Mental Health Stepped Care Model

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Glossary

Term	Meaning
ATAPS	Access to Allied Psychological Services
CALD	Culturally and Linguistically Diverse
Commissioning	The process by which PHNs, through a broad set of linked activities, plan, procure, monitor and evaluate services.
Consumer	Consumers are those who access or who could potentially access mental health services.
Gatekeeper	A person who holds an influential position in an organisation or community who coordinates the actions of others. This could be an informal local opinion leader or a specially designated person, such as a primary-care provider, who coordinates patient care and provides referrals to specialists, and other medical services.
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LHN	Local Hospital Network
MBS	Medicare Benefits Scheme
Mental illness	Mental illness is a clinically diagnosable disorder that interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classifications systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).
Mental health system	All the activities whose primary purpose is to promote, restore and/or maintain mental health.
	Primary mental health system - typically a person's first point of contact with the mental health system and is most often provided in a variety of settings outside of hospitals.
	Secondary mental health system - mental health care provided by a specialist or facility upon referral by a primary care practitioner
	Tertiary mental health system - acute mental health care usually provided in a hospital setting.
MHNIP	Mental Health Nurse Incentive Program
Natural supports	People who have a support role for someone living with a mental health difficulty. They may be a family member, friend, carer or have another close relationship with the person.

PBS	Pharmaceutical Benefits Schedule
PHN	Primary Health Network
Self-harm	Deliberate damage of body tissue, often in response to psychosocial distress, without the intent to die. Sometimes called self-injury, self-inflicted injuries, or non-suicidal self-harm/injury.
SEMPHN	South Eastern Melbourne Primary Health Network
SEWB	Social and Emotional Wellbeing
Treatment	Clinical services received by a consumer

1. Introduction

This document sets out a stepped care model for primary mental health services in the south-eastern Melbourne catchment, intended to guide South Eastern Melbourne Primary Health Network (SEMPHN) and other stakeholders in regional service planning and development.

1.1. What is the stepped care model?

The stepped care model describes a continuum of key service elements that are required to most efficiently provide needs-based support to people with (or at risk of) mental illness. It is based on six design principles, which seek to shape a regional mental health system that is:

1. Person-centred: The model is person centred, mindful of natural supports, and recovery orientated, and delivers a consistent experience no matter the entry point or pathway through the system

2. Effective: The overall model and the service elements within it are supported by the existing evidence base for approaches that work

3. Flexible: The model provides for a spectrum of service elements from least to most intensive, in a range of modalities, times and places

4. Efficient: The model seeks to deliver access to the lowest cost service that will meet each individual's need

5. Timely: The model facilitates timely access to services both over the life course and within an episode of illness

6. Coordinated: The model enables and supports coordination and integration of mental health and other services in the catchment

The services that fall within the scope of the model are defined by the Australian Government's guidance on developing stepped care approaches in mental health (Department of Health, 2016g), as well as specific guidance relating to different service types (Department of Health, 2016a, 2016b, 2016c, 2016d, 2016e, 2016f, 2016h).

1.2. Why has the stepped care model been developed?

Primary Health Networks (PHNs) have been established with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

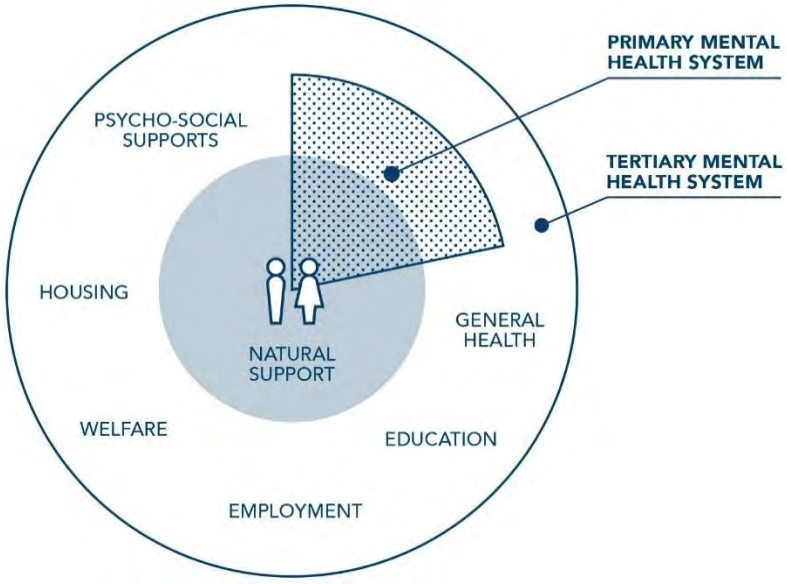
A priority area for PHNs is primary mental health care. PHNs have regional responsibility for commissioning approaches to service planning and development.

The stepped care model reflects SEMPHN's intentions for strengthened primary mental health services in the catchment, and provides SEMPHN with a clear basis for future work planning, including commissioning of services.

1.3. What is the scope of the stepped care model?

PHNs have been funded to undertake comprehensive regional mental health planning and identify primary mental health service gaps within a stepped care approach, and to commission primary mental health services.

Figure 1 - The stepped care model in context



While the stepped care model will intersect and provide linkages, the following areas are out of scope for the stepped care model:

- psychosocial support services for consumers and carers
- acute secondary and tertiary mental health services
- severe and persistent care packages delivered under the NDIS
- services outside of the SEMPHN catchment
- services funded through private health insurers.

1.4. How will it be used?

The services and programs ('service elements') described within the model are the building blocks for an effective primary mental health system. The model will directly inform how SEMPHN implements its role in collaboration with consumers, carers, providers and sector stakeholders to deliver on six priority areas of focus (Department of Health, 2016g):

1. appropriately support people with or at risk of mild mental illness through the development and/or commissioning of low intensity mental health services
2. support catchment-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 areas and other under-serviced and/or hard to reach populations

4. 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
5. encourage and promote a regional approach to suicide prevention
6. enhance and better integrate Aboriginal and Torres Strait Islander mental health services at a local level.

The model also emphasises intended outcomes for consumers and for the system overall. It provides guidance on how progress towards these can be measured.

