Country SA PHN

Primary Mental Health Care Activity Work Plan 2016-17

phn COUNTRY SA

An Australian Government Initiative

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1. (a) Strategic Vision

The National Mental Health Commission's Review of Mental Health Programmes and Services 'Contributing Lives, Thriving Communities', highlighted the existing complexity, inefficiency and fragmentation of the mental health system.

The Review further highlighted problems with the current targeting of mental health resources and pointed to the need for efficiencies to prevent both under-servicing and over-servicing.

Country SA PHN's (CSAPHN) approach to addressing the mental health and suicide prevention priorities lies within its mandate and objectives of:

- increasing the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and;
- Improving the coordination of care to ensure patients receive the right care in the right place at the right time.

The stepped care approach is a central reform priority, with a focus on service delivery matching the needs of individuals and with a particular emphasis on early intervention and self-care.

The approach promotes person centred care which targets the needs of the individual. It recognises individual needs can change and allows flexibility to move across service levels to most effectively support recovery facilitates receiving the right level of care in the right place at the right time.

To meet these key organizational and primary mental health care objectives CSAPHN utilises robust commissioning principles via adoption of the recommended PHN framework. These principles include the adoption of a continuous improvement cycle focussed on Strategic Planning, Appropriate Service Procurement and Monitoring and Evaluation.

Needs Assessment activity inclusive of key stakeholder consultation occurring throughout provides an important element toward assessing and prioritising need. It also provides the basis for evidence based annual planning and will flow into our regional mental health and suicide prevention planning. The completed plan will provide overarching collaborative leadership and guidance while identifying needs and gaps, reducing duplication, removing inefficiencies and encouraging innovation.

Country SA PHN approach and vision towards a joint Mental Health and Alcohol and Other Drugs (MHAOD) System Reform

Population estimates indicate that more than two thirds of individuals with an Alcohol and Other Drugs (AOD) use disorder have at least one comorbid mental health disorder; however the rate is even higher among those in AOD treatment programs. Additionally, there are a large number of people who present to AOD treatment who display symptoms of disorders while not meeting criteria for a diagnosis of a disorder. These estimates can also apply for people presenting to mental health services with an AOD use disorder.

Because of this significant relationship between MH&AOD, CSAPHN is combining their reform and commissioning approach to encourage as much synergy as possible between the treatment models and promote a seamless system of care across both MH&AOD to maximize commonalities and simplify system navigation and the patient journey.

In response to the Commonwealth MH&AOD reforms, the Country SA PHN is inviting MH&AOD service providers, consumers and other interested parties to actively contribute towards a co-design of a new and more effective primary MH&AOD treatment service system within a stepped care approach.

This invitation is extended to providers across the continuum, including frontline service delivery; training, education and promotion; prevention; and early intervention.

The Invitation to Apply (ITA) was released April 1st to test the market for new and innovative approaches providing the opportunity for intense collaboration and co-creation towards an integrated and coordinated stepped care model of care.

Information and content were derived from guidance material provided by the Department prior to a formal funding offer and schedule tabled in late April.

The approach allows service providers in the region to:

- actively participate in MH&AOD treatment reform; identify hard to reach and vulnerable populations;
- contribute to the creation of a new system (over time) which is coordinated, integrated, provides quality effective and efficient services and is fair and equitable;
- ensure services are being delivered to the community where and when they need them;
- promote better collaboration, connection, partnership and coordination of care (across the stepped care approach).
- Manage stakeholder expectations throughout the staged reform process.

Applicants are asked to identify and apply for service streams of interest and provide a model of care within a stepped care framework.

The six priorities this process was guided by included:

1. Appropriately support people with, or at risk of, mild mental illness through development and/or commissioning of low intensity mental health services;

2. Support region-specific, cross sectoral approaches for children and young people with, or at risk of, mental illness, including those with severe mental illness being managed in primary care;

3. Address service gaps in the provision of psychological therapies for people in rural and remote areas and other under-serviced and/or hard to reach populations;

4. Support clinical care coordination for people with severe and complex mental illness;

5. Encourage and promote a regional approach to suicide prevention; and

6. Enhance and better integrate Aboriginal and Torres Strait Islander mental health services at a local level.

These six priorities form the basis of the five mental health service streams of activity (inclusive of Child and Youth mental health) applicants are able to apply for.

These include:

- Low Intensity services
- Psychological therapies for underserviced groups
- Severe mental illness
- Suicide prevention
- ATSI mental health services

As a result specifics of activity highlighted in this workplan will be subjective to an evaluation and review of proposed activity from the ITA process which closes April 29.

Country SA PHN has sought to be proactive within the market and maximise the short timeframes in order to deliver a process which is as much in line with the commissioning principles and PHN tendering ideals as realistically possible.

Rationale and further information of the process are included within activity commissioning details.

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

Proposed Activities	
Priority Area 1: Low intensity mental health services	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • improve targeting of psychological interventions to most appropriately support people with or at risk of mild mental illness at the local level through the development and/or commissioning of **low intensity mental health services.**
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**1.1 headspace Transition to Country SA PHN (CSAPHN)** CSAPHN Priority Area: Lack of mental health support for young people **1.2 Group therapy provided to women with or at risk of perinatal depression** CSAPHN Priority Area: Perinatal Mental Health **1.3 Country SA PHN, Mental Health Alcohol Other Drugs (MHAOD) Invitation To Apply (ITA)** CSAPHN Priority Area: Health service coordination and integration, Mental Health & Drug and Alcohol Comorbidity, Properly integrated and holistic service **1.4 Development of community education and training for men in rural areas.** CSAPHN Priority Areas: Community education and training opportunities for sector staff, Rural and male specific suicide prevention services and activity.
Description of Activity(ies) and rationale (needs assessment)	**1.1 Aim of activity**

	Refunding of all headspace lead agencies in our region, including those yet to be established and maintain service delivery within headspace centres in line with the 2015-16 service delivery model as directed by the Department. **How the activity will address the priority** The activity will continue to provide early intervention services for young people with or at risk of mild mental illness as well as making it easy as possible for a young person and their family to get the help they need for problems affecting their wellbeing. This covers four core areas: mental health, physical health, work and study support and alcohol and other drug services. **Target population cohort** 12-25 year olds across the current four sites. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • include targeting population groups for low intensity mental health services in their regional mental health and suicide prevention planning; • promote resources for clinical and non-clinical professionals available under the National Centre of Excellence for Youth Mental Health; **1.2 Aim of activity** To identify, further develop and/or commission group therapy to women with or at risk of perinatal depression **How the activity will address the priority** Will meet the priority by identifying existing successful programs and building their capacity to expand models into further areas and regions of need providing women with or at risk of perinatal depression, their families and their GPs with more services and options in their communities. **Target population cohort** Women with or at risk of perinatal depression **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to:

	• include targeting population groups for low intensity mental health services in their regional mental health and suicide prevention planning; • commence the development of appropriate low intensity mental health service models for their region in line with regional plans **1.3 Aim of activity** Co-Design of activity with providers pending successful ITA applicant process to develop and/or commission low intensity mental health services to supplement online mental health therapies. **How the activity will address the priority** The Mental Health Alcohol Other Drugs ITA address the six Mental Health Priority Areas across five service streams of activity (inclusive of Child and Youth mental health) all required to be across the stepped care approach. Submissions received for Low Intensity Mental Health Services for early intervention while showing innovation and a variety of approaches largely missed the brief of providing efficient low cost alternatives to existing clinical services. CSAPHN will seek to progress the priority by incorporating it into all funded activity via • promoting the Digital Mental Health Gateway as a mechanism to deliver low intensity services; • utilising existing/established resources, in particular Commonwealth funded online and telephone based mental health treatment services; • connecting with local headspace centres; and • providing evidence based psychological intervention (e.g. cognitive behaviour therapy) to people with, or at risk of, mild mental illness (primarily anxiety and/or depressive disorders). CSAPHN is also exploring the funding of group therapy for women with or at risk of perinatal depression to support early intervention as described in 1.2. **Target population cohort** Communities identified and flagged through service gap and data analysis across the three identified needs within the CSAPHN catchment region**.** • young people with or at risk of mild mental illness;

	• women with or at risk of perinatal depression to support early intervention; and • men in rural areas. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • commence the development of appropriate low intensity mental health service models for their region in line with regional plans **1.4 Aim of activity** Research and sourcing and/or development of appropriate low intensity educational activities to promote awareness and community resilience and capacity building for men at risk of suicide. **How the activity will address the priority** Identified priority will be met by exploring peer support models, training and education and upskilling communities and local service providers **Target population cohort** Men 18-65+ **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • include targeting population groups for low intensity mental health services in their regional mental health and suicide prevention planning;
Collaboration	**1.1** CSAPHN will collaborate with headspace National Office to jointly identify lead agencies for new locations to be established in 2016 and in any other circumstances where a new lead agency needs to be appointed. As contract manager CSAPHN will have a relationship with lead agencies at all four rural sites. By proxy of the consortia model and requirements of headspace, centres will have a collaborative relationship and provision of primary care, mental health, alcohol and drug, and vocational services.

