS) service providers and local area coordinators, private providers and social service agencies.

LHNs and PHNs are expected to work towards data sharing and joint needs analyses to map available regional services and identify duplication, inefficiency and gaps. The guide provides advice on tools and approaches for identifying optimal service delivery and workforce requirements to meet the needs of the regional population.

Joint regional mental health and suicide prevention plans will be endorsed at a local level by PHNs and LHNs, as they require local ownership and support. They are expected to be publicly available. Commonwealth or State/Territory Government approval will not normally be sought to regional plans. However joint regional plans will not over-ride existing service agreements or broader jurisdictional planning. A clear implementation strategy should be developed which supports ongoing governance arrangements, a phased approach to change, identifies key milestones and provides opportunity for measurement and review of progress and planning priorities.

There are significant opportunities through regional planning to enhance integration of pathways and service delivery and reduce fragmentation in the system. Innovative funding and joint commissioning models which promote better outcomes and provide incentives for recovery focused models of care can be developed through regional planning. These should target needs which can't easily be met through traditional approaches. However clear roles and responsibilities, continuing consumer and carer feedback and input, and appropriate clinical governance arrangements will be vital to ensure the safety and quality of new service models. Monitoring and evaluation of these efforts will also be important.

Cross sectoral integration opportunities should be explored through regional planning to promote better outcomes for consumers, particularly those with severe mental illness. This is particularly important in relation to achieving commitment and partnerships to reducing the risk of suicide and implementing a systems-based approach to suicide prevention. Engagement of NDIS providers and local area coordinators in planning efforts will also help to ensure clear pathways to services for people with severe and persistent mental illness.

A compendium of resources and data sources is provided to complement the guide and assist LHNs and PHNs with advice on where to turn for further information.

Section 1 Highlights – Government expectations of joint planning

The process of developing a plan

- Regional plans must be jointly developed, approved and implemented by LHNs and PHNs. They are to be publicly available.
- A region will generally be defined as the area covered by a PHN
- Inclusion of consumers, carers, Aboriginal community controlled health services, community managed organisations, NDIS providers, private providers and social service agencies is essential in the process of developing plans.
- Joint regional plans are to be in place by mid-2020 and should cover a period of five years or more.
- LHNs and PHNs will endorse plans at a regional level – government approval will not normally be sought.
- Joint regional plans will not over-ride existing funding agreements, service agreements or broader jurisdictional planning or business protocols.
- LHNs and PHNs will work towards data sharing and joint needs analyses to map services and identify duplication, inefficiency and gaps.
- Evidence based planning tools such as the NMHSPF will be used.
- Regional plans should promote evidence based service delivery.
- Planning should take place within a stepped care approach to ensure a broad range and intensity of services are available to match the spectrum of needs.
- Regional plans will guide commissioning and delivery of mental health and suicide prevention services.
- Digital mental health services and emerging technology should be harnessed.
- Clear roles and responsibilities in implementing the plan should be delineated at a local level.
- Planning for measurement and review of progress against the plan is expected.

Key content and focus areas

- Planning for commissioning services across the stepped care spectrum and across the lifespan - from infants and children through young adults to older people.
- Actions to promote suicide prevention in line with the WHO Suicide Prevention: Global Imperative.
- Coordinated treatment and supports for people with severe and complex mental illness - including requirements of children and adolescents.
- Integrated service delivery services for Aboriginal and Torres Strait Islander peoples.
- Considering the needs of rural and remote populations or other groups with special needs within the region.
- Improving the physical health of people with mental illness.
- A focus on integration – through multiagency care planning, joined up services and pathways to care and information sharing.
- Planning for future workforce needs.

1. Government expectations in relation to joint regional planning

1.1 Overview

There is a strong commitment by governments to regional planning for mental health and suicide prevention through the Fifth Plan. As the first Action of the Fifth Plan, Commonwealth and state and territory governments are directing LHNs and PHNs to jointly develop and publicly release regional mental health and suicide prevention plans. There is also a strong expectation of implementation of key mental health reform actions from the Fifth Plan at a regional level.

Joint regional planning will improve outcomes for consumers and carers by:

- Addressing fragmentation of mental health services and pathways for consumers;
- Preventing parts of the service system operating in isolation from each other;
- Identifying gaps, duplication in roles and system failure in local service pathways;
- Supporting mental health and suicide prevention reform priorities at a regional level aimed at achieving more effective, patient-centred care.

1.2 The national context for joint regional planning

1.2.1 Fifth Plan expectations of joint regional planning by LHNs and PHNs

The Fifth Plan recognises that PHNs and LHNs provide the core architecture to support integration at the regional level and that they are positioned to work with stakeholders to identify what needs to change and when. It explains that *“this approach represents a fundamental reconceptualisation of the role of a National Mental Health Plan as one that sets an enabling environment for regional action instead of dictating change from the top down”*.³ Table 1 below summarises expectations of LHNs and PHNs in developing joint regional plans which are implicit in the Fifth Plan and the associated Fifth Plan Implementation Plan⁴ and the timeframes for implementation of these actions.

Table 1 - Expectations of LHNs and PHNs regarding regional planning in the Fifth Plan

Expectations of LHNs and PHNs	Action	Milestone
Governments are to direct LHNs and PHNs to develop and publicly release joint regional mental health and suicide prevention plans.	Action 1.1	Progressively from December 2017
LHNs and PHNs are to engage with the local community, including consumers and carers, community managed organisations, ACCHSs, NDIS providers, the NDIA, private providers and social service agencies in implementing integrated regional planning and service delivery	Action 2.2	Commencing early 2018
LHNs and PHNs are to undertake joint regional mental health needs assessments to identify gaps, duplications and inefficiencies to make better use of existing resources	Action 2.3	From June 2018
LHNs and PHNs are to examine innovative funding models, such as joint commissioning of services and fund pooling for packages of care and support to improve efficiencies, remove duplication and improve outcomes	Action 2.4	Commencing mid 2020
LHNs and PHNs are to commission services according to joint regional	Action 2.5	Commencing late

³ The Fifth National Mental Health and Suicide Prevention Plan, National Mental Health Strategy, 2017 p.19.

⁴ The Fifth National Mental Health and Suicide Prevention Plan Implementation Plan, National Mental Health Strategy, 2017

Expectations of LHNs and PHNs	Action	Milestone
mental health and suicide prevention plans. These plans should cover the lifespan from children through young adults to older people		2017. Completed mid 2020
Developing region-wide multi-agency agreements, shared care pathways, triage protocols and information-sharing protocols to improve integration and assist consumers and carers to navigate the system	Action 2.7	Mid 2021
Developing shared clinical governance mechanisms to allow for agreed care pathways, referral mechanisms, quality processes and review of adverse events	Action 2.8	Mid 2021.

Table 2 below identifies broader expectations in the Fifth Plan which require LHNs and PHNs to utilise regional planning processes to deliver on important areas of mental health reform including suicide prevention, Aboriginal and Torres Strait Islander mental health and the coordination of services and support for people with severe and complex mental illness.

Table 2 – Broader Fifth Plan expectations linked to joint regional planning

Expectations of regional planning linked to other priority areas in the Fifth Plan	Action	Milestone date
LHNs and PHNs should identify and harness opportunities for digital mental health and make best use of existing and emerging technology within an integrated stepped care approach through regional plans	Action 2.6	Commencing late 2017. Completed mid 2020
LHNs and PHNs are expected and will be supported to engage with local communities to develop suicide prevention actions as part of a joint regional mental health and suicide prevention plan	Action 5	Commencing 2019 and ongoing
LHNs and PHNs are to prioritise coordinated treatment and supports for people with severe and complex mental illness at the regional level and reflect this in regional planning.	Action 7	Completed mid-2018
LHNs and PHNs are expected to implement integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples at the regional level	Action 10	Completed mid-2018
LHNs and PHNs are expected to include mechanisms which support the physical health of people living with mental illness in joint service planning activities	Action 16	By mid-2020

1.2.2 Government commitment to National Mental Health Service Planning Framework

A number of actions and priority areas in the Fifth Plan also commit governments to supporting LHNs and PHNs in their role in developing and implementing joint regional plans through planning tools and regional data. This includes commitment to the development and application of the National Mental Health Service Planning Framework (NMHSPF) and releasing planning tools based on the NMHPSF to use in the regional planning process.

1.2.3 Connection to broader Commonwealth-State agreements

The Commonwealth and states and territory governments have agreements in place which have either targeted, or have relevance to the needs of people living with mental illness. The National Psychosocial Support Measure involves bilateral agreements supporting coordinated delivery of psychosocial services to people with severe mental illness and reduced psychosocial function, who are not eligible for the National Disability Insurance Scheme (NDIS). The Coordinated Care Bilateral Agreements also include a commitment to explore potential trialling of joint commissioning of service delivery for people with severe and complex mental health needs. Any mental health activities undertaken via the coordinated care bilateral agreement are required to be consistent with the priorities and objectives of the Fifth Plan. The National Disability Agreement (NDA) also involves bilateral agreements and contributes to ensuring people with disability and their carers have an enhanced quality of life.

1.3 What outcomes do governments expect a joint regional plan to achieve?

1.3.1. Objectives of joint regional planning

The ultimate aim of joint regional planning is to improve the mental health, physical health and wellbeing of people with or at risk of mental illness or at risk of suicide. Joint regional planning will enable services to be commissioned to provide patient centred care and effectively target resources to needs. In this context, there are two broad, complementary objectives associated with regional mental health and suicide prevention plans:

Objective 1: Joint regional plans should embed **integration** of mental health and suicide prevention pathways and services for people with or at risk of mental illness or suicide through a whole of system approach.

This objective is largely about LHNs and PHNs looking at what can be done in the short term to better use existing resources to develop new ways of working together to improve outcomes for people in their regions.

Objective 2: Joint regional plans should drive and inform **evidence-based service development** to address identified gaps and deliver on regional priorities which have been developed and delivered in partnership with local communities.

This objective is about looking to the future and developing a plan for how services should be developed to meet priority gaps as new resources become available, or existing resources are redirected to meet agreed priorities.

LHNs and PHNs that are well advanced in the joint planning process have found that these objectives represent a logical sequence of development. Achieving integration in the short term lays the foundation for the longer term service development planning process.

The extent to which LHNs and PHNs will be able to achieve both objectives will vary. Therefore, some regions may pursue the option to focus more on developing a ‘foundation plan’, that addresses the integration goals embodied in Objective 1, with a commitment to subsequently develop a more future looking service development plan by mid-2022. Other LHN and PHN partnerships will have already established strong integration partnerships and be in a position to prepare the more advanced and comprehensive regional service development plan, to further Objective 2, using evidence-based planning tools. Section 2.3 of this guide further describes these options.

1.3.2 Integration through joint planning

Joint regional planning should identify ways in which better joined up services can be achieved to deliver a single, connected system that facilitates the consumer’s transition between service platforms when required, including health and broader services.

Integration between activities and services commissioned through LHNs and PHNs can be sought at different levels, as Figure 2 illustrates and implemented gradually over the life of the plan. Section 4 of this guide will unpack further how regional planning can both harness and promote integrated service delivery which results in better outcomes for consumers and their carers and timeframes expected of different types of integration.

Figure 2: Different levels of integration



The extent to which joint regional planning by LHNs and PHNs may achieve more complex, cross-sectoral integration of services and pathways is discussed under Section 1.5 below in the context of different types of influence.

1.4 Roles and responsibilities for joint regional planning

1.4.1 The role of LHNs and PHNs in joint regional planning

The intent behind joint regional planning is that PHNs and LHNs would be equal partners in developing and implementing regional plans. This means that governance arrangements, executive commitment, resource allocation and sign off to the planning process should reflect the joint nature of regional mental health and suicide prevention planning.

The overall expectation of governments is that LHNs and PHNs will jointly take responsibility for initiating, developing and implementing regional plans and that resources would be committed to delivering on this expectation by both organisations.

1.4.2 The role of Commonwealth, state and territory governments

Commonwealth and state and territory governments will direct and authorise PHNs and LHNs respectively to undertake joint regional mental health and suicide prevention planning. PHNs and LHNs will not be expected to obtain government agreement to regional plans, except where the jurisdiction is effectively the local partner to the PHN for the plan, as is the case for smaller jurisdictions such as the NT and ACT. In general joint regional plans require local ownership and support, as they are plans for relationships between local entities. Therefore the endorsement or approval process should sit with LHNs and PHNs and other local stakeholders and it is not anticipated that Commonwealth, state or territory endorsement would be required.

However, joint regional plans will not override existing business arrangements or service agreements between LHNs, PHNs and their funding agencies. In this respect:

- Where there is an existing service agreement between governments and LHNs and PHNs for delivering certain activities, or arrangements for seeking approval for actions with additional cost implications, these arrangements would continue.

- It is anticipated that LHNs and PHNs will consult government authorities on the above issues over the course of development of regional plans, particularly in relation to cost implications of planning.
- Individual state/territory jurisdictions may also identify particular aspects of the planning process on which they would like to be consulted by LHNs or in relation to which their authority would need to be sought. For example, where services are commissioned at the jurisdictional level rather than by LHNs.
- Similarly, PHNs will continue to be expected to honour the expectations in their funding schedules for commissioning particular types of primary mental health services to address priority areas identified by the Commonwealth.

Governments have committed to supporting the development of joint regional planning. This will include the provision of data at a regional level to help to inform the planning process. It will also include further development of the NMHSPF. Further information on these supports is in Section 2 of this Guide.