1.5. How was it developed?

The stepped care model represents a key output to an extensive process led by SEMPHN. Sector wide consultations with consumers, carers, service providers and sector stakeholders commenced as part of needs assessment and planning activity, and culminated in a workshop in November 2016 at which the model was 'road tested' with key sector representatives. A consumer and carer panel was convened to provide direct input to its development, and a 'peer review' panel of experts reviewed the draft model.

2. The policy environment

The stepped care model outlined in this document sits within the context of mental health policy developments at the state and federal levels. This section outlines the policy context, identifying the key policies which have informed the development of the stepped care model.

2.1. PHN commissioning

A key role for PHNs is to lead mental health and suicide prevention planning and integration at a regional level in partnership with Local Hospital Networks (LHNs) and other key regional stakeholders, consistent with the Government Response to the Review of Mental Health Programmes and Services. All PHNs have key deliverables associated with this function in the 2017 financial year, including Mental Health and Suicide Prevention Needs Assessment (building on initial assessments in 2016), and Mental Health Activity Workplans (Department of Health, 2016i).

Primary Health Networks are also expected to deliver Regional Mental Health and Suicide Prevention Plans in 2017. There is a strong emphasis from government on the evidence-based and regionally collaborative nature of these plans, and that they should be comprehensive in that they are to address the full range of mental health services (with the apparent exception of inpatient services). A key outcome expected of the plans is that they will also guide the efficient commissioning and targeting of services by PHNs.

The focus of commissioning models is to be on strategically assessing needs and priorities and shaping the local service system in response. This requires a systemic focus that extends beyond narrow procurement of individual, siloed services.

SEMPHN has been identified as one of ten trial sites for a stepped care model. The Commonwealth Government outlines a stepped care model as an approach with a "hierarchy of interventions, from the least to the most intensive, matched to the individual's needs" (Department of Health, 2016g). The model is based on the approach outlined by the *Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services* (Department of Health, 2015). The Commonwealth Government expects SEMPHN to commission mental health services for its catchment based on the model.

2.2. Mental health policy

Mental health policy frameworks exist at both the state and national level, influencing SEMPHN's work in the south-eastern Melbourne catchment. The main policy frameworks of relevance to SEMPHN are:

- the Victorian 10-Year Mental Health Plan (Department of Health and Human Services, 2015)
- the Fifth National Mental Health Plan (currently in draft form under consultation).

The Victorian 10-Year Mental Health Plan was launched in 2015 and has four key focus areas:

- improving the mental health and wellbeing of all Victorians
- promoting mental health for all ages and stages of life
- supporting Victorians with mental illness to live fulfilling lives of their choosing, with or without symptoms of mental illness

- achieving an accessible, flexible and responsive mental health service system and workforce.

Additionally, the Fifth National Mental Health Plan is currently in draft and identifies the following seven priority areas:

- integrated regional planning and service delivery
- coordinated treatment and supports for people with severe and complex mental illness
- suicide prevention
- Aboriginal and Torres Strait Islander mental health and suicide prevention
- physical health of people living with mental health issues
- stigma and discrimination reduction
- safety and quality in mental health care.

These plans, and several other policy documents, identify a number of themes for the development of a mental health system that promotes the health, wellbeing and recovery of people with mental illness.

The primary goal of the mental health system is improved outcomes for people with mental illness, notably reduced rates of mental illness and suicide. As well as applying to all Australians at a population level, there are specific priority groups that experience high rates of mental ill-health which needs to be addressed, including Aboriginal and Torres Strait Islander people, LGBTI people and people with a culturally and linguistically diverse (CALD) background.

Part of the challenge of developing an effective mental health system is care coordination, both within the system and holistically across the dimensions of people's experiences. This means coordination between services to ensure appropriate referrals are made. Additionally, it requires mental health services to work with other community and social services to support a consumer's mental health, including education, housing, justice and family violence services.

In addition to improving the coordination of the system, there is a focus on improving the quality and equity of services. Services and their staff should treat consumers with respect. People should be able to access adequate services, regardless of their financial situation or location. Where possible, consumers should have choice and control over the services that they access.

Alongside the emphasis on improving the quality and accessibility of services, reducing the stigma and discrimination that people with mental illness face would improve their mental health and wellbeing. Policy frameworks at the state and federal level emphasise the importance of increasing action and education to reduce stigma, in the community and among the health workforce.

In addition to the directions provided at the strategic level, services providing mental health services are subject to the National Standards for Mental Health Services (Commonwealth of Australia, 2010). These Standards outline a number of principles for the delivery of equitable, quality mental health care, which inform the key performance indicators for health services.

NMHS: key principles for mental health service delivery		
Effectiveness	Accessibility	Capability
Appropriateness	Continuity	Safety
Efficiency	Responsiveness	Sustainability