	1.2, 1.3, 1.4 Within the stepped care approach of the Mental Health Alcohol Other Drug ITA CSAPHN is seeking evidence of establishment and formalization of partnerships between organisations and services in the region to facilitate 'joined up' service provision, specifically between the: • mental health sector • alcohol and other drugs sector • broader primary health care environment • acute services • community services • aged care services • child and youth services • social services • Aboriginal health services All applicants must provide a response indicating how their proposed model will support partnerships, clinical handover and linkages. Including where applicable, how their intervention model will: • incorporate and formalise effective mechanisms to enable appropriate clinical handover of an individual's care. • ensure an individual's transition through the steps of care are seamless and appropriate. • have systems in place to support the integration and coordination of services. • support referrers, in particular General Practice, to ensure individuals are appropriately triaged to the most suitable "stepped-level" of treatment available. • support referrers, in particular General Practice, to ensure individuals are jointly monitored to determine the selected treatment effectiveness and further care decisions. • interact with the broader social services sector. • engage with the local health networks and acute sector.
Duration	**1.1** 2016/17 – 18 (2 years) **1.2, 1.3, 1.4** 2016/17 – 18 (1 or 2 years)

Coverage	**1.1** Current headspace sites across the CSAPHN region; • Berri • Mount Gambier • Murray Bridge • Port Augusta **1.2, 1.3,1.4** Potential regions as defined - appendix A
Commissioning approach	Where applicable, Country SA PHN as adopted a competitive Most Capable Provider (MCP) approach to the market as a tendering and contract mechanism for 2016/17. We have adapted it to be competitive through an Invitation to Apply (ITA) process as a means of pre-selection. The approach is also inclusive of an Independent Commissioning Committee (ICC) which will endorse and approve all procurement over $200k. We have chosen this approach as we are seeking innovative solutions and wish to work with potential providers to develop the new stepped care service model. We also acknowledge that within some streams of activity there are existing successful programs still delivering services in scope by a clear most capable group of providers eg ATAPS, MHSSRA and activity we are required to fund back for 2 years, such as headspace and MHNIP activity. Across the CSAPHN rural and remote areas we also have unique challenges surrounding provider numbers, recruitment and retention of staff and a smaller pool of providers within some of our markets. The adopted ITA process will identify the most appropriate providers within streams of activity and regions of CSAPHN to engage with for progression and development of the six service streams within mental health and the overall system reform agenda. All contracted services will be monitored and evaluated in accordance with direction from provided schedules for activity and via the overarching performance and commissioning frameworks of the PHN.
Performance Indicator	The mandatory performance indicators for this priority are:

	• Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services. • Average cost per PHN-commissioned mental health service – Low intensity services. • Clinical outcomes for people receiving PHN-commissioned low intensity mental health services.
Local Performance Indicator target (where possible)	**1.1** As per headspace schedule and contracted deliverables **1.2, 1.3, 1.4** To be confirmed post ITA and following Co-design process, will be inclusive of but not limited to: • # of clients identified as at risk of, mild mental illness • # of clients receiving an evidence based psychological intervention • # of clients referred without a GP referral • # of clients utilising the Digital Mental Health Gateway • Modality of delivery format used (e.g. individual, group, telephone and web-based services, face-to-face, and combinations of modalities)
Local Performance Indicator Data source	The following data sources will be used to monitor progress against the performance indicators: • GP practice data obtained by CSAPHN through data sharing agreements. • PHN available datasets related to mental health such as Mental Health Nurse Incentive Programme, Access to Allied Psychological Services, and mental health specific MBS item numbers. • Service schedule performance and reporting requirements from contracted services • CSAPHN internal data collection and reporting, including provider survey and community survey methods in alignment with CSAPHN ongoing stakeholder consultation and engagement. Data specific to the evaluation of this activity will commence July 1st 2016.

Proposed Activities	
Priority Area 2: Youth mental health services	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • support region-specific, cross sectoral approaches to early intervention for **children and young people** with, or at risk of mental illness (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group.
Activity(ies) / Reference (e.g. Activity 2.1, 2.2, etc)	**2.1 headspace Transition to Country SA PHN (CSAPHN)** CSAPHN Priority Area: Lack of mental health support for young people **2.2 Country SA PHN, Mental Health Alcohol Other Drugs (MHAOD) Invitation To Apply (ITA)** CSAPHN Priority Area: Health service coordination and integration, Mental Health & Drug and Alcohol Comorbidity, Properly integrated and holistic service
Description of Activity(ies) and rationale (needs assessment)	**2.1 Aim of activity** Refunding of all headspace lead agencies in our region, including those yet to be established and maintain service delivery within headspace centres in line with the 2015-16 service delivery model as directed by the Department. **How the activity will address the priority** The activity will continue to provide early intervention services for young people with or at risk of mild mental illness as well as making it easy as possible for a young person and their family to get the help they need for problems affecting their wellbeing. This covers four core areas: mental health, physical health, work and study support and alcohol and other drug services. **Target population cohort** 12-25 year olds across the current four sites. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to:

	• maintain service delivery within headspace centres, in line with the existing headspace service delivery model; • improve the integration of headspace centres with broader primary mental health care services; physical health services; drug and alcohol services; and social and vocational support services; **2.2 Aim of activity** Co-Design of activity with providers pending successful ITA applicant process to develop and/or commission primary mental health care. **How the activity will address the priority** The MHAOD ITA address the six Mental Health Priority Areas across five service streams of activity (inclusive of Child and Youth mental health) all activity is required to be across the stepped care approach. While some applicants targeted children and young people with, or at risk of mental illness as a priority area across the various priority streams, CSAPHN intends to better explore additional service provision in this field when further funding becomes available in 2017/18. **Target population cohort** Communities identified through service gaps and data analysis across the three identified needs within the CSAPHN catchment region. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • commence the development and delivery of early intervention services for young people with, or at risk of, severe mental illness; • support service continuity for children and young people formerly provided under ATAPS and other mental health programs.
Collaboration	**2.1** CSAPHN will collaborate with headspace National Office to jointly identify lead agencies for new locations to be established in 2016 and in any other circumstances where a new lead agency need to be appointed. As the contracts manager CSAPHN will have a relationship with lead agencies at all four rural sites.

	By proxy of the consortia model and requirements of headspace, centres will have a collaborative relationship and provision of primary care, mental health, alcohol and drug, and vocational services. **2.2** Within the stepped care approach of the Mental Health Alcohol Other Drugs ITA, CSAPHN is seeking evidence of establishment and formalization of partnerships between organisations and services in the region to facilitate 'joined up' service provision, specifically between the: • mental health sector • alcohol and other drugs sector • broader primary health care environment • acute services • community services • aged care services • child and youth services • social services • Aboriginal health services All applicants to the ITA must provide a response indicating how their proposed model will support partnerships, clinical handover and linkages. Including where applicable, how their intervention model will: • incorporate and formalise effective mechanisms to enable appropriate clinical handover of an individual's care. • ensure an individual's transition through the steps of care are seamless and appropriate. • have systems in place to support the integration and coordination of services. • support referrers, in particular General Practice, to ensure individuals are appropriately triaged to the most suitable "stepped-level" of treatment available. • support referrers, in particular General Practice, to ensure individuals are jointly monitored to determine the selected treatment effectiveness and further care decisions. • interact with the broader social services sector. • engage with the local health networks and acute sector.
Duration	**2.1** 2016/17 – 18 (2 years)

	2.2 2016/17 – 18 (1-2 years)
Coverage	**2.1** Current headspace sites across the CSAPHN region; • Berri • Mount Gambier • Murray Bridge • Port Augusta **2.2** As per MHAOD defined regions - appendix A
Commissioning approach	**2.1** Contract for 2 years and maintain service delivery within headspace centres, in line with the existing headspace service delivery model. **2.2** Where applicable, Country SA PHN as adopted a competitive Most Capable Provider (MCP) approach to the market as a tendering and contract mechanism for 2016/17. We have adapted it to be competitive through an Invitation to Apply (ITA) process as a means of pre-selection. The approach is also inclusive of an Independent Commissioning Committee (ICC) which will endorse and approve all procurement over $200k. We have chosen this approach as we are seeking innovative solutions and wish to work with potential providers to develop the new stepped care service model. We also acknowledge that within some streams of activity there are existing successful programs still delivering services in scope by a clear most capable group of providers eg ATAPS, MHSSRA and activity we are required to fund back for 2 years, such as headspace and MHNIP activity. Across the CSAPHN rural and remote areas we also have unique challenges surrounding provider numbers, recruitment and retention of staff and a smaller pool of providers within some of our markets.