1.4.3 The role of other sector partners in regional planning

Non-government organisations (NGOs) play a very important role in delivering mental health and suicide prevention services and have both an interest and expertise which needs to be harnessed in planning efforts. Whilst many NGO provided mental health services are commissioned through LHN or PHN activities, some are commissioned at the jurisdictional level. Additionally, other NGO services also relevant to people with mental illness, for example, supported housing, are funded through other agencies or sectors. With the transition to the NDIS and efforts to increase involvement of non-health sectors, the engagement of NGOs in the planning process will be vital to get a full picture of the service system. The important role of consumer organisations and networks is discussed in Section 2 of this Guide. Similarly, the private sector plays a substantial role in provision of MBS funded services in the community, and private hospital services, and should be considered.

1.5 The scope and level of influence of joint regional planning

The Fifth Plan delivers the expectation that a whole-of-system approach to planning mental health and suicide prevention services at a regional level should be considered.

In summary, the expectation is that LHNs and PHNs will take a whole of system approach to regional planning which will at a minimum generally seek to encompass:

- Service planning provided through the health system funded or commissioned through the Commonwealth and state and territory governments, NGO delivered services and the private mental health sector; and
- Planning for the link between mental health services, suicide prevention services, drug and alcohol services and broader services provided to people including through the NDIS, employment, education and other social support services.

Table 3 - Levels of influence on different types of services through regional planning

Level of influence of regional plan	Objective 1 Planning for system integration	Objective 2 Planning for service development across the health system.
High influence – Direct authority or control	Mental health services commissioned or delivered within primary care and state government services and NGOs	Mental health services commissioned within primary care and state government services and some NGOs
Medium influence – Indirect influence within broader planning processes	NDIS services provided to people with psychosocial disability Mental health and wellbeing programs delivered through education and other services. Drug and alcohol services	Private mental health services Admitted patient services delivered by hospitals
Lower control – influence through partnerships	Broader human services e.g. housing, employment education, justice, community support, including family support services.	Limited influence on some mental health in education services and supported housing.

Mental health services funded by governments will be within the sphere of influence by LHNs and PHNs. Broader non-health human services are important to the objective of planning for integration, but are generally unlikely to be within the direct influence or control of systematic planning activity undertaken by LHNs and PHNs. Therefore, governments understand that LHNs and PHNs will vary in the extent to which they are able to engage other sectors and services in the development of the Regional Plan. Where the state/territory is a partner in negotiating the plan (e.g. ACT, NT, TAS), there may be more opportunity to seek cross-sectoral influence, at the jurisdictional level.

1.6 The timeframe for joint regional planning

The joint regional plan should be a detailed multi-year document. In general, Commonwealth and state and territory governments expect that a minimum period of five years should be covered by regional plans. Some LHNs and PHNs may wish to have a longer-term regional plan which could be subject to review. In some circumstances regional plans which have already been developed by PHNs with minimal consultation with LHNs, or vice versa, will need to be revised to form the basis for a joint plan.

All regional mental health and suicide prevention plans should be completed by mid-2020 in order to comply with expectations of the Fifth Plan. Specific timeframes and milestones in relation to integrated commissioning and service delivery are outlined in Section 4.

1.7 How to define a region for the purpose of regional planning

The boundaries of LHNs and PHNs align in most but not all circumstances. Governments have agreed that for the purpose of regional planning, the region, in most circumstances, represent the area covered by the PHN with the LHN boundaries also being considered for the purpose of sub-regional components. The number of regional plans which PHNs would need to negotiate could become excessive if defined consistently at the LHN level.

In most states there are a small number of LHNs to each PHN, however in Victoria the situation is somewhat more complex, given the high number of LHNs and the misalignment of some boundaries with PHNs. In some cases such as these, a regional plan may be negotiated between one PHN and LHN in a region as the leads, with input or contribution from other LHNs. However there is no one size fits all solution to this, and local and jurisdictional flexibility will be required to resolve this.

1.8 What flexibilities will LHNs and PHNs have?

Governments recognise that the joint regional plan is likely to vary significantly from one region to another, and that local priorities, aspirations and the extent of integration will vary. The joint regional plan provides opportunity for local innovation, and this may be reflected in a variety of ways.

Significant flexibility, variation and innovation is anticipated in relation to such things as:

- the format, structure and length of joint regional plans;
- priority issues and/or population groups;
- sub-regional issues requiring particular focus;
- aspirations for growth and change;
- innovative approaches to workforce, particularly in areas of workforce shortage;
- the extent to which the regional plan is able to address non-health sector planning;
- the approach to engagement of other stakeholders, including the extent to which the endorsement of local stakeholders is sought to the final regional plan; and
- whether detailed joint service mapping, planning and development is undertaken to inform the plan or is an agreed action over the life of the plan.

Section 2 Highlights - The process of development a joint regional plan

Step	Considerations
Groundwork	Preparing a plan for the plan and securing executive agreement Researching the local and state /territory context Establishing governance arrangements
Setting the scope and parameters	Setting the scope and reach of the plan Identify key assumptions and limitations Is it a foundation plan or a comprehensive service development plan?
Allocating resources	Identifying resources required for coordination, governance, consultation, mapping, data collection, and in kind support. Agreeing arrangements for sharing resource costs.
Consultation plan	Ensuring people with lived experience are partners in co-design How and when to engage key stakeholders in development.
Compiling the evidence	Demographic and mental health specific population data Service utilization data and evidence of service problems Needs assessment information and data on special needs Support from jurisdictions in providing regional data on mental health and suicide.
Mapping services and pathways	Mapping available services against a stepped care spectrum Establishing common language/taxonomy (eg NMHSPF) Identifying sub-regional variation in services and pathways
Identifying population needs, targets and gaps	Identifying optimal service requirements for the population and workforce requirements Identifying current and emerging gaps
Identifying priorities for change	Identifying what services need to change or grow What system changes are needed to address gaps and problems
Identifying duplication and inefficiencies	Considering services which are not efficient or evidence based Identifying duplication in services or unclear responsibilities
Identifying priorities for integration	Identifying service fragmentation experienced by consumers Considering opportunities for better joined up services and pathways
Implementation planning	Identifying ongoing governance to support the plan Agreeing on roles and responsibilities for implementation Phasing implementation of actions over the life of the plan
Measurement and review	Identifying a small number of KPIs Arrangements and timeframes for reporting and review
Seeking agreement	Gaining agreement of executives of PHNs and LHNs Obtaining agreement or support of other key stakeholders.

2 The process of developing a joint regional plan

2.1 Overview of steps involved in developing a joint regional plan

This section outlines issues and opportunities LHNs and PHNs may consider in developing and negotiating a joint regional plan. It is structured against the broad elements and steps involved in a regional planning process, noting that many LHNs and PHNs will already have progressed through some of these steps.

Whilst it is structured within the expectations outlined in Part 1 of this guide, this section is advisory only. LHNs and PHNs are not required to follow this particular process and may vary from the steps below, or implement the steps in a different sequence. However it offers best practice advice on rigorous, evidence based regional planning and options for implementing this approach to planning.

Figure 3: The process of developing a joint regional plan



2.2 The groundwork - Establishing partnerships and logistics

Whilst there is clearly an expectation from governments that regional planning will take place, the senior management of LHNs and the PHN in the region need to agree to move forward to commence the plan, and consider the logistics of doing so, including scope, parameters, available resources and overall timeframe for completion. The LHNs and PHNs may also agree on a lead organisation to take forward coordination of the plan's development. This may be a PHN or an LHN. In some circumstances a writer may be identified to lead development of the plan. Alternatively preparation of content can be delegated to multiple writers, with a single point of coordination, facilitation and editorial control.

Consideration of existing regional and jurisdictional policies, plans and frameworks will be vital at this point to inform the approach to the joint regional plan and identify limitations and existing local priorities and policies. Many LHNs may have regional mental health and suicide prevention clinical services plans or investment plans, supported by jurisdictional mental health plans and frameworks. Some PHNs have also commenced developing regional mental health and suicide prevention plans given this was a priority identified for them by the Commonwealth. This is discussed further in Section 3 of this guide.

2.3 Scope - a foundation plan or a comprehensive service development plan?

The LHNs and PHN involved in developing the plan will need to agree at the outset on the scope and reach of the plan they wish to develop, noting there is likely to be a continuum of planning and integration efforts. Some regions may wish to initially pursue a **foundation plan** for working together using existing resources and service systems, as an important first step towards a comprehensive regional plan. Foundation plans should be publicly released by mid-2020, and commit to completing more systematic service development planning by mid-2022, to coincide with the final year of the Fifth Plan.

This approach may particularly be appropriate where there is a level of complexity in the alignment between the PHN and LHNs, where there are particular geographic challenges to traditional planning approaches and tools, or where the two or more organisations need to further develop their working arrangement on mental health and suicide prevention. A foundation plan can be used to capture partnerships, agreed priorities to achieve improved outcomes and broad regional needs. Foundation plans will contribute significantly to the objective of achieving integration through joint regional planning and form the basis of the comprehensive service development plan.

Other LHNs and PHNs may already have the capacity and partnerships in place to commit at the outset to developing a **comprehensive service development plan**, informed by evidence based service planning tools and detailed service and workforce mapping. The development time and resources needed for such a plan would be greater than for a foundation plan. Comprehensive service development plans would deliver on both the objectives of integration and achieving evidence-based planning and service improvement, as outlined in Section 1.

The difference between the expectations of these types of plans is articulated below.

Expectations of the scope of regional plans

	Foundation plan	Comprehensive service development plan
Timing of detailed service planning and review	Foundation plan completed by mid-2020 and to include commitment to finalise longer term service development plan by mid-2022.	Comprehensive plan informed by planning tools delivered by mid-2020.
Approach to service planning	Focus on agreement about how to better use available resources to develop integrated approach to meet regional mental health and suicide prevention needs in the short term. A commitment to more detailed systematic needs assessment and planning is given as part of the overall regional plan.	Detailed mapping and rigorous, systematic service and workforce planning undertaken to inform the plan. Both LHNs and PHNs actively involved in joint planning and service development processes. Best practice principles in service planning used.
Provisions for continuous improvement and review	Initial plan is reviewed as a result of more detailed service development planning.	Initial comprehensive plan is reviewed to accommodate new data and or emerging gaps or workforce trends.
Capacity required	Commitment to building capacity and resources required to undertake detailed planning over the life of the plan.	Partnership between LHNs and PHN and other stakeholders well established. Planning teams skilled in use of evidence-based planning tools and resources available to undertake process.
Advantage	Enables momentum and interest in joint regional planning to be captured early to provide a framework for ongoing activity and significantly improve integration.	Offers genuine and precise service planning and development which makes best use of available resources and provides a clear blueprint for service development.

2.4 Setting other parameters for the regional plan – assumptions and focus.

LHNs and PHNs should also identify the key assumptions which underpin the joint regional plan. For example:

- What is a reasonable expectation of growth in available resources for mental health over the life of the joint regional plan?
- Is there an assumption of increased flexibility in use of some types of funding?
- Is there an assumption that some parts of the workforce might grow because of existing initiatives (e.g., low intensity workforce, peer workers, or mental health nurses)?

In some circumstances LHNs and PHNs may wish to agree to develop particular plans or discrete elements of focus within the overarching joint regional plan. This particularly may be relevant in relation to suicide prevention. It may also be a regional imperative to develop a dedicated Aboriginal and Torres Strait Islander mental health plan as part of the broader regional plan or to include a drug and alcohol services or a mental health workforce development plan.

2.5 Allocating resources to the planning process itself

Developing a joint regional plan is a significant task to which both LHNs and PHNs and jurisdictions will need to contribute. Aspects of developing the joint regional plan which may need resourcing from PHNs and LHNs include:

- Coordination of the planning process ;
- Establishing high level partnerships at senior management level;
- Liaison with stakeholders – senior staff may need to allocate significant time to this;
- Supporting governance arrangements – venues, communication with members, supporting consumer and carer members to attend and actively participate;
- Mapping services including those provided outside LHN and PHN funding, noting this can be a significant and time consuming task;
- Consultation costs;
- Data collection and analysis;
- Committing staff time to training and other activities associated with planning;
- Technical support to undertake systematic service planning using planning tools, if a comprehensive service development plan is to be pursued;
- Preparation of the Regional Plan itself; and
- Implementation arrangements – the LHN and PHN are likely to play a role in on-going arrangements to support and measure progress of the joint regional plan.

2.6 Establishing governance for the joint regional plan

Effective governance is vital to development and ultimately ownership of the end product. Governance bodies will need agility in order to provide timely and expert advice to the planning process, but they also need to include representation at the right level from LHNs and PHNs and any other agencies expected to endorse the joint regional plan.

At a minimum it could be expected that governance bodies to oversee the process of developing a regional mental health plan would include senior mental health directors and planning officers from each organisation, together with people with lived experience of mental illness. Some regions may also wish to include a broader range of stakeholders on the governance body itself. Others may instead establish a broader group of stakeholders with whom the governance body consults as a form of reference group.

In some states representatives from state/territory governments may offer to join and contribute to the governance body overseeing the regional plan.