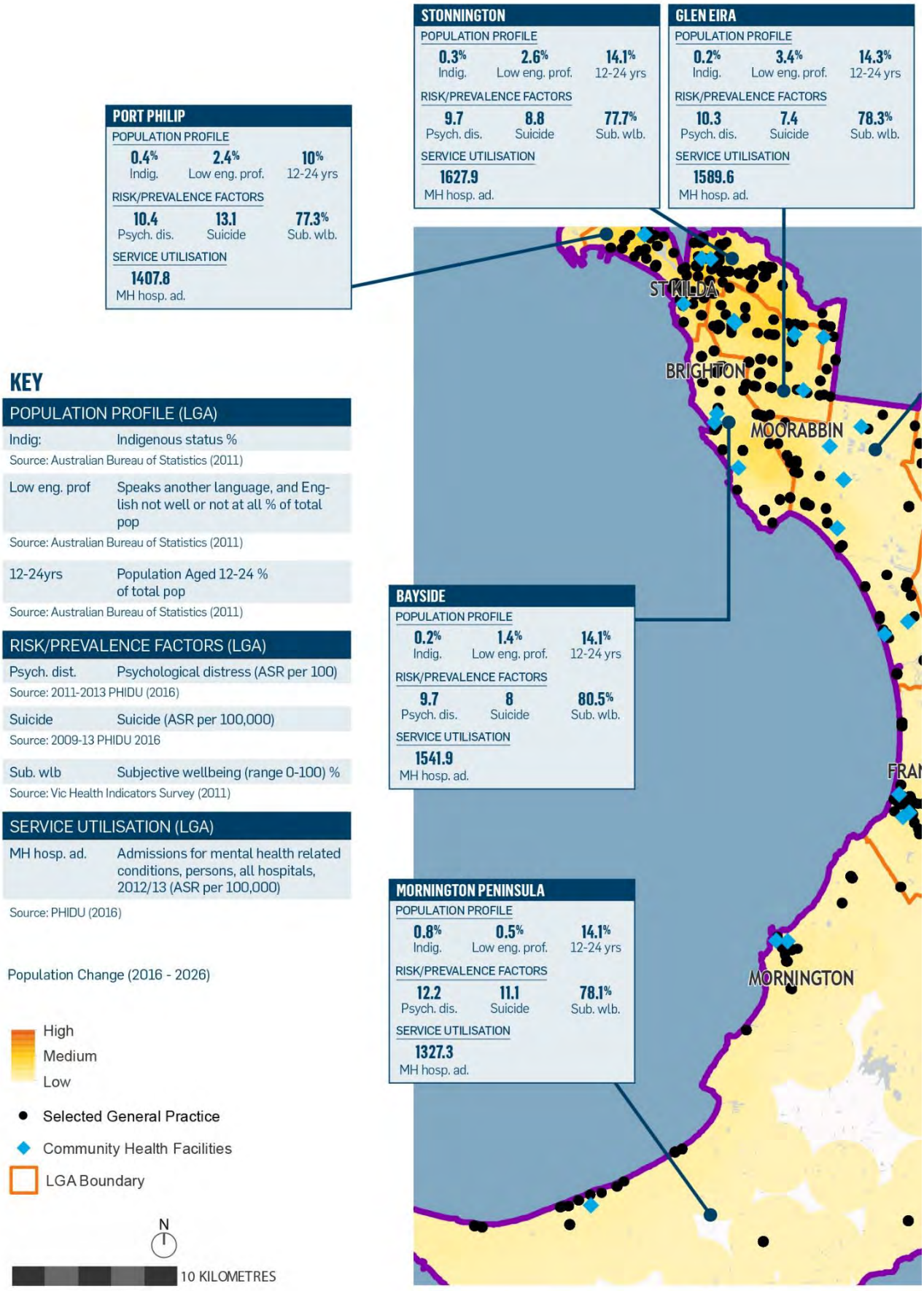
2.3. Broader policy links

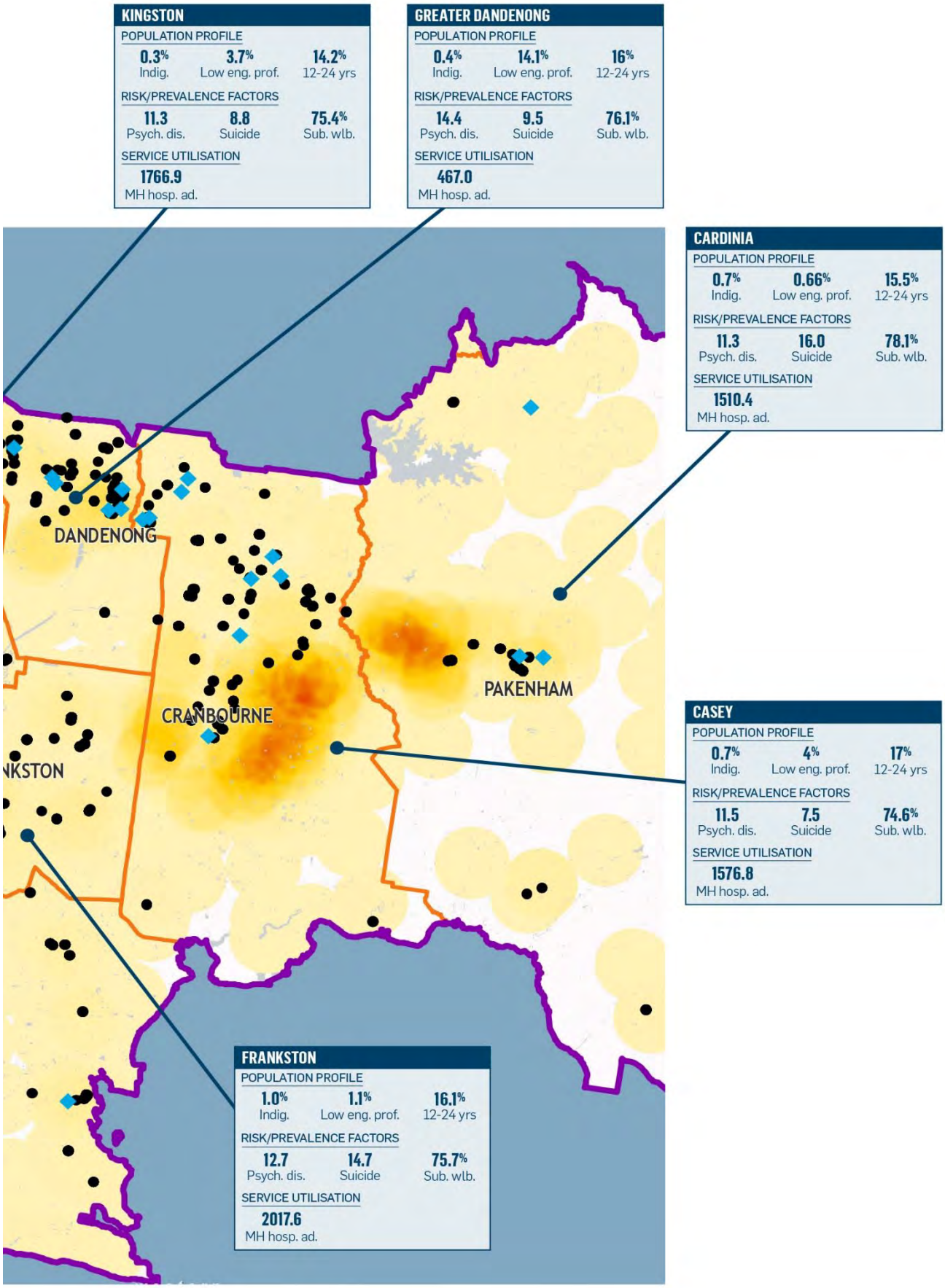
Mental health service delivery is complex, and intersects with a number of other health and social policy areas.