	The adopted ITA process will identify the most appropriate providers within streams of activity and regions of CSAPHN to engage with for progression and development of the six service streams within mental health and the overall system reform agenda. All contracted services will be monitored and evaluated in accordance with direction from provided schedules for activity and via the overarching performance and commissioning frameworks of the PHN.
Performance Indicator	The mandatory performance indicator for this priority is: • Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services.
Local Performance Indicator target (where possible)	**2.1** As per headspace schedule and contracted deliverables **2.2** To be confirmed post ITA and co-design process depending on which stream the priority is targeted under for 2016/17.
Local Performance Indicator Data source	CSAPHN monitors multiple indicators of mental health, such as MBS, MHNIP, ATAPS, as well as GP data. The following data sources will be used to monitor progress against the performance indicators: • Service schedule performance and reporting requirements from contracted services • PHN available datasets related to mental health such as Mental Health Nurse Incentive Programme, Access to Allied Psychological Services, and mental health specific MBS item numbers. • CSAPHN internal data collection and reporting, including provider survey and community survey methods in alignment with CSAPHN ongoing stakeholder consultation and engagement. Data specific to the evaluation of this activity will commence July 1st 2016.

Proposed Activities	
Priority Area 3: Psychological therapies for rural and remote, under-serviced and /or hard to reach groups	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • address service gaps in the provision of psychological therapies for people in **rural and remote areas and other under-serviced and/or hard to reach populations**, making optimal use of the available service infrastructure and workforce.
Activity(ies) / Reference (e.g. Activity 3.1, 3.2, etc)	**3.1 Continuation/transition of existing ATAPS and MHSRRA services** CSAPHN priority area: Increased access of services to areas of high disadvantage **3.2 Country SA PHN, Mental Health Alcohol Other Drugs (MHAOD) Invitation To Apply (ITA)** CSAPHN Priority Area: Health service coordination and integration, Mental Health & Drug and Alcohol Comorbidity, Properly integrated and holistic service
Description of Activity(ies) and rationale (needs assessment)	**3.1 Aim of activity** To ensure priority is given to individuals that are engaged in counselling services through the Access to Allied Psychological Services (ATAPS) Program and Mental Health Services in Rural and Remote Areas (MHSRRA) Program. ATAPS and MHSRRA activity from the previous financial year have been included within the CSAPHN Mental Health Alcohol Other Drugs ITA process. This process has been put in place to safeguard continuity of care and is inclusive of a 3 month transition period if new providers of care have been identified via the ITA for engagement 1 July 2016. **How the activity will address the priority** The Access to Allied Psychological Services (ATAPS) initiative provided access to effective, low cost treatment for people with a mental illness who may not otherwise be able to access services.

	The Mental Health Services in Rural and Remote Areas (MHSRRA) program delivered mental health services in rural and remote communities that would otherwise have little or no access to these services. By ATAPS and MHSSRA being inclusive under the Mental Health Alcohol Other Drugs ITA it ensures that if a new provider is identified the spirit and obligations of the current program will be maintained and transferred with clients to any new successful applicant. The above ethos of the previous funded programs fits within the goals of priority 3. CSAPHN hopes to further develop and evolve the programs within the Stepped Care model over the next 3 years. **Target population cohort** People in rural and remote areas and other under-serviced and/or hard to reach populations. In particular, population groups that may be underserviced include (but are not limited to): • people living in rural and remote communities; • children under the age of 12 years; • people experiencing, or at risk of, homelessness; • women experiencing perinatal depression; • people from culturally and linguistically diverse (CALD) backgrounds; and • population groups that are the subject of separate guidance material (Aboriginal and Torres Strait Islander people, people at risk of suicide and young people). **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • ensure service continuity for existing clients (where clinically appropriate to needs) in the first year, noting that this may involve continuation of existing arrangements (eg ATAPS) to minimise disruptions to services in the first year; • promote awareness within commissioning arrangements of targeted recipients, referral pathways and service parameters.

	• Consider ways to achieve more cost efficient and targeted service delivery, including where appropriate referral of individuals to low intensity services. **3.2 Aim of activity** Co-Design of activity with providers pending successful ITA applicant process to develop and/or commission primary mental health care services across CSAPHN region. **How the activity will address the priority** The Mental Health Alcohol Other Drugs ITA address the six Mental Health Priority Areas across five service streams of activity (inclusive of Child and Youth mental health) all required to be across the stepped care approach. After applications from the ITA were considered the existing providers of ATAPS and MHSRRA were found to be the most competent providers for Psychological Therapies for underserviced groups through our region. While some applicants displayed a willingness and displayed some sound modelling they failed to prove a superior model and approach to the incumbents across regional scope, clinical governance and experience. **Target population cohort** Communities identified and flagged through service gap and data analysis across the three identified needs within the CSAPHN catchment region, with a priority towards people in rural and remote areas and other under-serviced and/or hard to reach populations. In particular, population groups that may be underserviced include (but are not limited to): • people living in rural and remote communities; • children under the age of 12 years; • people experiencing, or at risk of, homelessness; • women experiencing perinatal depression; • people from culturally and linguistically diverse (CALD) backgrounds; and • population groups that are the subject of separate guidance material (Aboriginal and Torres Strait Islander people, people at risk of suicide and young people).

	Alignment with the PHN mental health funding objectives This will align with expectations for 2016/17 to: • Commence the development of appropriate primary mental health care service models for in line with regional plans, avoiding replication of service through currently funded activity.
Collaboration	**3.1, 3.2** Within the stepped care approach of the Mental Health Alcohol Other Drugs ITA, CSAPHN is seeking evidence of establishment and formalization of partnerships between organisations and services in the region to facilitate 'joined up' service provision, specifically between the: • mental health sector • alcohol and other drugs sector • broader primary health care environment • acute services • community services • aged care services • child and youth services • social services • Aboriginal health services All applicants must provide a response indicating how their proposed model will support partnerships, clinical handover and linkages. Including where applicable, how their intervention model will: • incorporate and formalise effective mechanisms to enable appropriate clinical handover of an individual's care. • ensure an individual's transition through the steps of care are seamless and appropriate. • have systems in place to support the integration and coordination of services. • support referrers, in particular General Practice, to ensure individuals are appropriately triaged to the most suitable "stepped-level" of treatment available. • support referrers, in particular General Practice, to ensure individuals are jointly monitored to determine the selected treatment effectiveness and further care decisions. • interact with the broader social services sector. • engage with the local health networks and acute sector.

Duration	**3.1, 3.2** 2016/17 - 18 (1 or 2 years)
Coverage	**3.1, 3.2** As per MHAOD defined regions – appendix A
Commissioning approach	Where applicable, Country SA PHN as adopted a competitive Most Capable Provider (MCP) approach to the market as a tendering and contract mechanism for 2016/17. We have adapted it to be competitive through an Invitation to Apply (ITA) process as a means of pre-selection. The approach is also inclusive of an Independent Commissioning Committee (ICC) which will endorse and approve all procurement over $200k. We have chosen this approach as we are seeking innovative solutions and wish to work with potential providers to develop the new stepped care service model. We also acknowledge that within some streams of activity there are existing successful programs still delivering services in scope by a clear most capable group of providers eg ATAPS, MHSSRA and activity we are required to fund back for 2 years, such as headspace and MHNIP activity. Across the CSAPHN rural and remote areas we also have unique challenges surrounding provider numbers, recruitment and retention of staff and a smaller pool of providers within some of our markets. The adopted ITA process will identify the most appropriate providers within streams of activity and regions of CSAPHN to engage with for progression and development of the six service streams within mental health and the overall system reform agenda. All contracted services will be monitored and evaluated in accordance with direction from provided schedules for activity and via the overarching performance and commissioning frameworks of the PHN.
Performance Indicator	The mandatory performance indicators for this priority are:

	• Proportion of regional population receiving PHN-commissioned mental health services – Psychological therapies delivered by mental health professionals. • Average cost per PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals. • Clinical outcomes for people receiving PHN-commissioned Psychological therapies delivered by mental health professionals. • Promote awareness within commissioning arrangements of targeted recipients, referral pathways and service parameters.
Local Performance Indicator target (where possible)	**3.1, 3.2** To be based on previous ATAPS and MHSRRA schedule and contracted deliverables including: The performance of the Contractor will be monitored against two groups of indicators: a. **service delivery** – these are designed to asses overall delivery of the activity in terms of the volume and targeting of services delivered in 2015/16; b. **programme management** – these are designed to assess Contractor management of the activity in 2016/17. **Service delivery indicators** Indicator: Number of clients and sessions delivered to the identified region population. Targets: Regional client numbers and sessions provided by CSAPHN be met or exceeded. **Low Intensity indicators** Indicator: Number of clients and sessions delivered to the identified region population. Targets: Regional client numbers and sessions provided by CSAPHN be met or exceeded. **Programme management indicators** The Contractor will be expected to report on a qualitative basis progress against each indicator in their Six and Twelve monthly reports. a. Governance and standards Indicator: Extent to which clinical governance processes are in place and being managed according to national, state and local standards, including the National Mental Health Standards 2010. Target: Fully achieved by 30 June 2017.