2.7 Developing a consultation plan for the joint regional plan

A consultation plan should be developed at the beginning of the planning process. Governments have an expectation that consultation should as a minimum include consumers and carers, people with lived experience of suicide, community managed organisations, Aboriginal Community Controlled Health Services, NDIS providers, Local Area Coordinators (LACs), private providers (such as GPs, psychiatrists, psychologists and private hospitals), and social service agencies. A broader range of non-health organisations are likely to be involved in suicide prevention efforts, including cross sectoral agencies, local government and first responders.

LHNs and PHNs will however, know their own stakeholders, have existing consultative forums and will be clear on other organisations and interest groups who may contribute to the development of the plan. Some specific considerations follow:

- The cultural context for the region requires careful consideration for the approach to consultation. This requires respecting the cultural governance associated with the local Aboriginal and Torres Strait Islander community. It also requires considering ways of engaging with the Culturally and Linguistically Diverse (CALD) groups within the region. Issues of accessibility of consultation materials should be considered.
- The timing of consultation will be important. Consultation, which is too early or too late, can impede ownership and development processes. Early input from key stakeholders at the outset will be important and it will also be important to utilise information obtained through earlier consultations on mental health issues.
- Mechanisms used for consultation will depend in part on the resources available and may range from direct involvement in governance, through open forums, use of existing committees or bodies and on-line surveys.
- Specific consultation may be needed to target issues or questions emerging from analysis of data and evidence.
- However it will be important to target consultation to the parameters and scope of the regional plan.
- Consulting with local or other experts may be advisable to develop strategies for addressing particular needs or issues – possibly through panel arrangements.
- The clinical workforce for mental health, substance abuse and suicide prevention, including psychiatrists, nurses; allied health workers, and peer workers would have much to offer in the development of the plan.

LHNs and PHNs may also wish to develop a communication strategy to support the development of the regional plan. This may help to ensure clear understanding of the remit and breadth of the plan and manage stakeholder expectations.

2.8 Including consumers, carers and people with lived experience in all steps of planning

Inclusion of consumers, carers and people with lived experience as partners in development of regional plans through governance and broader consultation is vital in order to plan for regionally appropriate person-centred care and to get the best results.

The principle and practice of co-design with consumers, carers and other stakeholders requires that there should be equal responsibility given to all parties likely to be affected in the process of designing mental health services to ensure their needs, expectations and requirements are addressed.

The National Mental Health Consumer & Carer Forum Advocacy Brief on Co-design and Co-production⁵ defines co-design as “Identifying and creating an entirely new plan, initiative or service, that is successful, sustainable and cost-effective, and reflects the needs, expectations and requirements of all those who participated in, and will be affected by the plan.” It defines co-production as “Implementing, delivering and evaluating supports, systems and services, where consumers, carers and professionals work in an equal and

⁵ National Mental Health Consumer and Carer Forum: Advocacy Brief on Co-Design and Co-Production, October 2017

reciprocal relationship, with shared power and responsibilities, to achieve positive change and improved outcomes”. The Advocacy Brief makes the following recommendations:

- It is only co-production and/or co-design if consumers and carers agree that it is.
- Genuine commitment and acceptance of co-design and/or co-production remains true to the principles of equity, equality, diversity and purpose.
- Genuine commitment to co-production and/or co-design is properly resourced, embedded from the outset; effects real change; and can successfully measure meaningful outcomes for consumers and carers.
- Reform systems and processes must acknowledge and respect the contributions, experience, unique expertise, skills and knowledge of consumers and carers. Any outcomes must represent equally the contributions of all those involved.

LHNs and PHNs may benefit from seeking different types of consumer experience. This could include consulting with people with lived experience of suicide, and consumers who have different levels of need from low intensity to high intensity, including people with severe mental illness, as well as consumers and carers from particular population groups, and if appropriate, sub-regions. Governance arrangements oversighting the development of regional plans may also support consumer representation from both LHNs and PHNs. Peer workers employed by either LHNs or PHNs will provide a conduit to ensuring the views of people with lived experience are included given their unique knowledge of both consumer issues and models of service delivery. They may also assist with harnessing consumer views through their networks to provide input to consultation. Drawing on the results of previous consultation with consumers will also help to inform the early stages of planning.

Co-design - More than consultation ⁶

“Government uses many mechanisms to consult mental health consumers, carers and stakeholders, for example committees, forums, and calls for submissions. Meaningful participation in the development of high quality policy and programs happens when:

- engagement is well planned and started before policy options have been decided;
- agencies have sufficient resources and expertise to facilitate effective engagement;
- external participants have the resources, skills or knowledge to participate fully;
- agencies acknowledge that consumers, carers and service providers are qualified to contribute;
- participant selection is diverse and representative;
- agencies provide sufficient time and information for participants to prepare to make considered and meaningful contributions.

Co-design goes beyond traditional methods of consultation by forming authentic partnerships with consumers, carers, service providers and key stakeholders. It utilises their knowledge and experience in the design, delivery and evaluation of mental health policies. The methodology is underpinned by principles of early engagement, inclusivity, transparency, shared power, and equity of knowledge and responsibility.”

⁶ Co-design in mental health policy: Mental Health Australia, 2017

Common mistakes made by organisations in relation to the broader engagement of consumers and carers in planning and service design are as follows:

- Involvement of consumers and carers too late;
- Using consultation processes to inform rather than to genuinely get input – the term ‘consultold’ has been used by consumers to describe this practice;
- Underestimating the value which consumers and carers can add to service design; and
- Failing to plan for a role of consumers and carers in implementation and review, particularly given the important role of consumers in supporting accountability.

The compendium provides resources which can assist LHNs and PHNs in putting in place appropriate co-design and consultation processes to ensure consumers and carers are partners in the process. The process followed by Brisbane North PHN and Metro North HHS in developing their regional plan, as outlined below, provides an example of how people with lived experience can actively help to shape regional plans.

The principles of co-design also apply to the engagement of other key stakeholders who have an interest in and can help to shape service planning and development.

The IAP2 Spectrum of Public Participation provides a useful participation framework which shows the increasing public impact achieved over the spectrum from informing through to empowering.⁷ More information on this framework is provided in the Compendium of resources.

Brisbane North Primary Health Network and Metro North HHS - Engagement of people with lived experience in the development of a regional mental health and suicide prevention plan.

The Brisbane North region already had a network of over 260 people with a lived experience who are interested in actively being involved in mental health services, supported by the PHN. People in the Peer Participation in Mental Health Services (PPIMS) Network connect via email, an on-line engagement platform, monthly meetings, occasional focus groups/workshops and a variety of other ways.

An initial briefing was provided to the PPIMS Network on the requirement of the PHN to develop a regional plan and to invite their input. The Network subsequently held workshops to generate ideas on what type of mental health system people wanted to see. The Network then elected delegates to attend the PHN convened regional planning symposia, feed back to the Network and be a planning group around the regional plan. The main message of the Network was to focus on and talk about what will be different for people, not what will be different for the system.

A range of existing partnership groups in the region (e.g. child & youth, suicide prevention) took charge of drafting chapters of the regional plan in their area of interest. Consumers and carers are included in all of these partnership groups and receive an honorarium for their participation. Many of the partnership groups went to a meeting of the Network to workshop ideas and seek further input via online surveys or focus groups. The PPIMS Network volunteered to write the chapter of the plan on people with a lived experience leading change. They will be responsible for developing and overseeing the implementation plan for this chapter. A pre-consultation draft was provided to all the partnership groups, including the PPIMS Network delegates group, for their input, having seen the full plan for the first time (focus to date had been on their chapter). The Network provided a lengthy written response. The revised plan was then released for public consultation, including via the PPIMS network.

The Regional Plan development and implementation is overseen by a Strategic Coordination Group of the PHN, HHS, Queensland Health, NGO peaks (mental health and AOD) and consumer and carer representatives, linked to the network.

⁷ <https://www.iap2.org.au/Resources/IAP2-Published-Resources>

2.9 Compiling the available evidence base

Evidence-informed planning will be a key element of the regional plan, and will help to avert the risk of advocacy for priorities which do not genuinely align with regional need. LHNs and PHNs should be informed by the characteristics of the local population, available services, service utilisation and any gaps in service provision. They also need evidence of special needs particularly relevant to the regional priorities and its sub-regions.

Evidence that should be readily available to LHNs and PHNs would include:

- The key demographics of the area – population, age, rurality, Aboriginal and Torres Strait Islander population, and sub-regional variation;
- Mental health and suicide prevention specific population data - prevalence of mental illness and psychological distress, suicide attempts, self-harm presentations, rate of suicide and numbers of suicides;
- Service utilisation data – covering primary care services provided through the MBS, PHN provided services, and services funded through the LHN and State/Territory health services; and
- Utilisation of NDIS services.

Evidence which may be harder to collect which may require qualitative sources will include:

- Evidence of special needs populations – demographics, service utilisation and any evidence that services are not targeting needs.
- Evidence of system problems and poorly integrated services from previous consultations and needs assessments.
- Evidence emerging from consumer-led research, e.g. state based consumer research networks.

Previous LHN and PHN needs assessments and associated consultation processes will help to inform the evidence base and shape questions to be asked, and may have already collated much of the above evidence. The Department of Health's PHN Needs Assessment Guide is an important resource to inform this step of the process.

Data sources which can provide information on the demographics of the local population are summarised in the attached compendium and include information on anticipated rates of mental illness against age groups, use of disability services and special needs within the population. The AIHW is developing a resource to facilitate availability of regional data for LHNs and PHNs at the Statistical Area Level 3 to inform mental health and suicide prevention planning. The AIHW is also working on a portal to provide information about mental health services at a regional level to support application of the NMHSPF. This will complement information available through PHN Minimum Data Sets about commissioned mental health services.

Finally, evidence of the efficacy and efficiency of services is vital to inform planning. This may be available through results of local or national evaluations of particular services. The National Mental Health Service Planning Framework (see below) can provide direction on best practice services to meet a need. Local experts or clinical councils may be engaged to provide advice on approaches for which there is evidence of efficacy and efficiency. Consideration also needs to be given to nationally and state funded services and programs

available locally – for example, population level, mental health services, school mental health programs or state-wide initiatives.

Mental Health Regional Level Data – AIHW

The Mental Health Services in Australia website (www.aihw.gov.au/mhsa) provides a comprehensive picture of the national response of the health and welfare service system to the mental health care needs of Australians. The AIHW is working on providing data at regional levels to provide a more local view of service use across Australia. Work is also underway to develop a single ‘portal’ for a range of datasets, possibly including Medicare, PBS, hospital and community mental health services, specifically to support local mental health planning activities that can be used in conjunction with the NMHSPF Planning Support Tool.

2.10 Identifying the level of population need against a stepped care spectrum.

Regions undertaking comprehensive service planning or reviewing plans to introduce detailed service development planning should access planning tools such as the NMHSPF to precisely identify need for different types of services and workforce implications, (see 2.12 below). However, for regions undertaking foundation plans, it may be helpful to undertake a high level analysis against available demographic data to identify how many people require services and the broad type of services which may meet their needs. The following table, informed by NMHSPF modelling will help to identify the number of people with different intensity of mental illness who need mental health services and the categories of services which may be effective to meet their needs across a stepped care spectrum.

What is the estimated population need for different service types in the region?

Intervention type	Early Intervention	Mild Mental Illness	Moderate Mental Illness	Severe Episodic Mental Illness	Severe Persistent Mental Illness
Estimated population prevalence	23.1% of population	9% of population	4.6% of population	2% of population	1.1% of population
Service need	24% need some services	50% need some services	80% need some services	100% need some services	100% need some services
Integrated physical health care		*	*	*	*
Specialist Public MHS Community and bed based					*
Individual community support and rehabilitation				*	*
Primary care support for severe – eg Mental Health Nurses, peer support				*	
Specialist Private MH - psychiatrists,			*	*	

Intervention type	Early Intervention	Mild Mental Illness	Moderate Mental Illness	Severe Episodic Mental Illness	Severe Persistent Mental Illness
private hospitals					
Primary Mental Health Care – GPs, psychological services	*	*	*	*	
* Low intensity eg digital services	*	*	*		

Not all service types are required by all consumers. For example, the table suggests that 2% of the population would have severe and episodic mental illness⁸ and that 100% of this group would require some services. For this group, the sort of services which could meet their needs include integrated physical health care, individual community support and rehabilitation, primary care support or specialist private mental health services. They wouldn't need and would be unlikely to access all of the above.⁹

For the purpose of planning for suicide prevention, estimates of the prevalence of suicidal behavior are available from the 2007 National Survey of Mental Health and Wellbeing. In the 12 months prior to interview for this survey, 2.4% of the total population reported some form of suicidality. Of these, 2.3% experienced suicidal ideation, 0.6% made suicide plans and 0.4% made a suicide attempt.¹⁰

2.11 Mapping existing services and pathways

Mapping the services currently available against a stepped care spectrum is vital to ensure that LHNs and PHNs have a clear understanding of the services available within each other's sector of the mental health system and can gain a better understanding of broader services available to people with mental illness which may be funded through other sectors.

To effectively undertake and utilise service mapping it will be important to:

- Ensure a common language or taxonomy is agreed and used to describe services – the NMHSPF offers such a taxonomy.
- Start mapping efforts early – mapping can be a long and resource intense process, and timeframes for regional plans should allow for this.