The National Disability Insurance Scheme (NDIS) will have a significant impact on the provision of mental health services in the community for consumers experiencing 'complex and persistent' psychosocial disability associated with mental illness (National Disability Insurance Agency, 2015). There are current concerns in the sector about the extent to which the NDIS can fully cover the number of consumers who experience severe and complex mental illness.

In addition to mental health services, PHNs are also responsible for commissioning some drug and alcohol treatment services. PHNs aim to reduce the harms associated with alcohol and other drugs, with a specific focus on methamphetamine use and supporting Indigenous services. Given the high prevalence of dual diagnosis of mental illness and substance misuse, it is important to acknowledge the potential interaction of services, while noting the separation of funding and commissioning arrangements.

3. Regional profile




KINGSTON
POPULATION PROFILE
0.3% Indig.
3.7% Low eng. prof.
14.2% 12-24 yrs
RISK/PREVALENCE FACTORS
11.3 Psych. dis.
8.8 Suicide
75.4% Sub. wlb.
SERVICE UTILISATION
1766.9 MH hosp. ad.
GREATER DANDENONG
POPULATION PROFILE
0.4% Indig.
14.1% Low eng. prof.
16% 12-24 yrs
RISK/PREVALENCE FACTORS
14.4 Psych. dis.
9.5 Suicide
76.1% Sub. wlb.
SERVICE UTILISATION
467.0 MH hosp. ad.
CARDINIA
POPULATION PROFILE
0.7% Indig.
0.66% Low eng. prof.
15.5% 12-24 yrs
RISK/PREVALENCE FACTORS
11.3 Psych. dis.
16.0 Suicide
78.1% Sub. wlb.
SERVICE UTILISATION
1510.4 MH hosp. ad.
DANDENONG
CRANBOURNE
PAKENHAM
CASEY
POPULATION PROFILE
0.7% Indig.
4% Low eng. prof.
17% 12-24 yrs
RISK/PREVALENCE FACTORS
11.5 Psych. dis.
7.5 Suicide
74.6% Sub. wlb.
SERVICE UTILISATION
1576.8 MH hosp. ad.
FRANKSTON
POPULATION PROFILE
1.0% Indig.
1.1% Low eng. prof.
16.1% 12-24 yrs
RISK/PREVALENCE FACTORS
12.7 Psych. dis.
14.7 Suicide
75.7% Sub. wlb.
SERVICE UTILISATION
2017.6 MH hosp. ad.

4. The stepped care model

4.1. Design principles

The core principles informing the stepped care model are set out in Table 1, along with high level outcomes that result from implementing these principles. These align to the Commonwealth's guidance for PHNs (Department of Health, 2016i, 2016j), and are informed by consultations completed by SEMPHN with consumers, carers and service providers in the catchment.

Table 1 – Core design principles

Design principle	Long term outcomes from design implementation
Person-centred: The model is person-centred, mindful of natural supports, and recovery orientated, and delivers a consistent experience no matter the entry point or pathway through the system	Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experiencing social disadvantage access care on an equitable basis Consumers access services that are culturally safe and age-appropriate Consumers have choice and control over their mental health service access
Effective: The overall model and the service elements within it are supported by the existing evidence base for approaches that work	Consumers experience improved mental health and wellbeing outcomes Rates of self-harm and suicide in at-risk groups are reduced
Flexible: The model provides for a spectrum of service elements from least to most intensive, in a range of modalities, times and places	Consumers access appropriate mental health care in modalities aligned to their individual needs Consumers access flexible services at times and places that meet their needs
Efficient: The model seeks to deliver access to the lowest cost service that will meet an individual's need	Resources available to the system are deployed sustainably and efficiently Services are available consistently and equitably across the catchment
Timely: The model facilitates timely access to services both over the life course and within an episode of illness	Downstream costs of care decrease through earlier intervention Consumers access needs-appropriate mental health care in a timely way

Coordinated: The model enables and supports coordination and integration of mental health and other services in the catchment	Consumers with mental illness experience improvement in cultural, physical and social outcomes Consumers experience well-coordinated services as they move through the stepped care model Service providers and clinicians experience a well-coordinated system

4.2. Model overview

A stepped care model has four core elements (Department of Health, 2016g):

1. stratification of the population into different '*needs groups*'
2. defining *differentiated interventions* for each group – this is necessary because not all needs require formal intervention
3. a comprehensive '*menu' of evidence based services* required to respond to the spectrum of need
4. *matching* service types to the treatment needs of each needs group.

The stepped care model shown in Figure 2 stratifies the population into five groups, ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions.

Like other health conditions, mental illness impacts at different levels of severity, ranging from mild to severe (Department of Health, 2015). Clinically, severity is judged according to the type of disorder the person has (diagnosis), the intensity of the symptoms they are experiencing, the length of time they have experienced those symptoms (duration) and the degree of disablement that is caused to social, personal, family and occupational functioning (disability). Some diagnoses, particularly schizophrenia and other psychoses, are usually assigned to the severe category automatically, but all disorders can have severe impact on some people.

Severe mental illness is characterised by a severe level of clinical symptoms and degree of disablement to social, personal, family and occupational functioning. An estimated 3.1% of the population have severe disorders, equivalent to 690,000 people. About one third of the severe group have a psychotic illness, primarily schizophrenia or bipolar disorder. The largest group (approximately 40%) is made of people with severely disabling forms of anxiety disorders and depression.

For the purpose of this document, severe and complex mental illness refers to individuals with clinically severe mental illness as well as complex multiagency needs, often both clinical and non-clinical, which may be or an episodic or persistent nature.