	Data source: 6 and 12 monthly reports. b. Stepped Care Model and System Reform Indicator: Extent to which stepped care processes are being progressed and integrated into operation and governance practices. Target: Progress achieved by 30 June 2017. Data source: 6 and 12 monthly reports. Timely reporting of MDS Indicator: Extent to which client and sessional data, including pre and post treatment outcome scores (and where applicable 90 day scores) for each client, has been entered into the MDS. Target: 100% compliance for each reporting period. Data source: 6 and 12 monthly reports. e. Financial management Indicator: Extent to which income and expenditure is managed in a financially appropriate manner that aligns with the Operational Guidelines and does not exceed 15% for administration expenses. Target: 100% compliance for each reporting period. Data source: 6 and 12 monthly reports.
Local Performance Indicator Data source	The following data sources will be used to monitor progress against the performance indicators: • Service schedule performance and reporting requirements from contracted services • GP practice data obtained by CSAPHN through data sharing agreements. • PHN available datasets related to mental health such as Mental Health Nurse Incentive Programme, Access to Allied Psychological Services, and mental health specific MBS item numbers. • CSAPHN internal data collection and reporting, including provider survey and community survey methods in alignment with CSAPHN ongoing stakeholder consultation and engagement. Data specific to the evaluation of this activity will commence July 1st 2016.

Proposed Activities	
Priority Area 4: Mental health services for people with severe and complex mental illness including care packages	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • commission primary mental health care services for people with severe mental illness being managed in primary care, including clinical care coordination for people with **severe and complex mental illness** who are being managed in primary care including through the phased implementation of primary mental health care packages and the use of mental health nurses.
Activity(ies) / Reference (e.g. Activity 4.1, 4.2, etc)	**4.1 Continuation/transition of existing Mental Health Nurse Incentive Program (MHNIP) services** CSAPHN Priority Area: Increased access to services to areas of high disadvantage **4.2 Country SA PHN, Mental Health Alcohol Other Drugs ITA** CSAPHN Priority Area: Health service coordination and integration, Mental Health & Drug and Alcohol Comorbidity, Properly integrated and holistic service **4.3 Support currently funded Partners in Recovery (PIR) programs while allowing for flexibility and innovation within system reform and transition to the National Disability Insurance Scheme (NDIS)** CSAPHN Priority Area: Build local capacity, resilience and sustainability of services, Develop solutions that meet a community's need and Commission services that are efficient, effective and equitable
Description of Activity(ies) and rationale (needs assessment)	**4.1 Aim of activity** To continue to provide services at current capacity to MHNIP clients with current providers for the next 12 months and where possibly expand program to other under serviced regions across the CSAPHN region. **How the activity will address the priority** This activity meets the mandate that CSAPHN must commission at a minimum, the same eligible MHNIP organisations across the region. **Target population cohort**

	GPs and psychiatrists determine clients that are eligible for services under the MHNIP across the CSAPHN region. Individuals that access the MHNIP program have a diagnosed mental health disorder that is significantly impacting their social, personal and work life or an individual that has been to hospital at least once for treatment of their mental disorder, or they are at risk of needing hospitalisation in the future if appropriate treatment and care is not provided. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • promote awareness within commissioning arrangements of targeted recipients, referral pathways and service parameters. • Consider ways to achieve more cost efficient and targeted service delivery, including where appropriate referral of individuals to low intensity services. **4.2 Aim of activity** Co-Design of activity with providers pending successful ITA applicant process to develop and/or commission primary mental health care services across CSAPHN region. **How the activity will address the priority** The MHAOD ITA addresses the six Mental Health Priority Areas across five service streams of activity (inclusive of Child and Youth mental health) all required to be across the stepped care approach. Applicants across Severe Mental Illness varied from existing and potential MHNIP providers and others offering new innovative activity. This approach addresses the priority in two ways with what is expected of the PHN in 2016/17. 1. CSAPHN has a mandate to refund current MHNIP providers back for the next 12 months which equates to half the annual funding pool. Existing providers were identified and requested to put in an application as part of the ITA process for refunding and any other requests surrounding increase of service or further innovation under the provided guidance; 2. The ITA allowed submissions for proposed models of activity under the broader approach of the priority area including: service integration and coordination objectives as well as GP management of patient care, which CSAPHN will explore with any excess funds left over after the refunding of previous MHNIP activity.

	CSAPHN acknowledges that direction regarding the continuation of MHNIP and substantial additional funding becomes available in 2017/18 and seeks to further evolve the Priority Area and its broader vision further as restrictions and flexibility of resources become more freely available. **Target population cohort** Communities identified and flagged through service gaps and data analysis across the identified needs within the CSAPHN catchment region. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • Commence the development of appropriate mental health models that are in line with regional plans, avoiding replication of service through currently funded activity. **4.3 Aim of activity** System reform and sector capacity building projects will no longer be funded within PIR as the programs will focus on their transition phase to supporting the NDIS rollout. CSAPHN will work with PIR programs within its catchment region to support this transition of system reform agenda and activity. CSAPHN will also remain the lead agency for Country North SA PIR for 2016/17 and will be responsible directly for the first phase of transition activity with NDIS for the next 12 months. **How the activity will address the priority** PIR aims to better support people with severe and persistent mental illness with complex needs, and their carers and families, by getting services and supports from multiple sectors they may come into contact with (and could benefit from) to work in a more collaborative, coordinated, and integrated way. PIR will facilitate better coordination of and more streamlined access to the clinical and other service and support needs of people experiencing severe and persistent mental illness with complex needs requiring a multi-agency response. PIR funding is transitioning to the NDIS. To ensure service continuity during transition and to support client transition to the NDIS, the Australian Government has extended the Program to 30 June 2019.

	The focus of the transition phase of the Program is to support the NDIS rollout. PIR organisations will ensure service continuity for existing clients and: • assist PIR clients to test their eligibility for NDIS supports; • assist eligible clients to access NDIS supports; and • provide PIR services to NDIS participants during the transition phase. **Target population cohort** Individuals across the CSAPHN region who have a severe and persistent mental illness with complex support needs that require a response from multiple agencies. These individuals have persistent symptoms, significant functional impairment and psychosocial disability, and may have become disconnected from social or family support networks. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • Support system reform as per direction from the department
Collaboration	**4.1** Proposed funding model for Severe Mental Illness currently revolves around the Mental Health Nurse Incentive Program (MHNIP) and CSAPHN's requirement to provide contracts to existing providers under this program. **4.2** Within the stepped care approach of the Mental Health Alcohol Other Drugs ITA, CSAPHN is seeking evidence of establishment and formalization of partnerships between organisations and services in the region to facilitate 'joined up' service provision, specifically between the: • mental health sector • alcohol and other drugs sector • broader primary health care environment • acute services • community services • aged care services

	• child and youth services • social services • Aboriginal health services All applicants must provide a response indicating how their proposed model will support partnerships, clinical handover and linkages. Including where applicable, how their intervention model will: • incorporate and formalise effective mechanisms to enable appropriate clinical handover of an individual's care. • ensure an individual's transition through the steps of care are seamless and appropriate. • have systems in place to support the integration and coordination of services. • support referrers, in particular General Practice, to ensure individuals are appropriately triaged to the most suitable "stepped-level" of treatment available. • support referrers, in particular General Practice, to ensure individuals are jointly monitored to determine the selected treatment effectiveness and further care decisions. • interact with the broader social services sector. • engage with the local health networks and acute sector. **4.3** There are a number of sectors central to the success of this initiative – • primary care (health and mental health), • the state and territory specialist mental health systems, • the mental health and broader non-government sector, • alcohol and other drug treatment services, • income support services, • as well as education, employment and housing supports. CSAPHN will also collaborate intensely with its service provider COBH and the local NDIS office.
Duration	**4.1** 2016/17 **4.2**

	2016/17 – 18 (1 or 2 years) **4.3** 2016/19 – (3 years)
Coverage	**4.1** • Adelaide Hills • Angaston • Clare • Kapunda • Millicent • Yorke – Northern region • Bordertown **4.2** As per defined MHAOD regions – appendix A **4.3** Country North SA region (directly through CSAPHN Lead Agency)
Commissioning approach	Where applicable, Country SA PHN has adopted to be competitive through an Invitation to Apply (ITA) process as a means of pre-selection. The approach is also inclusive of an Independent Commissioning Committee (ICC) which will endorse and approve all procurement over $200k. We have chosen this approach as we are seeking innovative solutions and wish to work with potential providers to develop the new stepped care service model. We also acknowledge that within some streams of activity there are existing successful programs still delivering services in scope by a clear most capable group of providers eg ATAPS, MHSSRA and activity we are required to fund back for 2 years, such as headspace and MHNIP activity. Across the CSAPHN rural and remote areas we also have unique challenges surrounding provider numbers, recruitment and retention of staff and a smaller pool of providers within some of our markets.