⁸ Breakdown of severe prevalence derived from Whiteford et al Estimating the number of adults with severe and persistent mental illness who have complex, multi-agency needs, *Australian & New Zealand Journal of Psychiatry*, 2016

⁹ Table adapted from 'Using the NMHSPF to estimate service requirements for stepped care' Presented at Sharing learnings from early implementation of stepped care: A PHN collaborative workshop, 2016, Sandra Diminic, School of Public Health, University of Queensland. Estimates of prevalence derived from National Service Planning Framework modelling.

¹⁰ Slade, T, Johnston, A, Teesson, M, Whiteford, H, Burgess, P, Pirkis, J, Saw, S. (2009) The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra.

- Match the detail and level of mapping to the approach to the regional plan. An overarching foundation plan focusing on ways of working together may wish to map services at a higher level in the first instance and commit through the plan to more detailed mapping.
- Consider services available through primary care, the specialist mental health system, tertiary services, the private sector and the NGO sector.
- Consider services funded at a national or state level which are available locally – for example population level digital mental health services, national school mental health programs or state-wide initiatives.

There are a range of tools and applications which may be used to assist mapping processes. Care needs to be taken that these applications gather information on primary care services as well as services funded through the state health system. Similarly information is available to assist mapping the available workforce, as outlined in the compendium.

Challenges in mapping include gathering information about services provided in the region by NGOs to people with mental illness; particularly given funding for these programs may come from different levels of government and different agencies or sectors. The assistance of people with lived experience can help to identify services which may have become part of service pathways and help shape mapping processes. The use of service mapping or 'snapshot surveys' to provide a one-off audit of services available to people across a stepped care spectrum may also be useful in the event that there is not easy access to information about available services. This might also help to map existing pathways and problems in accessing these from a consumer or carer perspective.

In regions with diverse geography where there is significant variation at a sub-regional level, it may be appropriate to undertake a high level mapping at a local area to identify service availability and to understand the pathways to accessing services which have developed in these areas.

2.12 Use of the National Mental Health Service Planning Framework (NMHSPF) to identify service needs and targets

The NMHSPF has been developed through Commonwealth, state and territory government funding. The NMHSPF is designed to support evidence-based planning and service development. It essentially provides guidance about the right mix and level of services and the workforce needed to deliver those services. The NMHSPF can be applied at a regional level to support joint planning and resource allocation in a nationally consistent way.

Training has been provided to support this application of the NMHSPF by LHNs and PHNs. This training has been aimed at developing an understanding of the NMHSPF model, its key concepts, modelling assumptions and limitations. It has also offered familiarisation with the profiles of care on which the NMHSPF is based across a stepped care framework. Licensing arrangements apply to use of the NMHSPF in order to ensure users have been trained and are supported in its use and to ensure that its application is well guided.

An extract of the NMHSPF standardised reports was previously made available to all PHNs in May 2017 through the Commonwealth with the assistance of a team from the University of Queensland, offering the key outputs of the NMHSPF to assist early regional planning

efforts. These reports helped to paint a picture of what the full spectrum of mental health services would look like in a ‘should be’, optimally functioning mental health system, based on provision of evidence based services.

Other standard output reports which are produced by the NMHSPF and available to licensed users are outlined in Table 4.

Table 4: NMHSPF standard reports

Report	Description of report
Epidemiology	Provides an overview of the population prevalence and demand for treatment identified in the model. Information is included on the total population analysed by level of severity and age group.
Summary of resources	Provides a summary of selected outputs from the database. The report focuses on key populations, resources (e.g. workforce FTEs and mental health beds) and costs, arranged by level of severity and funding source.
Workforce FTEs	Shows workforce FTE data, focusing on staff types (e.g. consumer peer worker, nurse practitioner, GP, psychologist and psychiatrist) and level of severity for each funder group (e.g. state or Commonwealth funding).
Beds	Shows bed program types for acute, sub-acute and non-acute hospital and community-based beds, arranged by target age group.
State ambulatory programs	Shows levels of activity and costs predicted for state-funded ambulatory clinical services such as adult continuing care, acute care services and consultation liaison.
Commonwealth clinical programs	Shows expected levels of activity, providers (e.g. GP or psychologist) and costs predicted for Commonwealth-funded clinical programs. Focuses on the following resources and outputs: occasions of service by staff, hours of client demand, workforce FTE and workforce FTE prices (\$million).
Community support sector programs	Shows expected levels of activity and costs for programs provided by the mental health community support sector such as family support services, respite services and individual or consumer peer work.
High intensity adult community support services	Shows the level of support provided to those populations with the highest level of modelled community support sector resource demand, a significant proportion of whom would be eligible for the National Disability Insurance Scheme.
Youth resources	Shows youth resources modelled for the 12-24 years age range such as population, workforce FTE, mental health beds and workforce FTE prices (\$ million) by severity level.

The NMHSPF identifies optimal service requirements and the associated workforce requirements to meet the needs for the population – it does not undertake a gap analysis, or inform roles and responsibilities in addressing service needs. Most importantly, the NMHSPF does not produce a joint regional plan, but rather provides critical information that can be taken into account in the development process. Additional work will be required by PHNs, LHNs and other stakeholders to review the evidence produced and determine regional priorities in terms of what they consider feasible with current or anticipated resources and workforce, and what can be achieved within the local context.

The NMHSPF offers a nationally consistent approach to estimating mental health service requirements for a given catchment which considers variations in age profile but does not reflect variations due to geographic or demographic variables. As additional analysis is required to apply these estimates to non-urban catchments and those which vary substantially from the national average on particular population attributes, this may be seen as limiting its utility for some regions at this point in time. Further development is currently being undertaken to extend the capacity of the NMHSPF to enable a standardised national application of the benchmarks to populations with special requirements. These include rural and remote, Aboriginal and Torres Strait Islander, transcultural, youth and forensic

populations. This work will facilitate more targeted application of the NMHSPF to planning resources for these populations.

There are a range of other tools, most of which have been developed internationally, available for mapping current service provision in the region. Use of these tools may help to supplement the reports from the NMHSPF, and assist with gap analysis. However, caution does need to be exercised to ensure consideration of Commonwealth funded mental health primary care services as well as specialised services are included in the mapping and gap analysis process. The NMHSPF is the only mental health specific planning tool in Australia covering the full spectrum of services and populations, based on a process of developing evidence-based benchmarks against a broad stepped care framework with the assistance of a range of experts, and suited to the Australian health system environment. Where possible, gap analyses should be based on available data collections recording current service capacity and activity. The AIHW is developing reporting mechanisms which map nationally reported data on mental health related activity and resources to the outputs of the NMHSPF, which will assist in this process.

Governments are committed to supporting and promoting the further development and application of the NMHSPF as a consistent and evidence based approach to regional planning. At this point in time, there are two options which might be pursued by LHNs and PHNs in drawing upon it to inform regional planning. These options involve:

- i) Full use of the NMHSPF to develop a comprehensive service development plan which is reflected in the regional mental health and suicide prevention plan
- ii) Preliminary use of the NMHSPF to inform taxonomy and benchmarks on which the plan is based.

These options align with the ‘two option’ approach to regional planning outlined in this guidance, and are summarised in Table 5.

Table 5 – Options for using the NMHSPF in development of regional plans

	Full use of NMHSPF	Preliminary use of NMHSPF
Type of plan	Comprehensive service development plan	Overarching foundation plan
Objective of use of NMHSPF	Development of evidence based, comparable service development for whole region	To guide discussions between partners by establishing common language regarding the service system and lay foundations for detailed service planning and workforce projections.
Timing of full use of NMHSPF	In development of regional plan by 2020	Potential commitment to future use of NMHSPF during the life of the plan and by 2020.
Familiarisation with NMHSPF documentation	Yes	Yes – fact sheets and other basic information will be made available
Formal training necessary	Yes – requires considerable investment of time by officers from PHNs and LHNs	No
Access to licensing arrangements needed	Yes	No
Access to benchmarks for service provision	Yes	Yes
Gap analysis enabled	Yes	No – other qualitative means of gap analysis required.

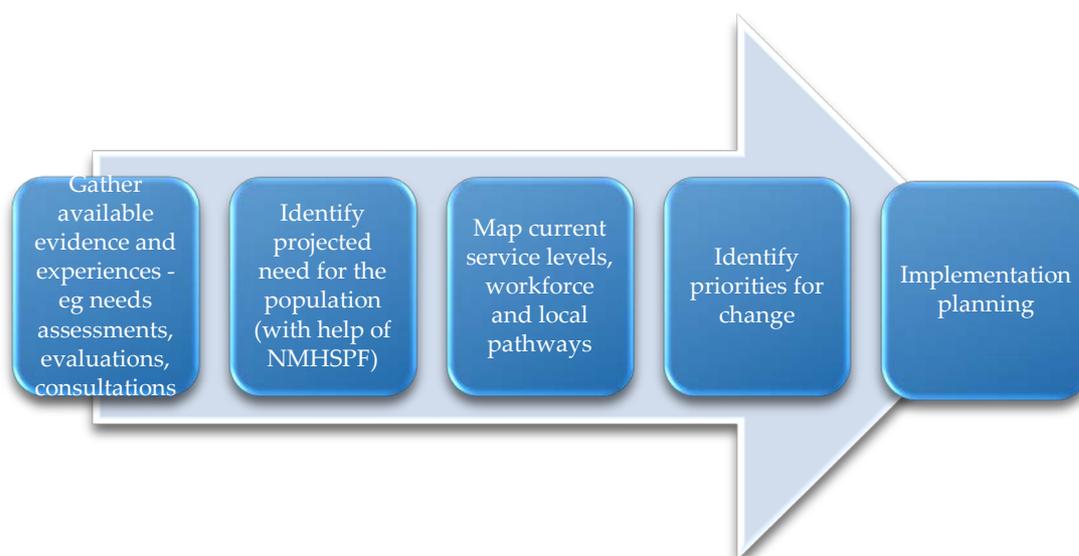
2.13 Identifying priorities for change and service development

The NMHSPF outputs and or other gap analyses undertaken by LHNs and PHNs will need to be subject to further analysis and discussion to secure agreement on which service gaps require priority action, and what other changes may be needed. The NMHSPF will not itself identify key priorities, though it will help to provide the evidence base for informing them.

Considerations in identifying priorities may include:

- What service areas need to grow? Which might need to grow selectively in sub-regions?
- What system changes are needed over time to deliver services in line with the service targets identified through the NMHSPF?
- What system failures have been identified in terms of how services work together which need to be addressed through better integrated service systems?
- What national or state policy priorities for people with mental illness are particularly relevant to the region? For example, building a stronger focus on managing the physical health care needs of people with severe mental illness into service development?
- Are agreements in place which require joint planned implementation at a local area such as the bilateral agreements negotiated between the Commonwealth and state or territory governments to support the Council of Australian Government's commitment to enhanced coordinated care.¹¹

Figure 4: Summary of steps involved in identifying priorities for change



2.13.1 Identifying duplication and inefficiencies

The current service system contains ambiguities in responsibility for service delivery which is sometimes best identified and resolved at a regional level. For example, responsibility for follow-up care after discharge following a suicide attempt in some places may be assigned to primary care or in other locations, to post-discharge outreach services from the hospital or state funded community mental health teams.

¹¹ As articulated in the *Addendum to the National Health Reform Agreement (NHRA) for 2017-18 to 2019-20*.

- Clarification of roles and responsibilities in addressing regional priorities will be vital to ensure best use of available resources.
- Analysis of pathways and available services should not only identify gaps but also where there are multiple providers delivering similar services.
- Rigorous service planning may identify some service delivery models which are not efficient or which do not make the best use of the available workforce or resources. The planning process will need to articulate the evidence for this and clearly communicate the need for change to providers and stakeholders. Guidance previously provided by the Commonwealth Department of Health on decommissioning may be useful in this respect.¹²
- Sometimes services which are funded for one purpose have transformed over time into a different service type to address a service vacuum, or because of lack of information about other parallel services.
- It may be important to identify the nature of the workforce and service delivery being undertaken within services to find duplication and to plan collaboratively to more optimally use the available workforce.

2.13.2 Priorities for improving integration

Where there are priority areas for growth or redevelopment, a key question will be how providers can work together to deliver these services in an integrated way. This is an area where some LHNs and PHNs may be able to stretch further to achieve more integration. It will depend on local relationships, agility of services, and the need for change. Key considerations include the following:

- What are the specific local problems in relation to lack of integrated care? What problems are consumers experiencing? This needs to be clear before opportunities for change can be identified and agreed. Is there fragmentation and problems in transition and pathways, particularly for vulnerable individuals with high intensity needs?
- Consideration of vertical and horizontal integration is important – transitions and links up and down the spectrum of stepped care as the intensity of care needs increases – but also integration horizontally across sectors and across service platforms.
- Is there a need to plan for resourcing care coordination or service connection? Or will creation of better pathways reduce this need?
- Synchronisation of commissioning and funding periods and arrangements will be one vital way in which integrated service delivery can be achieved.
- Finally, and very importantly, arrangements for smooth transitions between services should be subject to commitment in the joint regional Plan.

Further information on achieving integration through joint regional planning is provided in section 4 of this guidance.

2.14 Consideration of implementation issues

Joint regional plans should outline the approach to implementation. This could include the following considerations:

- What ongoing governance arrangements will be needed to support its implementation?
- What commitment may be needed to monitoring and review?
- Is there scope for trialling approaches to integrated service delivery and innovative funding models in particular sub-regional areas to address particular needs?
- Are responsibilities for implementing the plan clearly defined?
- What workforce planning is involved to support these requirements?
- What information and data-sharing infrastructure will be needed to support the level of communication and records management to support smooth pathways to care?
- Are specific MOUs or service agreements needed to support effective transitions? When and with whom will these be developed?
- What arrangements will be in place for monitoring the joint regional plan?