It also clusters service types by the demographic segment that they serve. The service groupings are:

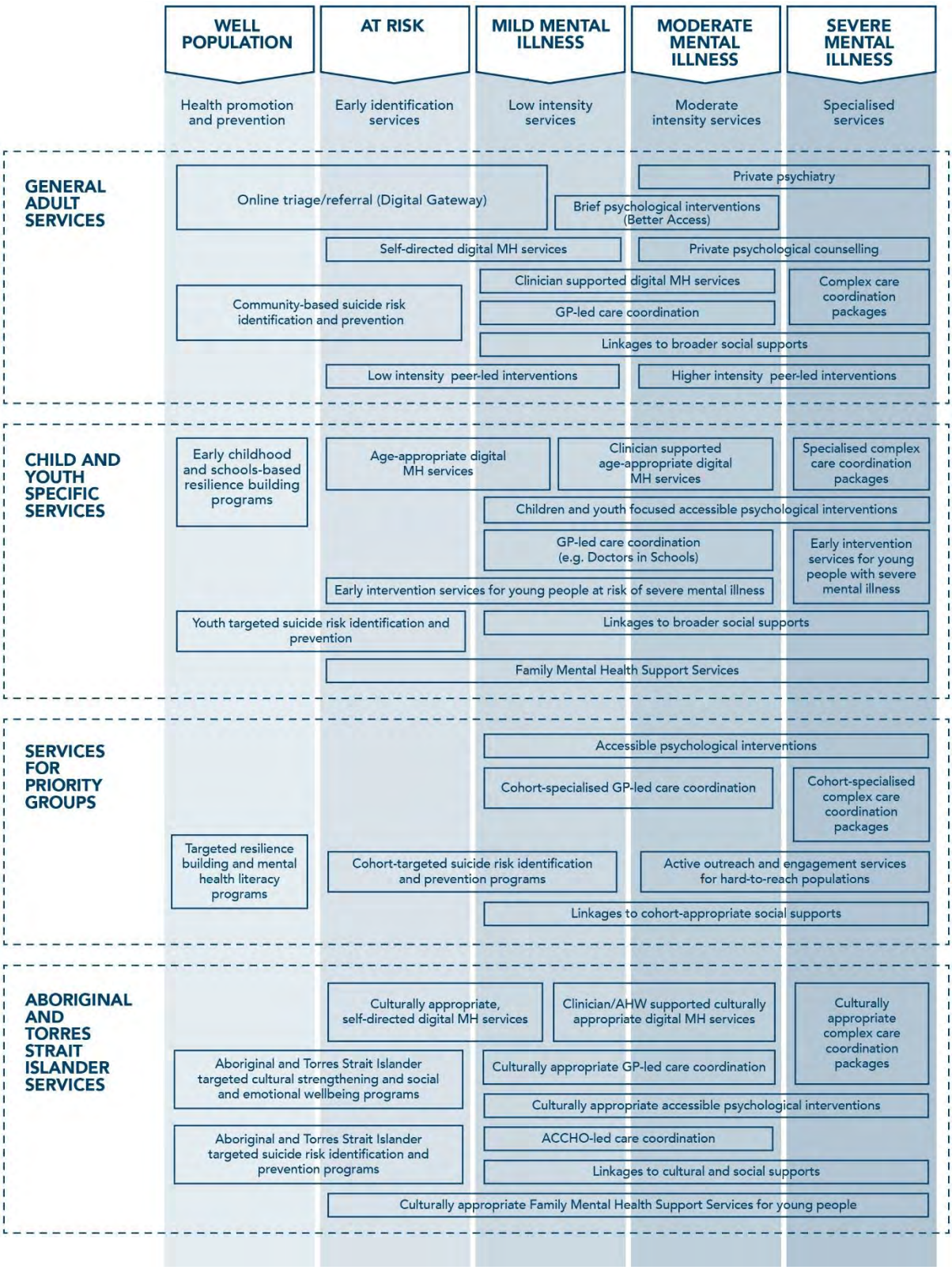
- General adult services, including services for older adults
- Child and youth specific services
- Services for priority groups, including (but not limited to), culturally and linguistically diverse (CALD) people and new migrants, people experiencing homelessness, and LGBTI people
- Aboriginal and Torres Strait Islander services.

The groupings are not mutually exclusive. Some consumers fall into all four groups, and most service providers operate across more than one service grouping.

Within each service grouping, 'service elements' are described. Service elements are high-level descriptions of the evidence-based service or programs that collectively make up the range of interventions available to consumers within the system.

Service elements are each described in more detail within section 7. Although some service elements fall outside the scope of the stepped care model, they are key system components that provide important context within the diagram.

Figure 2 - Stepped care model



What does the model mean for consumers?

The model depicts a system in which consumers access a range of well-coordinated services of varying levels of intensity, delivered in a way that is appropriate in the context of each individual personal circumstances.

Adam is 27 years old and lives at home with his mum. He has experienced episodes of depression and anxiety in the past and his mum is concerned that he may be unwell again. She accesses the online information on the beyondblue website to identify supports which might be useful for her son and passes the information onto him.

Adam chooses to complete a short online program to address his anxiety, but three weeks later is still feeling unwell. He makes an appointment to see his GP and they discuss his options. Adam decides that he would like to explore the option of participating in a program run by local peer workers.

Adam's GP links him into a local peer-led support service (the referral is brokered by the SEMPHN Intake service) and he chooses to contact an email-based 'helpline' account, which supports men with anxiety. Adam is able to discuss his concerns over email when he needs to, and with regular support from the peer-led email account, is starting to feel more confident.

A month or so after first emailing the peer-led email account, Adam's relationship with his girlfriend hits a rough patch. Adam feels his anxiety rising again, and returns to his GP to discuss his symptoms. The GP completes a Mental Health Plan and as part of that plan, recommends that Adam see a psychologist. As Adam is unemployed and would have difficulty in affording private sessions, his GP makes a referral to the Accessible Psychological Interventions (API) program through the SEMPHN Intake service, who allocate him to a nearby API service provider.

At his first visit to a psychologist, a psychological treatment plan is developed with him that is focused on developing specific skills with the goal of helping Adam to better manage situations which provoke anxiety for him. During this time, Adam continues to email the peer-support account for intermittent support when he feels particularly stressed.

After seeing the psychologist every three weeks for a few months, and regularly practicing his relaxation and coping skills, Adam feels that he is in a much better place. His final session with his psychologist includes a review of how he has progressed and the skills he has learnt. Adam returns to his GP for a regular check-up, and explains that his symptoms are less intense, and that the psychologist has provided him with effective strategies to recognise and get on top of situations that make him anxious. Adam doesn't feel like he needs to see the psychologist any more at this stage. Adam's GP and Adam agree to another appointment in a month to check in with him and make sure that he is still coping well.