	The adopted ITA process will identify the most appropriate providers within streams of activity and regions of CSAPHN to engage with for progression and development of the six service streams within mental health and the overall system reform agenda. All contracted services will be monitored and evaluated in accordance with direction from provided schedules for activity and via the overarching performance and commissioning frameworks of the PHN.
Performance Indicator	The mandatory performance indicators for this priority are: • Proportion of regional population receiving PHN-commissioned mental health services – Clinical care coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses). • Average cost per PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.
Local Performance Indicator target (where possible)	**4.1** As per current processes for contracted MHNIP sessions allocated to CSAPHN for services at current capacity **4.2** To be confirmed post ITA and co design process **4.3** As per PIR funding schedule
Local Performance Indicator Data source	The following data sources will be used to monitor progress against the performance indicators: • MHNIP program data (national dataset) • Service schedule performance and reporting requirements from contracted services • GP practice data obtained by CSAPHN through data sharing agreements. • Other PHN available datasets related to mental health such as mental health specific MBS item numbers.

	• CSAPHN internal data collection and reporting, including provider survey and community survey methods in alignment with CSAPHN ongoing stakeholder consultation and engagement. Data specific to the evaluation of this activity will commence July 1st 2016.

Proposed Activities	
Priority Area 5: Community based suicide prevention activities	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • encourage and promote a systems based regional approach to **suicide prevention** including community based activities and liaising with Local Hospital Networks (LHNs) and other providers to help ensure appropriate follow-up and support arrangements are in place at a regional level for individuals after a suicide attempt and for other people at high risk of suicide, including Aboriginal and Torres Strait Islander people.
Activity(ies) / Reference (e.g. Activity 5.1, 5.2, etc)	**5.1 A coordinated approach to suicide prevention across CSAPHN.** CSAPHN Priority Area: Service coordination and integration **5.2 Building strengths, partnerships, capacity & resilience in suicide prevention within Aboriginal Torres Strait Islander (ATSI) communities.** CSAPHN Priority Area: Culturally appropriate service provision **5.3 Improved support for individuals/communities who have been impacted by suicide, attempted suicide, self-harm or at high risk of suicide.** CSAPHN Priority Area: Coordination and continuity of care for rural, from acute to community care to facilitate a Stepped Care model **5.4 Support growth in male specific suicide prevention services and activity in regional South Australia.**

	CSAPHN Priority Area: Community education and training opportunities for sector staff, rural and male specific suicide prevention services and activities.
Description of Activity(ies) and rationale (needs assessment)	**5.1 Aim of activity** Manage stakeholder & key partnerships in suicide prevention services to ensure transparency in planning processes, development & implementation of regional operational Suicide prevention plan. The integration of primary care services with community based psychiatry services and state mental health services for people at risk of suicide. Community based suicide prevention activity through integrated and systems based approach in partnerships with LHNs and other local organisations, including arrangements for follow up care after suicide attempt or self-harm. Improving the understanding of referral pathways after suicide, attempted suicide or self -harm through quality education, awareness and promotion. **How the activity will address the priority** The activity meets the need for reform and create a systems based regional approach which is inclusive of community based activities in suicide prevention. Joined up servicing model of national state & regional services will highlight gaps, reduce duplication and encourage integration. **Target population cohort** Suicide prevention service providers across sectors. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • include targeting population groups for low intensity mental health services, and moderate mental illness in their regional mental health and suicide prevention planning; • commence the development of appropriate low intensity mental health service, integrated referral & discharge planning models for their region in line with regional plans **5.2 (a) Aim of activity**

	To identify & support Aboriginal specific suicide prevention networks and improve suicide awareness and training amongst 'gatekeepers' & 'natural helpers' in communities effected by self-harm & suicide. Improving understanding of culturally appropriate ATSI suicide prevention strategies through quality education, awareness and promotion. Including culturally appropriate resources, to generate high quality, meaningful resources supported by appropriate professional expertise. Encourage the integration of clinical services with cultural content to allow for programs/activities with high clinical governance & high cultural competency. **How the activity will address the priority** Identified priority will be met by exploring & enhancing peer support models, training and education and upskilling communities and local service providers to provide culturally appropriate Activity/service. **Target population cohort** Aboriginal & Torres Strait Islander people and communities across the CSAPHN region **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • include targeting ATSI peoples for low intensity mental health services in their regional mental health and suicide prevention planning; • commence the development of appropriate, early intervention, low intensity mental health service models for at risk groups, for their community in line with regional plans **5.2 (b) Aim of activity** To build strong communities through community-focused and integrated approaches to suicide prevention. Genuine engagement with Aboriginal and Torres Strait Islander peoples to allow ownership in developing local & regional specific community suicide prevention plans. Activities are to be holistic, early intervention focused with culturally appropriate strategies to identify and respond to those most at risk within our communities. Create connected servicing

	How the activity will address the priority The activity will increase ATSI help seeking behaviours & engagement in early interventions & low intensity mental health services. Increase awareness of suicide prevention strategies within ATSI communities. Within the MHAOD ITA Suicide Prevention took into account four previously funded programs that were to cease Department funding from June 30 2016. Of these four programs, 3 applied for refunding along with proposals from other parts of the mental health sector from current service providers to NGOs and consortia. Preferred providers were identified as part of the evaluation process and above activity will be inclusive of any co-design that progresses pre contract and engagement. **Target population cohort** Aboriginal & Torres strait Islander people and communities across the CSAPHN region **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • include targeting ATSI peoples for low intensity mental health services in their regional mental health and suicide prevention planning; • commence the development of appropriate, early intervention, low intensity mental health service models for at risk groups, for their community in line with regional plans **5.3 Aim of activity:** Support early intervention and postvention services for individuals / communities that that have been impacted by suicide. Encourage & promote integration between community prevention, intervention and postvention service providers with clinical services and LHN's. Increase community access of specific suicide prevention training and education including 'gatekeeper training' for communities & service providers to build capacity for intervention and confidence in communities after a suicide event.

	How the activity will address the priority Appropriate follow up and support arrangements in place for individuals after a suicide attempt and for those at high risk of suicide, also timely and specific postvention support for those individuals or communities impacted by suicide inc; ATSI communities. A systems based, joined up approach will create integrated referral pathways between LHN's, clinical & community services. Within the MHAOD ITA Suicide Prevention took into account four previously funded programs that were to cease Department funding from June 30 2016. Of these four programs, 3 applied for refunding along with proposals from other parts of the mental health sector from current service providers to NGOs and consortia. Preferred providers were identified as part of the evaluation process and above activity will be inclusive of any co-design that progresses pre contract and engagement. **Target population cohort** Individuals and communities at high risk of suicide, have attempted suicide or bereaved/impacted by suicide within the CSAPHN as highlighted from service gap & data analysis. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • include targeting population groups for low intensity mental health services in their regional mental health and suicide prevention planning; • commence the development of appropriate low intensity mental health service models for their region in line with regional plans **5.4 Aim of activity**: Identify and support male suicide prevention specific education including gender appropriate language & promotion activities. Improve understanding of male suicide and appropriate delivery modalities and support online help seeking resources and e-help applications

	How the activity will address the priority The activity will increase male help seeking behaviours and engagement with early intervention and low intensity mental health services. It will create male greater community & service provider understanding of male suicide and appropriate delivery modalities. **Target population cohort** Men 18-65+ **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • include targeting population groups for low intensity mental health services in their regional mental health and suicide prevention planning; • commence the development of appropriate low intensity mental health service models for their region in line with regional plans
Collaboration	**5.1** Activity will be jointly implemented across sectors within a stepped care approach with key stakeholders, including LHNs, state and territory Government, Aboriginal and Torres Strait Islander health services, consumer organisations, lived experience networks, Health Advisory Councils, NGOs ACCHO's and community. **5.2** Collaboration across CSAPHN region with LHN's, NGO's, ACCHO'S, communities, ATSI lived experience networks, ATSI youth mental health services. **5.3, 5.4 (as appropriate)** Collaboration with existing services & stakeholders building their capacity to expand and integrate models of service delivery to meet regional needs. Establishment and formalization of partnerships between organisations and services in the region to facilitate 'joined up' service provision, specifically between the: • mental health sector • Postvention service providers