Implementation should consider ways of phasing introduction of change. Trying to implement everything in the first year or two will almost certainly result in change overload and could deter workforce and management from supporting the plan.

One approach to phasing implementation is to break down and map key milestones for the plan on the following basis to reflect a gradual and iterative process of service development. The table is populated with milestones and actions by way of example only.

Table 7 - Phasing the approach to integration and service development – an example¹³.

Year	Integration and governance	Suicide prevention	Mental health	Workforce	Measuring progress
1	Regional and local governance is being put into place? What infrastructure is required for integration of information systems?	Continued rollout of trials and collaborations. Agreements or MOUs to embed/clarify responsibility for follow up care after a suicide attempt	Planning local collaboration in areas of shared service delivery Implementation of psychosocial support bilateral agreement	Strategies for better local networking and communication. Expectations of collaboration embedded in employment and service contracts.	Trial of innovative projects commences. Baseline information gathered. First annual report with focus on groundwork.
2	Joint needs assessment, clinical governance and planning for coordinated service delivery	Review of trials	New joint activity commenced informed by needs assessment.	Joint workforce plan developed informed by national planning tools.	Review of innovative projects Second annual report.
3	Joint implementation of coordinated service delivery	Implementation of new strategies arising from review	Commence collaborative engagement of other sectors	Joint implementation of workforce plan	Mid term review of plan as part of third annual report.
4	Shared data, performance management	Renew and continue suicide prevention activity collaborative.	Implement new strategies and joint projects (beyond health)	Potential innovative funding models for workforce	Fourth annual report. Commencing final evaluation.
5	Shared funding models implemented. Consumers in centre of care.	Joined up approach to preventing and responding to suicide helps to reduce impact of suicide in region.	Integrated system and pathways for mental health services with links to other sectors.	Workforce feels supported and optimal use of available workforce resources is achieved.	Evaluation to inform future shared planning arrangements.

¹³ Adapted from SE NSW Regional Mental Health and Suicide Prevention Plan – Consultation Draft

2.15 Approach to measurement and review

The joint regional plan should identify indicators of system reform for monitoring implementation progress. Similarly, there should be arrangements built in for a review process which could, if required, enable adjustments to the joint regional plan in the future.

The approach to measurement and review will need to balance the need to monitor progress against the joint regional plan with the need to also ensure that reporting does not significantly duplicate other organisational reporting requirements or place unsustainable demands on LHNs or PHNs. Measurement and reporting must also be supported by a resource commitment from all organisations.

Key performance indicators identified against priorities must be measurable and consider outcomes for consumers. Regions may wish to commit to producing annual reports against the joint regional plan which could offer opportunity to provide qualitative analysis of progress against key actions and support accountability to the community to deliver on the plan. A good starting point for identifying measurable performance indicators against national priority areas is the Fifth Plan itself and the mental health indicators against which PHNs are required to report. Consultation on key performance indicators and evaluation efforts is a very important part of their development to enable a reality check and help engage stakeholders as partners in implementation, measurement and review efforts.

Measurement of integration efforts provide particular challenges. Governments are still working on the development of better ways to support the clear measurement of progress in this respect. Regions will need to take an approach to this which reviews progress in addressing particular areas of system fragmentation. The views of people with lived experience in relation to the extent to which services and pathways had achieved greater integration and increased ease of navigation of the system will be vital in this respect. Consulting the workforce on the extent to which they are better connected within and beyond the mental health sector to support appropriate triage and referral pathways will also assist. One simple measure of integration could be exploring the extent to which consumers have in place multiagency agreements. This is explored later in the guide.

Other key considerations in building in measurement and review may include:

- Who should be involved in the monitoring and review process?
- How will people with lived experience be involved?
- What specific outcomes and targets could be articulated against which monitoring and evaluation of the joint regional plan could take place?
- Is there time to achieve these outcomes within the life of the joint regional plan – or is there a need to articulate process indicators which might represent stepping stones to achieving the vision for change that the joint regional plan presents?

A further consideration is the reporting requirements associated with jurisdictional, Commonwealth or National Mental Health Commission (NMHC) expectations of regional planning and broader implementation of Fifth Plan actions. Advice will be provided from the Mental Health Information Standing Committee (MHISC) on information and data collection priorities associated with measuring implementation of the Fifth Plan. Further information will also be available on NMHC expectations of reporting on regional plans.

2.16 Seeking agreement to the joint regional plan

Section 1 of this Guide sets forth expectations in relation to the agreement or authorising process for joint regional plans. It is not expected that joint regional plans will require approval or endorsement from either Commonwealth or state or territory governments. At another level, it could be inappropriate to have endorsement from one level of government and not another given the joint nature of regional plans. There may be aspects of the plan on which LHNs and/or PHNs may wish or need to consult governments to ensure that plans do not over-ride or conflict with existing service agreements or broader planning processes.

The minimum expectation is that joint regional plans will be subject to the endorsement by LHNs and PHNs. In some regions there could be opportunity to obtain endorsement and ownership more broadly from other stakeholders. In this could be a product of the governance arrangements established at the commencement of the process.

At a practical level, adequate time should be allowed to support the agreement process to obtain approval from organisational executives. Authority may also be required for consultation drafts. In finalising documents, it would normally be expected that the logos of LHNs and PHNs would appear on the regional plan. Logos or authorising statements from governments would not normally be expected or required given local ownership of the document.

Section 3 Summary Highlights – key areas of focus in regional planning

Area of focus	Considerations in planning
Local context	Defining local characteristics and factors Considering local/state plans and policies Issues impacting other sectors in the region
Providing services across the stepped care spectrum	Considering opportunities for early intervention Meeting different levels and types of service need Addressing needs across the lifespan
Severe and complex mental illness	Providing coordinated treatment and support Planning for psychosocial support needs Addressing needs across the lifespan
Supporting the physical health of people with mental illness	Planning for preventive activity to reduce the impact of mental illness on physical health Screening for, and meeting physical health needs Joint clinical governance and information sharing
Suicide prevention	Embedding a systems based approach Arrangements for follow-up after suicide attempt Drawing on lessons from suicide prevention trials
Aboriginal and Torres Strait Islander mental health and suicide prevention	Balancing clinical and culturally informed services including trauma informed care A holistic approach to care Workforce planning Collaboration with the community-controlled sector
Rural and remote populations	Workforce strategies which best use available resources Considering optimal use of digital services Possible use of shared service platforms
Other special need groups or sub-regional issues	Collecting evidence on the nature of service gaps Considering whether existing services can be adapted to meet needs or whether there is the need for specific service. Consideration of particular sub-regional needs.
Workforce planning	Building capacity and supply Developing and supporting current workforce Building capacity of the broader workforce Innovative approaches to best use of the workforce.
Overall	Considering links to broader strategies or planning Responding to particular local needs or opportunities Utilising available resources and guidelines cited in the compendium to support particular areas of focus.

3. The content of the joint regional plan – key areas of focus

3.1 Overview

This section of guidance focuses on the content areas which may be addressed by LHNs and PHNs through the joint regional plan. It is intended to provide some guiding information on key topics governments would expect joint regional plans to address and the range of considerations which may guide local planning around these issues. This does not preclude LHNs and PHNs from identifying other areas of priority. This section provides the minimum expectations of government relating to these areas, and also offers advice on considerations and linkages in developing these areas of the joint regional plan. It does not intend to replace more detailed topic specific guidance or guidelines which is or will be available through resources identified in the compendium and alluded to below.

3.2 The local context

The joint regional plan needs to be framed within the policy and circumstance of the local areas covered by the region and should be contextualised by:

- Jurisdictional policies or frameworks relating to mental health, suicide prevention or integration. Some of these state/territory policies and frameworks are identified in the compendium;
- Existing LHN or PHN mental health and suicide prevention plans, strategies, or policy imperatives;
- The timeframe of existing local mental health and suicide prevention planning or funding activity;
- Issues facing other sectors within the area which may impact their capacity to engage in mental health and suicide prevention issues; and
- Other local factors of concern to the local community, or consumers and carers, such as the status of rollout of the NDIS, or key defining local characteristics such as size, rurality or high profile needs such as known high suicide rates or spikes in illicit drug use.

3.3 Embedding a stepped care framework within the joint regional plan

Early planning and commissioning efforts by PHNs have been underpinned by the importance of establishment of a stepped care service delivery system which can provide a spectrum of services targeting a range of needs. Stepped care supports a system of care which ensures early intervention ‘upstream’ and does not wait for acuity to develop before services are offered. Embedding this early in the joint regional plan will be vital in order to achieve a balanced approach to service planning, and provide a disciplined approach to considering the spectrum of need from population level prevention through mild to moderate mental illness to the need for services of the highest intensity. A stepped care lens can also help LHNs and PHNs to maintain a focus on early intervention, and avoid a disproportionate or sole focus on high acuity needs and high intensity services.

LHNs and PHNs may wish to:

- Consider seeking agreement to a stepped care approach as a foundation principle for the joint regional plan;
- Consider embedding the principle of early intervention into the joint regional plan to secure commitment to providing access to services early in life and early in the trajectory of disease and for low intensity presentations;
- In this context ensure planning accommodates current and future need for providing services to people at risk of mental illness and with mild to moderate illness as well as severe mental illness;
- Articulate a local stepped care framework as the basis for service planning, and for identifying service targets and gaps supported by the NMHSPF planning support tools.

LHNs and PHNs should also consider the key role that joint regional plans will play in informing commissioning activity across the lifespan in the context of a stepped care model. This will require particular consideration of the needs of infants (including perinatal mental health needs), children, youth, adults and older people in terms of ensuring the right services are provided at the right time. Partnerships with particular sectors, including education and the aged care sector will be important in planning needs for early intervention and appropriate services across the lifespan.

3.4 Treatment and supports for people with severe and complex mental illness

3.4.1 Government expectations of coordinated treatment and support

Whilst providing services across the spectrum of need will be important to support a stepped care approach, there is an imperative for LHNs and PHNs to jointly plan for addressing the needs of people who are severely impacted by mental illness and may have other complex needs for services from a range of agencies through coordinated action.

Commonwealth and state and territory governments will require PHNs and LHNs to prioritise coordinated treatment and supports for people with severe and complex mental illness at the regional level and reflect this in regional planning and service delivery (Action 7 of the Fifth Plan).

National guidelines are to be developed as part of the Fifth Plan implementation, which will support improving coordination of treatment and supports for people with severe and complex mental illness. However in planning for coordinated service provision for this group, there are emerging opportunities which governments would expect PHNs and LHNs to consider.

People with severe mental illness and complex needs are most disadvantaged by the fractured and poorly coordinated nature of services. Conversely they may have most to gain from development of a well-planned, and integrated service system which addresses problems of fragmentation.

Many within this group have the need to access services from a range of agencies – services could include primary care, specialist or acute, community support services, drug and alcohol services, and non-health services including the NDIS. Joint regional plans will be expected to give priority to developing opportunities for collaboration between LHNs and

PHNs to develop joined up services and pathways which support better outcomes and early intervention for people with severe mental illness.

Approaches to planning and integration for this group will need to be tailored to address the gaps and system failures or problems identified through the processes of mapping and evidence gathering, and the service platforms which are available. Flexibilities which LHNs and PHNs may wish to explore to promote integration through the plan for this group include:

- The use of multiagency care plans and agreements to support joined up care;
- Introducing shared or collaborative assessment and triage arrangements for people with severe mental illness and complex needs;
- Exploring innovative approaches such as co-commissioning and fund pooling to make better use of workforce and other resources, particularly in areas of workforce shortage;
- Facilitating support for GPs from specialist mental health services where there is shared management of people with severe mental illness and complex needs; and
- Promoting information-sharing protocols and better communication to support more seamless care.

Planning in consultation with local NDIS providers and Local Area Coordinators will be vital to ensure that the health needs of people with psychosocial disabilities are addressed, and that there is ongoing communication about existing or emerging gaps in services.

3.4.2 Planning for the psychosocial support needs of people with severe mental illness who are not more appropriately supported through the NDIS

Governments expect that joint regional planning by LHNs and PHNs will support the planned implementation and coordination of psychosocial support services for people with severe mental illness and associated psychosocial impairment who are not more appropriately supported through the NDIS. This will be a very challenging area of joint regional planning for LHNs and PHNs, given the changes associated with NDIS reform.

The implementation of the NDIS is providing psychosocial support and other disability services to people with severe mental illness who qualify for a NDIS support package as a result of their reduced psychosocial functional capacity. However, there are other people with severe and complex mental illness who have some level of reduced psychosocial functional capacity but do not meet the NDIA access requirements for severity or permanence of disability. Many of these people would benefit from access to a level of psychosocial support to raise their capacity to recover and to complement clinical services they receive. Key considerations for LHNs and PHNs in planning for this group of people include the following:

- It is important to plan for continuity of support provisions through which people with disability who are currently receiving psychosocial support services through transitioning programs are not disadvantaged in the transition to the NDIS. The NDIS continuity of support commitment will seek to ensure that this cohort continues to be supported to achieve similar outcomes. Funding will be made available for this purpose;
- The needs of other people with severe mental illness and reduced psychosocial capacity who are not covered by continuity of support provisions and are not more appropriately supported through the NDIS also require joint planning consideration. Bilateral

agreements negotiated in early 2018 between the Commonwealth and State Governments provide some additional psychosocial support through the mental health system to target this group. The Commonwealth has provided guidance to PHNs to support implementation of new psychosocial support funding announced in 2017 for this purpose¹⁴.