At the follow up appointment, Adam tells his GP that he is now feeling that he is 'back in control', and that his anxiety – while still present – is no longer as big a problem for him. Adam is now regularly employing a few self-care strategies which he has acquired from the psychologist and the peer-led email account – and is able to maintain stable mental health. If Adam feels that needs support again he has agreed with his GP that he will return for a wellbeing check-up.

What does the model mean for services?

The model depicts a system in which a range of different service elements are efficiently delivered at lowest level intensity appropriate to individual needs, at the earliest possible point in a **consumer's illness.**

Bianca is 43 years old and has recently spent time in hospital following an acute psychotic episode. She is discharged from hospital into the care of a GP.

At the first appointment with her GP following her discharge from hospital, the GP identifies that Bianca will need to access a number of services to support her now she's back in the community, including her psychiatrist, a drug and alcohol service, and psychosocial supports such as housing.

The GP refers Bianca to the complex care coordination service. Based on the information provided to the Intake service by her GP, Bianca is eligible for a complex care coordination package. A Mental Health Nurse works with her to support her attendance at appointments and adherence to her medication, and provides her with psycho-education to support her recovery. The support facilitator provides the nurse with a referral to an agency which supports Bianca with her housing and welfare claims.

The nurse meets with her GP, psychiatrist and other allied health providers regularly to discuss her case. During one of these case conferences, they identify that Bianca could benefit from an intensive peer worker program, particularly as she tends to miss appointments. She is assigned a peer worker who meets with her once a week to provide her with peer support to attend her appointments. Her GP continues to coordinate her care.

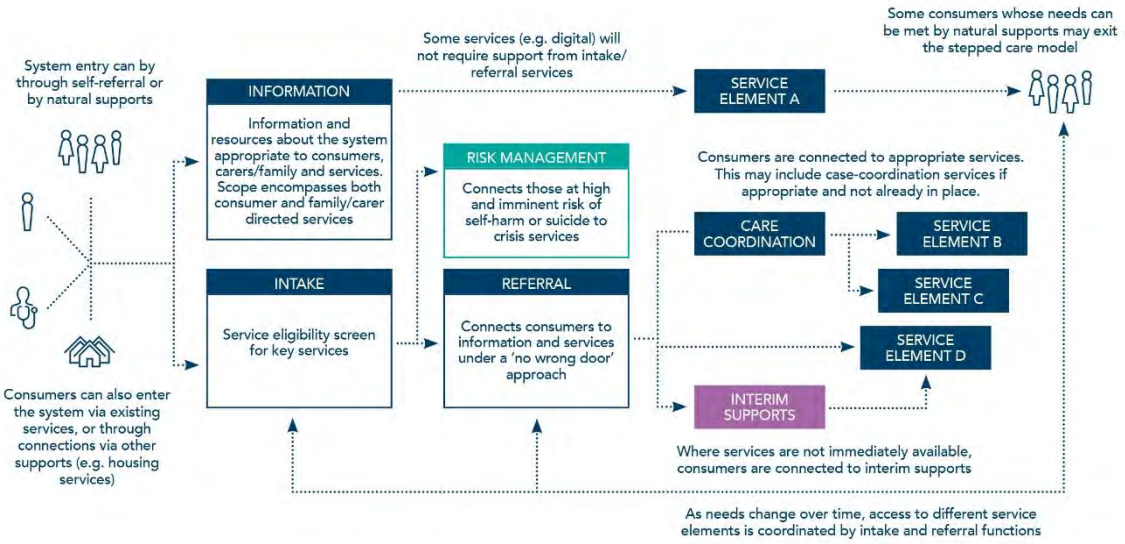
After another eight months, following discussions with Bianca, the peer worker recommends to her GP that Bianca finishes up the high intensity peer worker program. Bianca is provided with information about a lower intensity peer support program, which includes an online forum and helpline.

Bianca calls the helpline periodically, which provides her coping strategies and support to access her other health practitioners, including her GP and psychiatrist.

4.3. Service access and coordination

The stepped care model described in Figure 2 focuses on articulating the range of key service elements available to people with different needs. Effective pathways into and between services are also a critical feature of the model overall, and will be supported through the operation of a centralised intake service. The primary pathways into and through the system are shown in Figure 3.

Figure 3 – Consumer pathways



The approach to service access and coordination is consistent with the key principles that underpin the stepped care model. The intake service will be *person-centred*, adopting a no-wrong-door approach with multiple possible entry points, and *coordinated*, offering efficient linkage to a range of service elements of different intensities over a person's recovery journey. This supports consumers to access appropriate services in a *timely* and *efficient* way, while minimising duplicative contact.

In addition to articulating what consumers can expect from their pathway through the system, a coordinated approach articulates the roles and responsibilities for services, including relevant communication and information sharing channels.

Exiting from the stepped care model does not mean a 'hard exit' from mental health services and supports, but rather a step down to natural supports. Exit does not preclude someone from re-entering the stepped care model in the future if their needs change.

Table 2 sets out the key design parameters for the intake service, and the expected outcomes that follow from its implementation. Key design parameters are high-level descriptions of the critical aspects of a service and guide the subsequent development of service model or detailed specifications.