	• suicide prevention networks • alcohol and other drugs sector • broader primary health care environment • acute services • community services • aged care services • child and youth services • social services • Aboriginal health services
Duration	**5.1** 2016/17 – 18 **5.2, 5.3, 5.4** 2016/17 – 18 (1 or 2 years)
Coverage	**5.1, 5.3, 5.4** All activity across CSAPHN region and as identified in the MHAOD – appendix A **5.2** Identified Aboriginal Torres Strait Islander communities across the CSAPHN region
Commissioning approach	Where applicable, Country SA PHN has adopted a competitive Most Capable Provider (MCP) approach to the market as a tendering and contract mechanism for 2016/17. We have adapted it to be competitive through an Invitation to Apply (ITA) process as a means of pre-selection. The approach is also inclusive of an Independent Commissioning Committee (ICC) which will endorse and approve all procurement over $200k. We chose this approach as we are seeking innovative solutions and wish to work with potential providers to develop the new stepped care service model. We also acknowledge that within some streams of activity there are existing successful programs still delivering services in scope by a clear most capable group of providers eg ATAPS, MHSSRA and activity we are required to fund back such as headspace for 2 years.

	In rural and remote areas we also have unique issues surrounding provider numbers and recruitment and retention of staff and a smaller pool of providers within some of our markets. The adopted ITA process will identify the most appropriate providers within streams of activity and region of CSAPHN to engage with for progression and development of the six service streams within mental health and the overall system reform agenda. All contracted services will be monitored and evaluated in accordance with direction from provided schedules for activity and via the overarching performance and commissioning frameworks of the PHN
Performance Indicator	The mandatory performance indicator for this priority is: • Number of people who are followed up by PHN-commissioned services following a recent suicide attempt.
Local Performance Indicator target (where possible)	Possible indicators will be adapted from the following through co-design: • reductions in suicide attempts and/or suicidal thinking; • reductions in risk factors and vulnerabilities to suicidal behaviours • increase in individual and/or community awareness of appropriate suicide prevention; • changes in behaviours and response to suicide prevention strategies; • improvements in individual protective or resiliency factors • improvements in service models or practices to reduce adverse effects of the system on individuals
Local Performance Indicator Data source	The following data sources will be used to monitor progress against the performance indicators: • SA Health Inpatient Separations and ED presentations datasets, specifically self-harm or suicidal ideation admissions • Service schedule performance and reporting requirements from contracted services • CSAPHN internal data collection and reporting, including provider survey and community survey methods in alignment with CSAPHN ongoing stakeholder consultation and engagement. Data specific to the evaluation of this activity will commence July 1st 2016.

Proposed Activities	
Priority Area 6: Aboriginal and Torres Strait Islander mental health services	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • enhance access to and better integrate **Aboriginal and Torres Strait Islander mental health** services at a local level facilitating a joined up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services. For this Objective, both the *Primary Health Networks Grant Programme Guidelines - Annexure A1 - Primary Mental Health Care* and the *Indigenous Australians' Health Programme – Programme Guidelines* apply.
Activity(ies) / Reference (e.g. Activity 6.1, 6.2, etc)	**6.1 Building strengths, resilience, partnerships & capacity in mental health activities within Aboriginal Torres Strait Islander (ATSI) communities** CSAPHN Priority Area: Culturally appropriate service provision **6.2 Commission culturally appropriate evidenced based services for ATSI people via the Country SA PHN, Mental Health Alcohol Other Drugs (MHAOD) Invitation To Apply (ITA)** CSAPHN Priority Area: Improved connection of ATSI community to appropriate services CSAPHN Priority Area: Health service coordination and integration, Mental Health & Drug and Alcohol Comorbidity, Properly integrated and holistic service **6.3 Engage with local communities and consult with relevant local indigenous and mainstream primary health care organisations to better identify the specific mental health needs of ATSI people** CSAPHN Priority Area: Local ownership of community mental health
Description of Activity(ies) and rationale (needs assessment)	**6.1 Aim of activity** To work with Aboriginal community organisations/ACCHOs to identify any current shortcomings and discuss and develop potential strategies to support ACCHO's to promote greater competitiveness in tendering for commissioned services. In consultation with ACCHOs, develop and implement a Stakeholder Engagement Framework for the PHN.

	Establish a joint high level mental health annual planning forum between CSAPHN, SA Aboriginal Health Council and CSALHN to identify shared high level priorities for service delivery. **How the activity will address the priority** This will address priority by working towards and commissioning activity with integration of clinical services with cultural competency and vice versa. **Target population cohort** Aboriginal Torres Strait Islander communities across CSAPHN region **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • include targeting ATSI people for mental health services in their regional mental health plans • commence the development of appropriate, early intervention, low intensity mental health service models for at risk groups, for their community in line with regional plans **6.2 Aim of activity** Culturally appropriate co-Design of activity with providers pending successful ITA applicant process to develop and/or commission low intensity mental health services to supplement online mental health therapies. Further engagement and consultation with the ACCHO and Aboriginal community sector to identify areas for improved service linkages and interface between primary health care and Hospital services. **How will this address the priority area** The Mental Health Alcohol Other Drugs ITA address the six Mental Health Priority Areas across five service streams of activity (inclusive of Child and Youth mental health) all required to be across the stepped care approach. Submissions received for Low Intensity Mental Health Services for early intervention while showing innovation and a variety of approaches largely missed the brief of providing efficient low cost alternatives to existing clinical services.

	CSAPHN will seek to progress the priority by incorporating it into all funded activity via • promoting the Digital Mental Health Gateway as a mechanism to deliver low intensity services; • utilising existing/established resources, in particular Commonwealth funded online and telephone based mental health treatment services; • connecting with local headspace centres; and • providing evidence based psychological intervention (e.g. cognitive behaviour therapy) to people with, or at risk of, mild mental illness (primarily anxiety and/or depressive disorders). Activity will also build capacity and capability of current and potential service providers through access to culturally responsive and appropriate activity. **Target population** Aboriginal and Torres Strait Island people and communities across the CSAPHN region. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • include targeting ATSI people for mental health services in their regional mental health plans • commence the development of appropriate, early intervention, low intensity mental health service models for at risk groups, for their community in line with regional plans **6.3 Aim of activity** To determine the most appropriate mix of service delivery modalities for commissioning in each region, developing partnerships within Aboriginal communities to implement community specific responses and support models and identify needs targeted to individual or small groups of individual communities. **How the activity will address the priority** Engagement with local communities will allow needs to be regionally targeted to individuals as well as small groups of individual communities

	Target population cohort Aboriginal and Torres Strait Island people and communities across the CSAPHN region. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • include targeting ATSI people for mental health services in their regional mental health plans • commence the development of appropriate, early intervention, low intensity mental health service models for at risk groups, for their community in line with regional plans
Collaboration	**6.1, 6.3** Engaged ACCHOS were heavily involved in the co design phase as part of delivering a culturally safe and appropriate service to their local indigenous communities. A commitment to further consultation, co-design and collaboration with peak bodies Aboriginal Drug and Alcohol Council (SA) Aboriginal Corporation (ADAC) and Aboriginal Health Council of South Australia (AHCSA) are also part of ongoing activities. **6.2** Within the stepped care approach of the Mental Health Alcohol Other Drug ITA CSAPHN is seeking evidence of establishment and formalization of partnerships between organisations and services in the region to facilitate 'joined up' service provision, specifically between the: • mental health sector • alcohol and other drugs sector • broader primary health care environment • acute services • community services • aged care services • child and youth services • social services • Aboriginal health services

	All applicants must provide a response indicating how their proposed model will support partnerships, clinical handover and linkages. Including where applicable, how their intervention model will: • incorporate and formalise effective mechanisms to enable appropriate clinical handover of an individual's care. • ensure an individual's transition through the steps of care are seamless and appropriate. • have systems in place to support the integration and coordination of services. • support referrers, in particular General Practice, to ensure individuals are appropriately triaged to the most suitable "stepped-level" of treatment available. • support referrers, in particular General Practice, to ensure individuals are jointly monitored to determine the selected treatment effectiveness and further care decisions. • interact with the broader social services sector. • engage with the local health networks and acute sector.
Duration	**6.1, 6.2, 6.3** 2016-17 (1-2 years)
Coverage	**6.1,6.2,6.3** All activity across CSAPHN region and as identified Aboriginal Torres Strait Islander communities across the CSAPHN region
Commissioning approach	Where applicable, Country SA PHN has adopted a competitive Most Capable Provider (MCP) approach to the market as a tendering and contract mechanism for 2016/17. We have adapted it to be competitive through an Invitation to Apply (ITA) process as a means of pre-selection. The approach is also inclusive of an Independent Commissioning Committee (ICC) which will endorse and approve all procurement over $200k. We chose this approach as we are seeking innovative solutions and wish to work with potential providers to develop the new stepped care service model. We also acknowledge that within some streams of activity there are existing successful programs still delivering services in scope by a clear most capable group of providers eg ATAPS, MHSSRA and activity we are required to fund back such as headspace for 2 years.