- LHNs and PHNs should consider the particular needs or gaps in provision of psychosocial services in their region. For example is there a deficit of group services or a shortfall of services in some geographic areas?
- LHNs and PHNs should also consider ways of ensuring that mainstream capacity of NGOs delivering psychosocial support and associated workforce to enable service coverage to the broader population is not lost as a result of transition to the NDIS.

It will be vital to work closely with NGOs which are providing psychosocial support services under NDIS arrangements and/or through transitioning programs to establish new psychosocial support arrangements.

3.4.3 Planning for services for people with severe and complex mental illness across the lifespan.

Governments expect specific consideration of the requirements of children and adolescents with or at risk of severe mental illness in joint regional plans. However there is also opportunity to consider the different needs of people with severe mental illness across the lifespan, including in relation to older people with mental illness.

The importance of investment in early intervention services for children and young people with severe mental illness has been established for some time. This is an area where both the Commonwealth through PHNs and States and Territories through LHNs are funding services and there is a need for locally appropriate shared planning. LHNs have longstanding investment in these services through Child and Adolescent Mental Health Services as part of the specialist community mental health system and in a range of youth focused interventions. PHNs have been funded by the Commonwealth to commission services targeting the needs of young people with or at risk of severe mental illness.

Planning for services for children and young people with severe mental illness will need to consider:

- Prevalence Information available on the number of young people in the region likely to have severe mental illness, and their distribution across sub-regional areas;
- Available services targeting the needs of young people with severe mental illness funded through LHNs, PHNs and NGO;
- Identified gaps in services – is there an indication young people with particular types of disorders are falling through the cracks, as indicated through needs assessments or other qualitative information or consultation;
- Opportunities to better use available service capacity and to join up referral arrangements and services to promote better outcomes;
- The potential for multidisciplinary team approaches to service delivery; and

¹⁴ Psychosocial Support for People with Severe Mental Illness who are not Eligible for the NDIS - Guidance for PHNs, Commonwealth Department of Health, 2018.

- Integration of mental health services with drug and alcohol services, housing, vocational and educational supports for young people with mental illness and broader family and social support.

Joint regional plans should also promote coordinated provision of services for older people with high intensity mental health needs. In this respect the high suicide rate of older men and the commensurate need for mental health services should be considered, and local data interrogated. Services for older people with severe mental illness are provided both by primary care and specialist older persons mental health services. They also intersect with the role of specialised dementia services and residential care facilities. There is also a need for planning integrated services for older people with severe mental illness which address the high level of chronic illness among this group and provide screening, treatment and support for physical health problems.

3.5 Supporting the physical health of people with mental illness

A priority for the Commonwealth, state and territory governments is improving the physical health of people with mental illness. This is an area in which there is an opportunity and an imperative for effective planning and integration efforts to address an overwhelming inequity currently in the system for people with mental illness.

Through the Fifth Plan, governments are committed to the principles of Equally Well – The National Consensus Statement on improving the physical health and wellbeing of people living with mental illness in Australia.

The key elements underpinning the Equally Well Consensus Statement are:

- a holistic, person-centred approach to physical and mental health and wellbeing;
- effective promotion, prevention and early intervention;
- equity of access to all services;
- improved quality of health care;
- care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life; and
- the monitoring of progress towards improved physical health and wellbeing.

There is significant evidence showing poor health outcomes and reduced life expectancy for people with mental illness compared with the general population, and indications that physical health needs may be overlooked particularly in the treatment of people with severe mental illness.

The Fifth Plan makes clear the expectation that joint regional plans developed by LHNs and PHNs should address the physical health needs of people with mental illness through:

- joint service planning activity which should consider ways to support these needs;
- including these needs in joint clinical governance activity; and
- documenting roles and responsibilities for the delivery of physical health services to people with mental illness as part of local service agreements.

In implementing these expectations through joint regional plans, LHNs and PHNs should also consider opportunities for:

- planning for early intervention and prevention activity to reduce the impact of mental illness on physical health, particularly addressing lifestyle issues early in disease. This could for example mean offering routine smoking cessation and support services;
- building in expectations of routine screening for physical health needs of people with mental illness, and regular medication review;
- ensuring access to services for physical health needs are readily available when the screening process detects these needs;
- consideration of the mental health needs of people living with a chronic physical illness; and
- introducing physical health questions to standard measures of consumer experience (for example, through the Your Experience of Service Survey).

Reporting requirements associated with the plan should encourage reporting the percentages of consumers who have been routinely screened for physical health and who have been offered smoking cessation or other preventive health services.

Planning for clinical governance arrangements and improved communication and information sharing protocols will help to promote integrated service provision and help to address the inequity in treatment experienced by people with mental illness. Importantly, it can also raise the confidence of people and their families in the services they receive.

3.6 Suicide prevention – a systems approach

3.6.1 Expectations of governments

A joint regional plan should drive home the imperative to have in place integrated services, well developed pathways for care and follow-up, and the communication required to support a coordinated, systems-based approach to suicide prevention. It offers the potential to identify and address key local factors in suicide prevention which require high level, cross sectoral agreement and to shift service delivery to early intervention.

The expectations of the Fifth Plan in relation to suicide are that regional plans will include a focus on:

- A system based approach to suicide in line with the 11 elements of suicide prevention derived from the WHO Preventing Suicide: Global Imperative and identified in the Fifth Plan (see below);
- How to work together to lay the groundwork for effective integrated suicide prevention activity and plan for service improvement;
- An emphasis on other priorities identified in the Fifth Plan including:
 - follow-up after a suicide attempt;
 - cultural safety and Aboriginal and Torres Strait Islander suicide prevention;
 - promoting relationships between particular providers – e.g. emergency services; and
 - planning for data and evaluation to improve actions.

In terms of the process of planning for suicide prevention, it is expected the regional plan may focus on the importance of:

- engaging with local communities in planning for suicide prevention;

- establishing collaborative arrangements to support integrated action;
- mapping suicide prevention providers and other relevant services
- identifying service gaps;
- enhancing referral pathways through integrated planning processes;
- promoting local knowledge of available services; and
- reporting on suicide prevention activity.

3.6.2 A system based approach to suicide prevention

Governments expect LHNs and PHNs to utilise joint regional planning to embed a system based approach to suicide prevention. The essential elements of such an approach are below.

Consistent with the WHO's Preventing suicide: A global imperative, the Fifth Plan commits all governments to a systems-based approach which focuses on the following 11 elements:

1. Surveillance—increase the quality and timeliness of data on suicide and suicide attempts.
2. Means restriction—reduce the availability, accessibility and attractiveness of the means to suicide.
3. Media—promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.
4. Access to services—promote increased access to comprehensive services for those vulnerable to suicidal behaviours and remove barriers to care.
5. Training and education—maintain comprehensive training programs for identified gatekeepers.
6. Treatment—improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt.
7. Crisis intervention—ensure that communities have the capacity to respond to crises with appropriate interventions.
8. Post-vention—improve response to and caring for those affected by suicide and suicide attempts.
9. Awareness—establish public information campaigns to support the understanding that suicides are preventable.
10. Stigma reduction—promote the use of mental health services.
11. Oversight and coordination—utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours.¹⁵

3.6.3 National and jurisdictional activity underway to inform best practice

All jurisdictions have suicide prevention frameworks or policies in place which will help guide suicide prevention planning. There are also currently a number of trials of systems based approaches to suicide prevention taking place at a regional level across the country which will both help to inform and could be supported by a regional planning process. Some trials have been funded through Commonwealth and state or territory governments. By their very nature these trials require a range of partners to work together with services, people with lived experience and communities to plan and deliver suicide prevention activities and recovery oriented care in specific geographic regions. Where a trial is taking place in the region, it is likely this will promote a collaborative integrated approach to suicide prevention which addresses the above issues. The plan may commit to a review of the trial to inform future activity. Broader information dissemination about progress and evaluations of these trials will also help to inform planning.

Work has also commenced as part of implementation of the Fifth Plan on the development of a national suicide prevention implementation strategy by the Suicide Prevention Project Reference Group. This Strategy will be available to inform national and local action on

¹⁵ The Fifth National Mental Health and Suicide Prevention Plan, p.24

suicide prevention by 2020. Regional organisations should build in opportunity to review their planned approach to suicide prevention in light of this strategy as part of a phased approach to implementation when it is available. The resources provided in the compendium provide more detail on the elements of a systems approach to planning for suicide prevention.

3.6.4 Other considerations in regional planning for suicide prevention

In building the above 11 elements into joint regional plans, it will also be important to give consideration to the following:

- both LHNs and PHNs will need to contribute to resourcing a coordinated approach to suicide prevention planning to ensure equal and effective partnerships;
- local protocols identifying who is responsible to provide follow-up to individuals after presentation to health services associated with a suicide attempt, and the minimum level of service which should be provided;
- clear and well communicated arrangements for crisis support including phone-based support and acute interventions;
- a shared approach to addressing particular regional risk factors for suicide – such as local suicide ‘hot spots’ or other ways of reducing means of suicide, or particular local population groups at heightened risk of suicide including Aboriginal and Torres Strait Islander groups or individuals with drug and alcohol problems;
- cross-sectoral support arrangements in the event of a high profile event or suicide cluster – such as the support which health services should locally provide schools, local employers and others in the event of heightened suicide risk;
- commitment to supporting key workforce including GPs and local first responders including ambulance services to identify and be able to support individuals at high risk of suicide; and
- arrangements for agile cross service and cross sectoral communication and networking to ensure information sharing, early awareness and action at a community and individual level.

One area of flexibility will be whether or not joint regional plans includes or links to a separate suicide prevention plan or framework to articulate in greater detail commitments and local needs. In some instances regions may already have such a plan or framework under development. This plan or framework should be cross-referenced in the broader joint regional plan, and ideally should complement it, given the interdependence between mental health service delivery and suicide prevention.

The importance of cross-sectoral engagement and consultation in developing and implementing joint regional plans has been outlined earlier in this guide. However suicide prevention in particular demands wider discourse and engagement with education, local councils, child and family services, police sectors, justice, local business councils and first responders as well as consultation within the health and mental health sectors to support full integration.

Input from people with a lived experience of suicide should be central in the development of the regional plan. The approach to preventing the suicide of Aboriginal and Torres Strait Islander people also must be developed in consultation with representatives of this community as outlined below, through structures which support collaborative partnerships.

There are a range of resources and organisations available to inform and provide expert evidence-based advice on regional efforts to plan and coordinate suicide prevention activity. The PHN Guide to *Evidence-Based Commissioning for a Systems Approach to Suicide Prevention* prepared in 2016 by the NHMRC Centre of Research Excellence in Suicide Prevention at the Black Dog Institute includes detailed advice on setting up multiagency groups to develop suicide prevention plans, and provides a useful resource for LHNs and PHNs.¹⁶ Other resources and organisations are outlined in the attached compendium.

3.7 Aboriginal and Torres Strait Islander mental health and suicide prevention

The Fifth Plan is the first National Mental Health Plan to specify an agreed set of actions to address social and emotional wellbeing, mental illness and suicide amongst Aboriginal and Torres Strait Islander people as a priority. It is vital therefore that this priority should be reflected in action to develop regional plans.

A regional plan is an opportunity to engage in collaborative action to identify strengths and build protective factors within Aboriginal and Torres Strait Islander populations and prevent the onset and exacerbation of mental health problems, substance misuse and other problems. It is also an opportunity to plan to achieve the vital integration and locally-led tailoring of services and pathways needed to address these problems. The approach to planning Aboriginal and Torres Strait Islander mental health and suicide prevention services through the Regional Plan will be likely to vary enormously across regions. However there are a number of common expectations of PHNs and LHNs regarding how this should be approached.

The Fifth Plan's expectations for LHNs and PHNs for implementing integrated planning and service delivery for Aboriginal and Torres Strait Islander people at the regional level are articulated in Action 10 of the plan, and include:

- engaging Aboriginal and Torres Strait Islander communities in the co-design of all aspects of regional planning and service delivery
- collaborating with service providers regionally to improve referral pathways between GPs, ACCHSs, social and emotional wellbeing services, alcohol and other drug services and mental health services
- developing mechanisms and agreements that enable shared patient information, with informed consent as an enabler of care coordination and service integration, and;
- ensuring a strong presence of Aboriginal and Torres Strait Islander leadership in governance structures.

Expectations of better integration of services for Aboriginal and Torres Strait Islander people require an approach to service planning which seeks:

- a balance of clinical and culturally informed services, which are supported by staff sensitive to the impact of intergenerational trauma;
- a holistic approach to care which recognises the importance of physical health, mental health, spiritual needs and social and emotional wellbeing;

¹⁶ Black Dog Institute, *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring*. Commonwealth of Australia 2016. Available at http://www.health.gov.au/internet/main/publishing.nsf/content/phn-mental_tools

- a recognition of the interconnection and vital need for links in efforts to address mental illness, suicide prevention, alcohol and other drug problems and social and emotional wellbeing among Aboriginal and Torres Strait Islander people; and
- planning for a local workforce which understands these interconnections, has been trained in building culture into therapy to incorporate client/family world views in to service provision, and is sensitive to the impact of intergenerational trauma.