Table 2 - Intake service: key design parameters

	Key design parameters	Outcomes
Intake service The purpose of this service element will be to provide a single point of access for information, linkage and referral to services available through the primary mental health care system.	Consumers, carers and service providers can access a single point of information about available services either online and by telephone. Consumers can self-refer to the intake service and be connected in a timely way to appropriate service elements. Where service elements are not immediately available (e.g. due to wait lists), consumers are linked to interim supports. Consumer contact will be with appropriately skilled and qualified clinical staff able to undertake preliminary needs assessments and determine the most appropriate point of immediate referral. Staff also undertake risk assessments and connect people to crisis service where there is high and imminent risk of self-harm. Care-coordination type service providers (including GPs) can connect consumers to service elements that make up a person's care plan/recovery plan through the intake service. Consumers will be connected to care-coordination services as a priority after screening, where these are necessary and not already in place. Service providers must refer consumers through the intake service to access SEMPHN funded services and programs. The service collects key data from consumers and providers consistent with the Minimum Data Set. This will provide SEMPHN funded services and programs (and others by negotiated agreement) data on episode commencement and closure, and on consumer outcomes. Data collected by the intake service will be available to services (with consumer consent) to minimise duplication and repetition. The service complements (rather than duplicating) existing system entry points and processes, including entry via specific services.	Consumers experience well-coordinated services as they move through the stepped care model Service providers and clinicians experience a well-coordinated system Consumers access appropriate mental health care in modalities aligned to their individual needs Consumers access flexible services at times and places that meet their needs Consumers and those supporting them have a good experience when accessing support, care and treatment Resources available to the system are deployed sustainably and efficiently Downstream costs of care decrease through earlier intervention

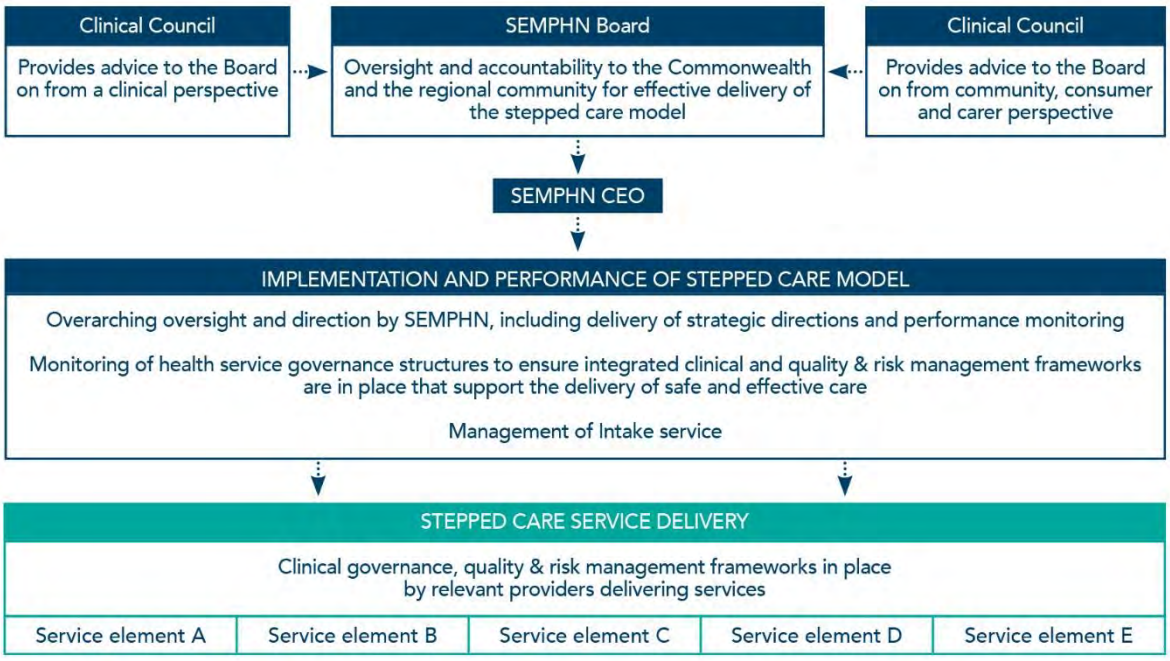
5. Operationalising the model

5.1. Governance

The SEMPHN Board is accountable for the implementation of the stepped care model, and in delivering this mandate receives advice from the Clinical and Community Councils established by SEMPHN. Specific service elements implemented under the model will be expected to have arrangements in place to ensure appropriate levels of clinical governance, quality and risk management.

The proposed governance arrangements are summarised in Figure 4.

Figure 4 - Governance arrangements



5.2. Implementation approach

SEMPHN has been tasked with a regional leadership role in primary mental health care, and will have overall responsibility for advocating and enabling the implementation of the stepped care model.

This will involve SEMPHN directly commissioning and funding some services (e.g. low intensity services, targeted psychological therapies, clinical care coordination), but also extends to regional planning, coordination and service integration (e.g. regional suicide prevention).

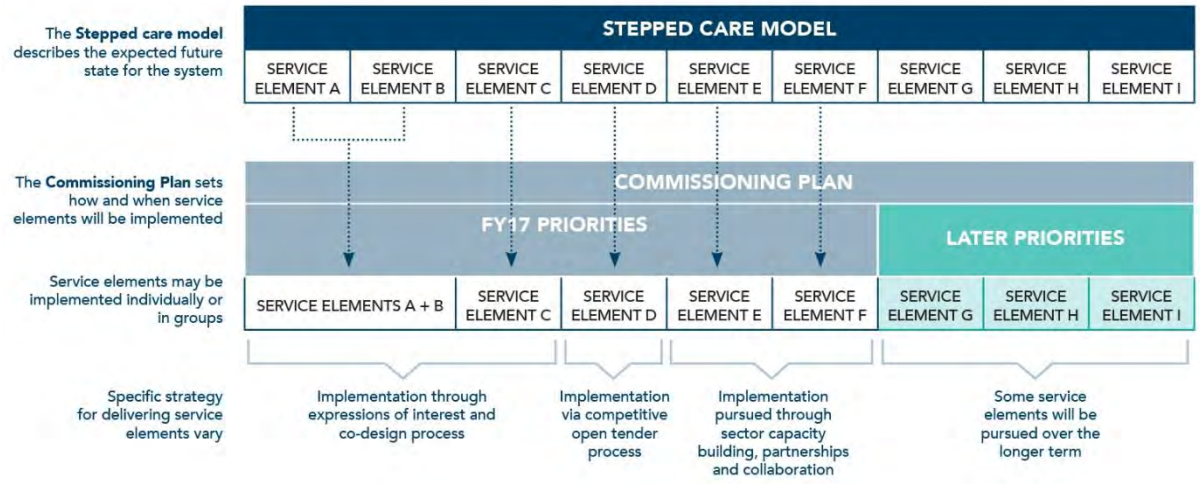
While this document sets out the aspirations for the stepped care model, implementation will be staged. An early priority will be commissioning targeted psychological therapies and clinical care coordination services and ensuring a smooth transitioning from the Access to Allied Psychological Services (ATAPS) and Mental Health Nurse Incentive Program (MHNIP).