	In rural and remote areas we also have unique issues surrounding provider numbers and recruitment and retention of staff and a smaller pool of providers within some of our markets. The adopted ITA process will identify the most appropriate providers within streams of activity and region of CSAPHN to engage with for progression and development of the six service streams within mental health and the overall system reform agenda. All contracted services will be monitored and evaluated in accordance with direction from provided schedules for activity and via the overarching performance and commissioning frameworks of the PHN
Performance Indicator	The mandatory performance indicator for this priority is: • Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate.
Local Performance Indicator target (where possible)	Aboriginal and Torres Strait Islander peoples' view social and emotional wellbeing in a different way to non-Indigenous concepts of mental health and wellbeing and mental illness. While non Indigenous mental health and wellbeing focuses largely on the ability of the individual to function within their environment, Aboriginal and Torres Strait Islander social and emotional wellbeing encompasses not only the wellbeing of the individual, but also the wellbeing of their family and community. It reflects a holistic understanding of life and health which includes mental health, but also considers other factors such as cultural, spiritual and social wellbeing. The report Key performance indicators for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and substance misuse in Queensland21 identified indicators under three domains: Health and wellbeing status / outcomes 1. Psychological distress (social and emotional wellbeing) 2. Racism and resilience (social and emotional wellbeing)

	3. Suicide (social and emotional wellbeing / mental health) 4. Hospitalisations: mental and behavioural disorders (mental health) 5. Hospitalisations: psychoactive substance use (substance misuse) 6. Alcohol-related mortality (substance misuse) Health system performance 7. Mental health / social and emotional wellbeing service gap (social and emotional wellbeing / mental health) 8. Pre-admission community care for mental health patients (mental health) 9. Post-discharge community care for mental health patients (mental health) 10 .Alcohol, tobacco and other drugs service gap (Substance misuse) 11. Access to community controlled health services (social and emotional wellbeing / mental health / substance misuse) 12. Aboriginal and Torres Strait Islander staff in mainstream services (social and emotional wellbeing / mental health / substance misuse) Social and cultural determinants 13. Connectedness to culture and community 14. Early childhood development 15. Child protection 16. Contact with the criminal justice system 17. Income

	As part of CSAPHN MHAOD comorbidity priority the above findings would be considered when developing culturally appropriate local indicators and service measures as part of our capacity building agenda surrounding ACCHOs.
Local Performance Indicator Data source	The following data sources will be used to monitor progress against the performance indicators: • Service schedule performance and reporting requirements from contracted services • CSAPHN internal data collection and reporting, including provider survey and community survey methods in alignment with CSAPHN ongoing stakeholder consultation and engagement. Data specific to the evaluation of this activity will commence July 1st 2016.

Proposed Activities	
Priority Area 7: Stepped care approach	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • a continuum of primary mental health services within a person-centred **stepped care approach** so that a range of service types, making the best use of available workforce and technology, are available within local regions to better match with individual and local population need.
Activity(ies) / Reference (e.g. Activity 7.1, 7.2, etc)	**7.1 Country SA PHN MHAOD ITA** CSAPHN Priority Area: Health service coordination and integration, Mental Health & Drug and Alcohol Comorbidity, Properly integrated and holistic service **7.2 Service Planning, Integration and Quality Assurance** CSAPHN Priority Area: Mental & AOD reform; **7.3 Clinical governance and service quality** CSAPHN Priority Area: Health service coordination and integration, Mental Health & Drug and Alcohol Comorbidity, Properly integrated and holistic service

Description of Activity(ies) and rationale (needs assessment)	**7.1 Aim of Activity** To design, promote and commission primary mental health services within a person-centred stepped care approach. **How the activity will address the priority** Mental Health Alcohol Other Drugs ITA is to explore and expand new strategies and modalities of service design through research analysis and innovation to create and operationalized needs based services for our CSAPHN's rural communities. **Target population cohort** Rural primary mental health service providers, LHNs **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to • to take a lead role in mental health and suicide prevention service planning, integration and quality assurance activities at the local level **7.2 Aim of Activity** To support and champion the stepped care system reform via direct CSAPHN operational support. **How the activity will address the priority** Through strategic activity planning based on community need and engagement MH&AOD IISD creates and co-designs appropriate services across mental health suicide prevention and drug and alcohol. The portfolio is also tasked with championing and initiating system reform through integrated stepped and coordinated care models, National Strategies and State based joint planning and collaboration and promotion of technology and workforce strategy. **Target cohort** Rural primary mental health service providers, LHNs, CSAPHN communities **Alignment with PHN mental health funding objectives** • to take a lead role in mental health and suicide prevention service planning, integration and quality assurance activities at the local level

	7.3 Aim of Activity To foster and fund activities in the mental sector to build capacity in governance, quality, access and recovery. **How the activity will address the priority** Through small grants, future compliance requirements and best practice principles CSAPHN will encourage and incentivise the accreditation of the sector under the National Mental Health Standards and promotion of the Recovery Framework and principles. This will be ingrained in all CSAPHN commissioning activity and contractual arrangements along with stepped care requirements. This will seek to ensure: • ensuring a high quality standard of service delivery which is supported by appropriate quality assurance processes; • ensuring the workforce is practicing within their area of qualification and competence; • ensuring appropriate clinical supervision arrangements are in place; • ensuring appropriate risk assessment and management procedures are in place; • establishing and maintaining appropriate consumer feedback procedures, including complaint handling procedures; • ensuring appropriate crisis support mechanisms are in place to provide information to patients on how to access other services in a crisis situation, noting it is not the role of the PHN to provide or commission this type of service; and • ensuring transition pathways are in place that allow consumers to seamlessly move to an appropriate alternate service should their circumstances change. **Target population cohort** Rural primary mental health service providers **Alignment with the PHN mental health funding objectives** This will align with the PHN mental health funding objectives 2016/17

	• to take a lead role in mental health and suicide prevention service planning, integration and quality assurance activities at the local level
Collaboration	Within the stepped care approach of the Mental Health Alcohol Other Drugs ITA, CSAPHN is seeking evidence of establishment and formalization of partnerships between organisations and services in the region to facilitate 'joined up' service provision, specifically between the: • mental health sector • alcohol and other drugs sector • broader primary health care environment • acute services • community services • aged care services • child and youth services • social services • Aboriginal health services All applicants must provide a response indicating how their proposed model will support partnerships, clinical handover and linkages. Including where applicable, how their intervention model will: • incorporate and formalise effective mechanisms to enable appropriate clinical handover of an individual's care. • ensure an individual's transition through the steps of care are seamless and appropriate. • have systems in place to support the integration and coordination of services. • support referrers, in particular General Practice, to ensure individuals are appropriately triaged to the most suitable "stepped-level" of treatment available. • support referrers, in particular General Practice, to ensure individuals are jointly monitored to determine the selected treatment effectiveness and further care decisions. • interact with the broader social services sector. • engage with the local health networks and acute sector.

Duration	Ongoing
Coverage	CSAPHN Region
Commissioning approach (If applicable)	Where applicable, Country SA PHN has adopted a competitive Most Capable Provider (MCP) approach to the market as a tendering and contract mechanism for 2016/17. We have adapted it to be competitive through an Invitation to Apply (ITA) process as a means of pre-selection. The approach is also inclusive of an Independent Commissioning Committee (ICC) which will endorse and approve all procurement over $200k. We chose this approach as we are seeking innovative solutions and wish to work with potential providers to develop the new stepped care service model. We also acknowledge that within some streams of activity there are existing successful programs still delivering services in scope by a clear most capable group of providers eg ATAPS, MHSSRA and activity we are required to fund back such as headspace for 2 years. In rural and remote areas we also have unique issues surrounding provider numbers and recruitment and retention of staff and a smaller pool of providers within some of our markets. The adopted ITA process will identify the most appropriate providers within streams of activity and region of CSAPHN to engage with for progression and development of the six service streams within mental health and the overall system reform agenda. All contracted services will be monitored and evaluated in accordance with direction from provided schedules for activity and via the overarching performance and commissioning frameworks of the PHN.
Performance Indicator	The mandatory performance indicator for this priority is: • Proportion of PHN flexible mental health funding allocated to low intensity services, psychological therapies and for clinical care coordination for those with severe and complex mental illness.
Local Performance Indicator target (where possible)	All applicants in the MHAOD ITA were asked to indicate how their proposed service model will support a stepped care model, and where applicable, how their intervention model will: • work within and/or across the stepped care model • allow for flexibility to move across service levels (given the MH &/or AOD needs of an individual are fluid).