LHNs and PHNs will have established relationships with local Aboriginal Community Controlled Health Organisations (ACCHOs) on which to build the planning process and will have underway new commissioning arrangements for Aboriginal and Torres Strait Islander mental health and substance misuse as well as suicide prevention. Additionally, LHNs and PHNs should acknowledge the role of, and engage with, jurisdictional Aboriginal Health partnership forums when developing the plan.

Consideration of cultural governance issues will be important in the development and implementation of regional plans and in the development of co-commissioning arrangements. This includes, for example, ensuring the cultural safety of Aboriginal and Torres Strait Islander people working with LHNs and PHNs, culturally respectful partnerships, and embedding cultural governance as part of plans for commissioning services. Further information on cultural governance can be obtained from the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and from other references provided in the compendium to this Guide.

To achieve integrated pathways and effectively planned mental health and suicide prevention services, strong partnerships and shared planning will be vital with drug and alcohol services for Aboriginal and Torres Strait Islander people. This could include consideration of joint prevention-focused cultural activities or programs led by communities to build protective factors.

A number of valuable resources are available to help inform efforts to plan for Aboriginal and Torres Strait Islander mental health and suicide prevention service development and integration. Details on these are provided in the resource compendium, but the attention of LHNs and PHNs is particularly drawn to:

- The Gayaa Dhuwii (Proud Spirit) declaration, the implementation of which was supported through the Fifth Plan.¹⁷
- The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) Report which offers a guide to planning, commissioning and evaluation of suicide prevention initiatives.¹⁸
- The National Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2017¹⁹
- The forthcoming 'Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities – A guide for Primary Health Networks', being developed by

¹⁷ National Aboriginal and Torres Strait Islander Leadership in Mental Health, Gayaa Dhuwii (Proud Spirit) declaration, NATSILMH, 2015

¹⁸ University of Western Australia, Solutions that work – what the evidence and the people tell us, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report, November 2016

¹⁹ National Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing, Department of Prime Minister and Cabinet, 2017

the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and the Black Dog Institute.

- The National Cultural Respect Framework (CRF) for Aboriginal and Torres Strait Islander Health 2016 - 2026²⁰. The CRF commits the Commonwealth Government and all States and Territories to embedding cultural respect principles into their health services; from developing policy and legislation, to how organisations are run, through to the planning and delivery of services. It seeks to guide the delivery of quality, culturally safe, responsive health care to Aboriginal and Torres Strait Islander people, and contribute to Closing the Gap.
- State government Aboriginal health plans and resources, such as the healing resources available through Aboriginal Affairs NSW.

Key considerations in the development of the Aboriginal and Torres Strait Islander mental health elements of the Regional Plan also include;

- Ensuring local Aboriginal and Torres Strait Islander communities and services are engaged in the development and implementation of the joint regional plan;
- Utilising state or regional Aboriginal and Torres Strait Islander health or mental health plans or frameworks to help inform priorities;
- Planning for genuinely holistic services which consider a range of needs including the connection to culture, community and country as well as issues such as physical health, substance misuse, social emotional wellbeing and suicide prevention;
- Utilising cross sectoral partnerships to support whole of government solutions, through linking up efforts in areas such as health, education, justice, housing and other mainstream services; and
- Ensuring that Aboriginal and Torres Strait Islander suicide prevention is a key priority in relation to the Regional Plan, and/or an area for system change through collaborative action.

Gayaa Dhuwii (Proud Spirit) Declaration

The five themes of the Gayaa Dhuwii (Proud Spirit) Declaration, set out below, are central to the development and implementation of actions in the Fifth Plan.

1. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.
2. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.
3. Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.
4. Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.
5. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

²⁰ The National Cultural Respect Framework (CRF) for Aboriginal and Torres Strait Islander Health 2016 - 2026, available at www.coag.gov.au

3.8 Planning for rural and remote populations

An important area of focus for many regions will be planning for populations at a sub-regional level where, because of remoteness or other locational reasons, there is a significant service shortfall. Service planning tools such as the NMHSPF will provide a useful taxonomy and evidence to inform planning in rural areas. However it may have limited application in these areas at this point in time, and alternative approaches may be needed to identify realistic and location specific service development priorities. In the medium term, a consistent and evidence based approach to allowing for rurality in planning should be pursued as the NMHSPF is redeveloped for application within these areas. Further updates will be provided to LHNs and PHNs on the status of planning tools for this purpose. These challenges will be exacerbated by the reality that in many regions there is a mix of rural and urban sub-regional areas. A whole of region approach to mapping needs and workforce may not pick up the maldistribution on the ground of services.

Particular considerations in planning for rural and remote service development include collecting evidence on the following:

- Known concerns and shortfalls in rural and remote services which have been the subject of previous consultations or review;
- Evidence of particular groups of consumers missing out on services – e.g. children, Aboriginal and Torres Strait Islander people, people with severe mental illness;
- Mapping available services provided by LHNs and PHNs in rural areas, together with outreach services which may be provided to these areas;
- Particular shortages of key workforce – and consideration of recruitment or retention strategies which may be in place;
- Referral pathways or partnerships which enable rural or remote services to be supported by larger services in more highly populated and resourced areas;
- The extent to which larger regional centres are providing services to a broad catchment area; and
- Access to services outside the region.

Joint regional plans could be expected to focus on:

- Workforce strategies, which utilise innovative approaches to pooling or otherwise making best use of available staff resources to support shared objectives in service delivery. Optimal use of outreach services to deliver specialist services. These strategies should also focus on a shared approach to ensuring the available workforce is skilled and supported to deliver services – e.g. cultural competency.
- Optimal use of digital mental health to supplement face to face services. Telehealth services including videoconferencing and online services should be explored and promoted through the regional plan.
- Considering shared use of existing service platforms in rural and remote areas.

3.9 Population or special need groups

Specific population groups should be identified in the process of developing the joint regional plan for whom there is an imperative to design for better service provision. This may include CALD communities, including people from a refugee background, people from a LGBTIQ background or groups which have particular needs that are not met by mainstream mental health services for cultural or other reasons.

Governments will not be prescriptive in the expectations of these particular groups in recognition that each region is in the best position to know its own populations and their needs. However PHNs may wish to consider the following factors in identifying special needs groups:

- Is there an evidence base indicating that there is a service gap for this particular group and articulating the nature of the gap?
- Are there data on the number of individuals within the group for whom services are needed?
- Is there a need for specific services to meet their needs, or can existing services be adapted to meet their needs?
- Are there particular groups at greater risk of suicide for whom there is a need to plan mental health and other service delivery?
- If the population group involves a particular sub-region, which has significantly different needs and issues to the rest of the region, is there a case for the joint regional plan to be broken down at a sub-regional level?

3.10 Workforce Planning

Workforce planning is a vitally important part of regional planning and a critical component of service development. It is necessary to ensure that service needs can be met across the stepped care spectrum. Some regional plans may include or commit to development of a separate mental health workforce plan for the region as part of systematic service development and planning.

The National Mental Health Strategy in 2011 identifies five key outcome areas:

1. Developing, supporting and securing the current workforce.
2. Building capacity for workforce innovation and reform.
3. Building the supply of the mental health workforce.
4. Building the capacity of the general health and wellbeing workforce.
5. Data and monitoring and evaluation.

Joint regional planning could also therefore be expected to cover supply, support, development, and capacity of the mental health and broader workforce.

Use of the NMHSPF planning tools will support calculation of robust estimates of the nature and size of the workforce needed to deliver services to the region. LHNs and PHNs may need to overlay this information with their mapping to identify whether the region has the workforce to provide the right services in the right locations to meet current and expected service need. Evidence from the regional plan development process can also be used to support shared efforts between primary care settings and LHNs to grow particular elements of the workforce through recruitment, training and sometimes reallocation of resources.

The process of regional planning can also identify development or support needs of the existing workforce. This might include:

- Particular training needs – e.g. better understanding of trauma-informed care or cultural competency training

- The need for better support of particular parts of the workforce – e.g. mentoring and support for peer workforce or for the workforce in remote areas
- Opportunities for building career pathways to retain the workforce – for example, workforce exchange between LHNs and PHNs to build better cross system links and understanding.
- Need for improved clinical governance or supervision to ensure quality of service in line with the National Practice Standards for the Mental Health Workforce²¹ and the National Safety and Quality Health Service Standards.²²

Workforce planning offers opportunity for innovative use of the available public and private workforce. In addressing capacity issues for innovation within the workforce in the regional plan, LHNs and PHNs may consider:

- Innovative approaches to making the best use of workforce in remote locations or areas of service shortage – for example shared arrangements between mental health nurses and remote health care professionals or, use of tele-health and digital technologies to enable clinician facilitated treatment to people in isolated areas.
- Joined up approaches to training and skill development for regional workforce – for example in areas such as responding to individuals in crisis, or in delivering culturally appropriate services to Aboriginal and Torres Strait Islander people.
- Joint efforts to plan to recruit and retain staff needed for service growth identified in the regional plan.
- Ways to optimally use the private mental health workforce –services provided through Medicare and private hospitals.
- Extending use of the peer workforce particularly to support coordination of care for people with severe and complex mental illness.
- Information and training needed for the broader health and wellbeing workforce.

Workforce planning for mental health is closely connected to broader health workforce strategies and plans. Workforce needs arising from joint regional plans may need to be informed by and inform these strategies.

²¹ National Practice Standards for the Mental Health Workforce, Safety and Quality Partnership Standing Committee, 2013

²² Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards (September 2012). Sydney. ACSQHC, 2012. © Commonwealth of Australia 2012

Section 4 Highlights - Opportunities for integration through joint regional planning

Type of integration	Considerations in planning
Innovative funding models which promote integration	<p>Coordinated or joint commissioning</p> <p>Fund pooling for packages of care</p> <p>Incentives for integrated and recovery-focused service delivery</p> <p>Focus innovation on targeting needs which can't be easily met through traditional methods</p> <p>Evaluating innovative funding approaches</p>
Planning for joint clinical governance and quality control	<p>Managing the risks of innovative approaches to services</p> <p>Ensuring clear clinical governance and responsibilities</p> <p>Promoting joined up service pathways</p>
Cross sectoral integration	<p>Joined up approaches to promoting protective factors</p> <p>Coordinated cross-sectoral support for people with severe and complex mental illness and multi-agency needs.</p> <p>Secure cross-sectoral commitment to reduce the risk of suicide.</p>
Integration with the NDIS	<p>Joint planning to ensure links between the NDIS and mainstream health and mental health services, and NGO capacity.</p> <p>Planning for the needs of people who are not in the NDIS</p> <p>Developing close relationships with NDIS Local Area Coordinators</p>

4. Opportunities for integration within the mental health system through joint regional planning

4.1 Overview

This section of the guidance provides more detail on the expectations, challenges and opportunities associated with using regional mental health and suicide prevention planning to achieve a more integrated service system for people with or at risk of mental illness. It offers advice to LHNs and PHNs on how to deliver on the objective of achieving the integration objective of regional planning.

4.2 Levels and types of integration – expectations of government

Section 1 of this guidance explains that there are different levels and types of integration within the mental health system. A summary of the expectations of governments against these different types or levels of integration within the health system, and when this could be expected is provided in Table 8:

Table 8 – Government expectations of integration

Level of integration within the mental health system	Government expectations
Information and Data Sharing	LHNs and PHNs will share information and data to inform regional planning commencing from 2018
Collaborative needs assessment, service mapping and joint planning	LHNs and PHNs will undertake joint regional mental health and suicide prevention needs assessments to identify gaps and duplication and make better use of existing resources commencing from 2018. In early planning this may involve sharing results of recently undertaken needs assessments.
Coordinated service delivery, and shared service pathways	Regional plans will support coordinated service delivery and to include plans for shared service pathways. Regional plans are expected to be in place by mid-2020.
Shared data systems, performance management and accountability	LHNs and PHNs will explore opportunities for shared data systems through the life of the plan, commencing in 2018.
Shared funding and governance structures	LHNs and PHNs will examine innovative funding models through the course of the implementation of regional plans. These models to commence by 2020.

4.3 Innovative approaches to integrated service delivery

The Fifth Plan encourages LHNs and PHNs to examine innovative funding models, including joint commissioning of services and fund pooling for packages of care to create incentives to focus service delivery on prevention, early intervention and recovery (Action 2.4). As above, this is not something which is urgently sought or which must be resolved before regional plans are finalised. The opportunity and need for integrated service models may vary from region to region.

These innovative approaches will be particularly relevant to the delivery of coordinated care to people with severe mental illness. They may also assist making optimal use of available scarce resources and workforce in rural and remote areas. At one level, even coordinated commissioning to dovetail pathways and services will make a difference. In other regions, there may be opportunity to jointly commission services which pool workforce and resources to deliver a more optimal mix and level of services to particular groups.

Another form of innovative approach could be building incentives for integrated service delivery into regional planning. This might take forms such as:

- Incentivising the workforce through employment contracts or funding agreements to deliver on collaborative service provision and integrated pathways to care;
- Promoting a more seamless transfer back into the community from acute care through incentives for staff and providers within hospital and primary care settings to communicate, refer and receive patients, or;
- Rewarding NGOs commissioned to deliver services for coordinating their services with other providers.