	• incorporate a 'no wrong door' policy for MH&AOD referrals • incorporate person centred care models (needs of the individual) • work in a way that does not preclude an individual from accessing more the one service at a time • actively engage with GPs, recognising that they are often first point of contact for individuals • demonstrate that the intervention model provides clear referral pathways that result in timely and appropriate care to the individual • involve/engage with service users and their carers/families LPIs will be developed on further information concerning above information and Low Intensity based target information.
Local Performance Indicator Data source	The following data sources will be used to monitor progress against the performance indicators: • Service schedule performance and reporting requirements from contracted services • GP practice data obtained by CSAPHN through data sharing agreements. • PHN available datasets related to mental health such as Access to Allied Psychological Services and mental health specific MBS item numbers. • CSAPHN internal data collection and reporting, including provider survey and community survey methods in alignment with CSAPHN ongoing stakeholder consultation and engagement. Data specific to the evaluation of this activity will commence July 1st 2016.

Proposed Activities	
Priority Area 8: Regional mental health and suicide prevention plan	This must reflect priorities as identified in Section 4 of your Needs Assessment, in line with the objectives of the PHN mental health funding: • evidence based **regional mental health and suicide prevention** plans and service mapping to identify needs and gaps, reduce duplication, remove inefficiencies and encourage integration.
Activity(ies) / Reference (e.g. Activity 8.1, 8.2, etc)	**8.1 To promote and advocate a sustainable, coordinated approach to service delivery, resources and information to assist community's in mental health & suicide prevention.** CSAPHN Priority Area: Mental health & suicide prevention service coordination & integration

	8.2 To identify, encourage and support targeted initiatives, activities and programs that are regionally specific in needs and delivery. CSAPHN Priority Area: Development and commissioning of regionally specific joined up servicing to provide interventions across the spectrum of mental health & suicide prevention in a stepped care model **8.3 To identify, encourage and support targeted regional postvention activities and programs.** CSAPHN Priority Area: Minimise risk of suicide due to exposure and bereavement by suicide. Regional support frameworks for at risk communities **8.4 To maintain and further develop growth in service mapping and needs analysis across CSAPHN region** CSAPHN Priority Area: CSAPHN service mapping and needs analysis
Description of Activity(ies) and rationale (needs assessment)	**8.1 Aim of activity** Transparent partnerships greater coordination, linkage and accountability between state federal, local governments', NGO sector, LHN's, community, lived experience groups, suicide prevention networks, Health Advisory Councils, ATSI & CALD communities in regions Effective linking of metropolitan based services to rural services and communities within 'follow up' care of individuals after a suicide attempt, self-harm or mental health episode, so there is no ambiguity in the responsibility in the provision of this care. Initial collaboration needed with key stakeholders such as LHN'S, Community mental health teams, Integrated Care Units. Support forums for cross fertilisation throughout service delivery in mental health and suicide prevention & focus on key partnerships with, but not limited to regional leadership personnel in mental health, Chief Psychiatrist office, SA Health principle suicide prevention officer, University of SA **How the activity will address the priority** Co-Design of activity with providers pending successful ITA applicant process to develop and/or commission mental health & suicide prevention services in a stepped care model. **Target population cohort** People with or at risk of, mild to moderate mental illness. People at risk of suicide, or whom have attempted suicide or self-harm within the CSAPHN catchment area.

	Alignment with the PHN mental health funding objectives This will align with expectations for 2016/17 to: • Addressing service gaps in provision of therapies for people in rural & remote areas & other underserviced and or hard to reach populations, making optimal use of the available service infrastructure and workforce • Targeting population groups for low intensity mental health services in their regional mental health and suicide prevention planning; **8.2 Aim of activity** Mental Health, Drug and Alcohol specific survey as well as the distribution of Suicide Prevention Surveys across community and health provider networks. Support and encourage activities that improve access to mental health services, decrease stigma and encourage help seeking behaviours. Support of existing State & Federally funded suicide prevention networks with aim of greater linkage and collaboration across sectors and regions **How the activity will address the priority** Will meet the priority by identifying existing successful programs and building their capacity to expand models into further areas and regions of need, providing joined up low intensity, early intervention through to high levels of care for families & individuals. **Target population cohort** People with or at risk of, mild to moderate mental illness. People at risk of suicide, or whom have attempted suicide or self-harm within the CSAPHN catchment area. **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • Addressing service gaps in provision of therapies and or activities for people in rural & remote areas & other underserviced and or hard to reach populations, making optimal use of the available service infrastructure and workforce. • Support service continuity for people formerly provided under ATAPS and other mental health programs.

	8.3 Aim of activity Advocacy and leadership of responsible reporting of mental health and suicide in the media through collaboration with Mind*frame*, to support local service providers with appropriate information and media strategies. To form relationships with intention of developing partnerships with existing postvention services such as StandBy Response, Living Beyond Suicide, headspace School Support and emergency responders. To aim to provide access to Gatekeeper training for communities & service providers to build capacity for intervention and confidence in communities after a suicide event. **How the activity will address the priority** A systems based, joined up approach creates integrated postvention referral pathways and learnings between LHN's, clinical, community services and emergency responders. *low intensity mental health service models for at risk groups.* **Target population cohort** Communities & individuals bereaved and impacted by suicide across the CSAPHN region **Alignment with the PHN mental health funding objectives** This will align with expectations for 2016/17 to: • Appropriate regional postvention strategies in early intervention, follow up and support arrangements for timely and postvention specific responses for those individuals or communities impacted by suicide. inc; ATSI communities. **8.4 Aim of activity** To improve mental health related service mapping to help identify and address service gaps where needed. **How the activity will address the priority** Focus on local sector workforce as highlighted from service mapping and needs analysis to remove inefficiencies and improve integration.

	Target population cohort Workforce across sectors within CSAPHN catchment region **Alignment with the PHN mental health funding objectives** • understanding the health care needs of their PHN communities through analysis and planning. They will know what services are available and help to identify and address service gaps where needed, including in rural and remote areas, while getting value for money.
Collaboration	**8.1, 8.2, 8.3, 8.4** Within the stepped care approach of the mental health & suicide prevention ITA CSAPHN is seeking evidence of establishment and formalization of partnerships between organisations and services in the region to facilitate 'joined up' service provision with applicants providing a response indicating how their proposed model will support partnerships, clinical handover, referral pathways and linkages; • mental health sector • broader primary health care environment • acute services • community services • health advisory councils • Aboriginal health services • suicide prevention networks • child and youth services • social services • current postvention service providers: StandBy Response Service, Living Beyond Suicide & headspace school support • LHN's • Media monitoring & reporting organisations: Mind*frame* • mental health & suicide prevention education & training providers • Partners in Recovery (PIR) and National Disability Insurance Scheme (NDIS)
Duration	**8.1,8.2,8.3,8.4** 2016/17 (1 to 2 years)

Coverage	Across the CSAPHN region
Commissioning approach (If applicable)	As the activities are internal and operational the commissioning approach can be deemed not applicable. The Regional Mental Health and Suicide Prevention Plan will however be part of our strategic planning as part of our annual planning cycle within the PHN's commissioning framework. It will provide evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery which will feed into informed tendering and procurement of services.
Performance Indicator	The mandatory performance indicator for this priority is: • Evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery.
Local Performance Indicator target (where possible)	Work in progress but will be inclusive of possible: • MOUs • Progression of stepped care reform • Joint planning with local LHNs
Local Performance Indicator Data source	The following data sources will be used to monitor progress against the performance indicators: • Service schedule performance and reporting requirements from contracted services • CSAPHN internal data collection and reporting, including provider survey and community survey methods in alignment with CSAPHN ongoing stakeholder consultation and engagement. • SA Health inpatient separations dataset – discharge referral items Data specific to the evaluation of this activity will commence July 1st 2016.

APPENDIX A


Mental Health Regional Service Areas
Coober Pedy
Outback
Roxby Downs
Far West
Ceduna
Port Augusta
Whyalla
Port Pirie
Eyre and Flinders
Yorke and Northern
Nuriootpa
Berri
Riverland
Port Lincoln
Mount Barker
Murray Bridge
Murray Mallee
Kangaroo Island
Victor Harbor
Limestone Coast
Mount Gambier
Regional Service Areas:
Barossa - Gawler
Hills - Fleurieu
Kangaroo Island
Limestone Coast
Murray Mallee
Yorke and Northern
Eyre and Flinders
Riverland
Far West
Outback
Adelaide PHN