Whilst innovation is encouraged, it will be important that LHNs and PHNs work within the service agreements and funding protocols which apply to their programs and services. Furthermore, innovation must be targeted to addressing needs which cannot be met through traditional models of service delivery, and must not be pursued at the expense of clinical standards or quality. However in areas of shared objectives, and for patients who receive services from both levels of government there is much to be gained from flexible approaches to achieving shared objectives and integrated services.

4.4 Planning for clinical governance and quality control

Whilst there are many opportunities and benefits associated with innovative approaches to integrated and joined up service delivery there are also risks which need to be managed. Where there are shared service models, accountability and clinical governance arrangements must be carefully planned and agreed. This includes the following:

- Ensuring responsibility for supervising service delivery is clear;
- Ensuring consumers know to whom to complain in the event of a perceived problem;
- Agreeing responsibility for investigating adverse events or system failures.

Shared clinical governance arrangements will have broader benefits of promoting communication and further opportunities for establishing joined up pathways and services. Shared clinical governance will also support efforts to evaluate innovative and integrated approaches. This will be a vital element of ensuring innovative approaches improve patient outcomes and pathways and do not result in unintended consequences.

4.5 Cross-sectoral planning and integration

Integration between mental health and other service sectors is more complex and provides challenges associated with the reduced level of influence of LHNs and PHNs beyond health. Governments strongly encourage LHNs and PHNs to seek input from and links to other sectors in regional plans. However they do not expect regional plans to cover detailed service development and planning for all services for people with mental illness, including those provided by other sectors.

As previously acknowledged, the extent to which LHNs and PHNs may be able to engage non-health sectors in the development of the Regional Plan will vary. Opportunities for engagement through development of joint regional plans could include the following:

- Planning for a joined-up approach to promoting protective factors which prevent and reduce the impact of mental illness and suicide.
- Promote better outcomes for children and young people through embedding links between education, mental health services and related social support for children and youth. This could for example seek to connect school based mental health professionals with broader networks for purpose of referral, communication and even shared professional development.
- Seek multi-agency commitment to coordinated access by people with severe mental illness to health and broader social support services in the region.
- Plan for integrated approaches to supporting people with mental illness to gain employment and/or broader vocational support

4.6 Integration with the National Disability Insurance Scheme (NDIS)

In planning for the needs of people with severe mental illness who experience a functional impairment it will be vital to provide a platform for joint planning arrangements which ensure that the NDIS has appropriate links with mainstream mental health services. Mental health services and broader health services will need to continue to cater for clinical and physical health needs of people who are eligible for the NDIS and planning and pathways should accommodate this.

An earlier section of this guidance explained the role of regional planning in relation to the needs of people with severe mental illness who are not eligible for the NDIS. Specifically there will be a need to plan for psychosocial support services for people with severe mental illness and reduced psychosocial capacity who are not eligible for entry into the NDIS. The NGO sector providing services under the NDIS may also be likely to support service provision to this group.

In planning for integration with the NDIS, consultation and linkages with the Local Area Coordinators (LACs) and with the NDIA will be vital to ensure continuing clear communication about service infrastructure and the status of the planned rollout of the NDIS. Implementation of the NDIS is also impacting the shape and capacity of the NGO community services sector. Mapping both the current and anticipated future capacity of the NGO sector will be important to regional planning.

4.7 Planning for the interface with alcohol and other drug services

For some jurisdictions, a joint planning approach to mental health and drug and alcohol services is expected, as outlined in the jurisdiction specific sections of the attached compendium. In general, however, governments do not require or expect regional mental health and suicide prevention plans to also encompass detailed service planning for drug and alcohol services. For most jurisdictions, planning for drug and alcohol services takes place through a separate process.

However governments would expect linkages to drug and alcohol services to be considered as part of the regional plan, and consideration of how to provide better integrated care for people with comorbid mental illness and substance misuse problems. The regional planning offers an opportunity to address the disconnection between specialist drug and alcohol services, primary care and state mental health services which has presented a problem to people with comorbid mental illness and substance misuse problems, or who are at risk of substance misuse because of mental health problems. There may be opportunities through regional planning to:

- Promote integration between the drug and alcohol and mental health sectors – particularly between primary care and specialist drug services;
- Consider provision of integrated services in a single location for people with comorbidity or for other forms of integrated service delivery; and
- Consider provision of integrated local preventive activity associated with reducing the impact of mental illness and substance misuse, given the shared protective factors and the importance to both of early intervention.

For the purposes of this Guide, the terms below have the following meanings.

Aboriginal Community Controlled Health Services (ACCHS) A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health service to the community that controls it, through a locally elected Board of Management.

Carer A person who cares for or otherwise supports a person living with mental illness. A carer has a close relationship with the person living with mental illness and may be a family member, friend, neighbour or member of a broader community.

Community supports Non-clinical services in the community that assist people living with mental illness to live meaningful and contributing lives and support them in their recovery. These may include services that relate to daily living skills, self-care and self-management, physical health, social connectedness, housing, education and employment.

Community managed sector The community managed sector is predominantly made up of not-for-profit organisations providing community-based support services that help keep people well in the community.

Comorbidity The presence of one or more diseases or disorders in a person, in addition to a primary disease or disorder.

Consumer A person living with mental illness who uses, has used or may use a mental health service.

Early intervention The early identification of risk factors and provision of timely treatment, care or support for people experiencing early signs and symptoms of mental illness. It aims to prevent the incidence, severity and impact of mental illness.

Gayaa Dhuwi (Proud Spirit) Declaration A declaration on Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

Governments Commonwealth, state and territory governments.

Lived experience (mental illness) People with lived experience are people who identify either as someone who is living with (or has lived with) mental illness or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness. People with lived experience are sometimes referred to as consumers and carers.

²³ Adapted from Glossary in the Fifth National Mental Health and Suicide Prevention Plan.

Lived experience (suicide) People who think about suicide, people who have attempted suicide, people who care for someone with suicidal behaviour, people who are bereaved by suicide, and people who are impacted by suicide in some other way, such as a workplace incident.

Local Hospital Networks (LHNs) Entities established by state and territory governments to manage single or small groups of public hospital services, including managing budgets and being directly responsible for performance. Most, but not all, LHNs are responsible for managing public hospital services in a defined geographical area. At the discretion of states and territories, LHNs may also manage other health services such as community-based health services. LHNs may have different names in some jurisdictions.

Mental disorder See mental illness.

Mental health The World Health Organization defines mental health as a state of wellbeing in which every person realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.

Mental health service system Comprises all services that have a primary function of providing treatment, care or support to people living with mental illness and/or their carers.

Mental health problem Diminished cognitive, emotional or social abilities but not to the extent that the diagnostic criteria for a mental illness are met.

Mental illness A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders, and schizophrenia.

National Disability Insurance Scheme (NDIS) Provides eligible participants with permanent and significant disability with the reasonable and necessary supports they need to enjoy an ordinary life. The NDIS also connects people with disability and their carers, including people who are not NDIS participants and their carers, to supports in their community.

National Mental Health Service Planning Framework (NMHSPF) A framework to guide evidence-based decision-making about the mix and level of mental health services and workforce needed to meet local circumstances.

National Mental Health Strategy A framework to guide mental health reform. It includes the National Mental Health Policy, the Mental Health Statement of Rights and Responsibilities and four successive National Mental Health Plans.

National Safety and Quality Health Service (NSQHS) Standards Standards that aim to protect the public from harm and improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure expected standards of safety and quality are met.

National Standards for Mental Health Services (NSMHS) Standards that assist in the development and implementation of appropriate practices and guide continuous quality improvement across the broad range of mental health services.

Non-Government Organisation (NGO) A not-for-profit, non-government organisation governed by a Board of Management. NGOs range from single-focus, locally based organisations to large national and international organisations working across a range of areas including but not limited to mental health.

Indicator A quantitative measure that is used to assess the extent to which a given objective has been achieved.

Peer worker Workers who have a lived experience of mental illness and who provide valuable contributions by sharing their experience of mental illness and recovery with others. Peer workers are employed across a range of service settings and perform a variety of roles, including providing individual support, delivering education programs, providing support for housing and employment, coaching and running groups and activities.

Person-centred Treatment, care and support that places the person at the centre of their own care and considers the needs of the person's carers.

Prevention (mental illness) Action taken to prevent the development of mental illness, including action to promote mental health and wellbeing and action to reduce the risk factors for mental illness.

Prevention (suicide) Action taken to reduce the incidence of suicide.

Primary Health Networks (PHNs) Entities contracted by the Commonwealth to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

Primary care Generally the first point of contact for people living with mental health problems or mental illness and their carers. Primary care providers include general practitioners, nurses, allied health professionals, pharmacists and Aboriginal and Torres Strait Islander health workers.

Promotion (mental illness) Action taken to promote mental health and wellbeing.

Psychosocial disability The disability experience of people with impairments and participation restrictions related to mental illness. These impairments and restrictions can include reduced ability to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives.

Recovery The National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers outlines that there is no single description or definition of recovery, because recovery is different for everyone. It notes that central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination. Some characteristics of recovery commonly cited are that it is a unique and personal journey; a normal human process; an ongoing experience and not the same as an end point or cure; a journey rarely taken alone; and nonlinear, with it

being frequently interspersed with both achievement and setbacks. It defines personal recovery as being able to create and live a meaningful and contributing life in a community of choice, with or without the presence of mental illness.

Regional level The level between the macro level of governments and micro level of service delivery. The regional level is where practical, targeted and locally appropriate action can be taken and strong community collaborations and partnerships can be formed.

Regional mental health and suicide prevention plan A plan agreed between LHNs and PHNs to embed planning for integrated mental health and suicide prevention services and pathways at a regional level. Joint regional plans should drive and inform evidence-based service development to address identified gaps and deliver on regional priorities. There are two different levels of regional mental health and suicide prevention plans discussed in this guide:

A **foundation plan** A joint regional mental health and suicide prevention plan for working together using existing resources and service systems. It may be pursued by LHN/PHN partnerships which do not have the capacity to develop a comprehensive service development plan. A foundation plan captures key partnerships, and agreed priorities to achieve improved outcomes and regional mental health and suicide prevention needs. A foundation plan supports immediate action towards integrated service delivery and lays the groundwork for and commits to future development of a comprehensive service development plan within the timeframes in this Guide.

A **comprehensive service development plan** is a more detailed regional plan which is informed by evidence based service planning tools and detailed service and workforce mapping. It supports objectives of both achieving integrated services and joint planning for future service development. It may be developed by LHNs and PHNs which already have significant capacity and partnerships in place. The development time and resources needed for such a plan would be greater than for a foundation plan.

Secondary care Care provided by medical specialists. Secondary care providers can include psychiatrists and psychologists.

Severe mental illness Characterised by a severe level of clinical symptoms and often some degree of disruption to social, personal, family and occupational functioning. Severe mental illness is often described as comprising three subcategories:

Severe and episodic mental illness—refers to people who have discrete episodes of illness interspersed with periods of minimal symptoms and disability or even remission. This group comprises about two-thirds of all adults who have a severe mental illness.

Severe and persistent mental illness—refers to people with a severe mental illness where symptoms and/or associated disability continue at moderate to high levels without remission over long period (years rather than months). This group represents about one-third of all adults who have a severe mental illness.

Severe and persistent illness with complex multi-agency needs—refers to people with severe and persistent illness whose symptoms are the most severe and who are the most disabled. The most intensive clinical care (assertive clinical treatment in the community

often supplemented by hospitalisation), along with regular non-clinical support from multiple agencies, is required to assist the person in managing their day-to-day roles in life (for example, personal and housing support). This group is relatively small (approx. 0.4 per cent of adult population, or 60 000 people) and is the group targeted for Tier 3 packages under the NDIS.

Severe and complex mental illness Refers to mental illness that is not directly aligned to any one of the above subcategories of severe mental illness. Rather, it is broader and may include episodic or chronic (persistent) conditions that are not confined to specific diagnostic categories. While incorporating severely disabled people (that is, people with persistent illness with complex multi-agency needs), it also includes people who have complexities that are not disability related— for example, people who have a severe mental illness comorbid with a chronic physical illness; people who may have no functional impairment arising from their mental illness but whose illness is adversely impacted on by complex social factors; people with multiple recurrent acute episodes that require frequent hospital care; people who present a high suicide risk; or people who have a need for coordinated assistance across a range of health and disability support agencies.

Social and emotional wellbeing Refers to the Aboriginal and Torres Strait Islander view of health. This view is holistic and includes mental health and other factors such as the social, spiritual and cultural wellbeing of people and the broader community.

Social inclusion The opportunity for people to participate in society through employment and access to services; connect with family, friends, personal interests and the local community; deal with personal crises; and have their voices heard.

Specialised mental health services Include services provided by psychiatric hospitals, psychiatric units or wards in hospitals, community mental health care services and residential mental health services.

Stepped care An evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to a person's needs. Within a stepped care approach, a person is supported to transition up to higher-intensity services or transition down to lower-intensity services as their needs change.

Suicidal behaviours A range of behaviours that include thinking about suicide (ideation), planning a suicide, attempting suicide and taking one's own life.

Trauma informed care and practice An organisational and practice approach to delivering health and human services directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and its prevalence in society. It is a strengths-based framework that emphasises physical, psychological and emotional safety for consumers, their families and carers, and service providers.

Your Experience of Service (YES) survey Gathers information from consumers about their experiences of care and aims to help mental health services and consumers to work together to build better services.