Figure 5 provides an overview of the implementation approach. SEMPHN will develop a working plan for commissioning that will draw on the stepped care model. It will include high-level specifications for system elements (or groups of system elements) being commissioned,

including the purpose, general scope and service parameters, key design features and intended outcomes, and relationship to the stepped care model.

Implementation will be supported by extensive workforce-readiness campaign led by SEMPHN. This will include targeted education for GPs, practice managers, allied health providers and others engaged in primary mental health service delivery.

Figure 5 - Implementation of the Stepped care model



5.3. Program transition

The introduction of the stepped care model will result in some existing services and programs moving into the model, or where programs cease, consumers will need to be transitioned to new supports. While the stepped care model describes the intended end state, transitional arrangements are likely to be in place for some services to ensure minimal disruption to consumers.

Service element working groups will have responsibility for identifying transition issues and developing strategies to maintain continuity of service, with input from clinical and consumer advisory groups as appropriate.

6. Telling the story

6.1. Introduction

A key tenet of successful implementation of the stepped care model is a commitment to monitoring and evaluation. Monitoring and evaluation serve two key purposes:

- maintaining accountability to consumers and their support networks, the community and funders
- providing data to inform ongoing implementation and future design improvements.

Gathering the right data will allow a 'performance story' to be told about how well the system is operating and the extent to which it is achieving its intended outcomes.

6.2. Measuring outcomes

The outcomes framework for the stepped care model is set out in Table 3 over the page.

The stepped care model design principles articulated in section 4.1 are intended to result in the achievement of key long term outcomes for consumers and for the system overall. Indicators are included for each outcome that will signal change in the long-term outcomes.

However, many of these outcomes may take some time to be realised. To allow for progress to be monitored, lead indicators are also proposed within this framework to provide an earlier picture in the trajectory of achievement. These indicators are indicated by the ▲symbol, and are those expected to show positive change within three years.

6.3. Reporting on performance

The outcomes framework will support SEMPHN to tell the 'performance story' for the catchment's primary mental health services. The key indicators that make up the framework provide insight into different dimensions of performance, and will capture significant changes over time.

Analysing system performance enables targeted effort to improve areas of underperformance, and provides a form of systemic accountability. The complexity of the health system, and the socio-economic environment it is situated within, means that there are many factors that can lead to changes in indicators. The extent to which SEMPHN is able to directly influence indicator results will vary.

Once specific measures are developed for each indicator, regular reports on system performance will be published by SEMPHN to ensure system accountability to the community.

Table 3 - Stepped care model outcomes framework

	Long term outcomes	Proposed indicators
PERSON-CENTREDNESS	Consumers and those supporting them have a good experience when accessing support, care and treatment	• Consumer satisfaction with primary care services ▲ • Carer/family satisfaction with primary care services ▲ • Consumer satisfaction with referred services ▲
	Consumers experiencing social disadvantage access care on an equitable basis	• Service utilisation rates by population sub-groups • Distribution of centres of service provision ▲
	Consumers access services that are culturally safe and age-appropriate	• Consumer satisfaction with primary mental health services by sub-group • Utilisation rates for sub-group targeted services ▲ • Utilisation rates for interpreter services ▲
	Consumers have choice and control over their mental health service access	• Distribution of services • Consumer satisfaction with care planning and coordination
EFFECTIVENESS	Consumers experience improved mental health and wellbeing outcomes	• Population rates of subjective wellbeing • Population rates of psychological distress • Reported clinical outcomes from primary mental health care ▲
	Rates of self-harm and suicide in at-risk groups are reduced	• Age-standardised rate of death by suicide • Emergency department presentations relating to intentional self-harm • Hospital admissions relating to intentional self-harm
FLEXIBILITY	Consumers access to appropriate mental health care in modalities aligned to their individual needs	• Service utilisation rates by diagnosis and functional ability • Service utilisation rates by low, moderate and high intensity services ▲ • Service utilisation rates by modality • Consumer satisfaction by low, moderate and high intensity services ▲
	Consumers access flexible services at times and places that meet their needs	• Service utilisation after-hours ▲ • Consumer self-reported difficulty accessing health services ▲

	Long term outcomes	Proposed indicators
EFFICIENCY	Resources available to the system are deployed sustainably and efficiently	• Rates of referral completion ▲ • Rates of service episode completion ▲ • Service element continuity over time
	Services are available equitably across the catchment	• Ratio of key mental health professions to population • Distribution of centres of service provision • Service utilisation rates by geography ▲
TIMELINESS	Downstream costs of care decrease through earlier intervention	• Avoidable hospital admissions related to mental health • Hospital admissions related to intentional self-harm • Avoidable emergency department presentations related to mental health ▲
	Consumers access needs-appropriate mental health care in a timely way	• Consumer self-reported difficulty accessing health services ▲ • Carer/family self-reported difficulty accessing health services ▲ • Waiting times to appointments with mental health professionals • Avoidable emergency department presentations related to mental health
COORDINATION	Consumers with mental illness experience improvement in cultural, physical and social outcomes	• Consumer physical health status on key markers • Consumer economic participation • Consumer social participation and personal connectedness
	Consumers experience well-coordinated services as they move through the stepped care model	• Consumer satisfaction with referred services ▲ • Consumer satisfaction with care coordination ▲ • Population rate of mental health plans ▲
	Service providers and clinicians experience a well-coordinated system	• Service satisfaction with referral and care coordination pathways ▲

7. Service elements

This section provides a concise description of the key service elements that make up the stepped care model. These service elements may be amended over time by SEMPHN in consultation with sector stakeholders and finalised as services are commissioned.

Each service element is summarised in tabular form, with key design parameters and high-level service element outcomes defined, and a brief rationale provided.

Design parameters may relate to geography, service scale/scope/purpose, inclusions/exclusions. They are intended as the first step toward specification development, and are not exhaustive.

7.1. General adult services

7.1.1. Community based suicide risk identification and prevention

Service Element	Key design parameters	Service element outcomes
Community-based suicide risk identification and prevention The purpose of this element is to support existing community-based suicide risk identification and prevention through workforce training and education, particularly for **system 'gatekeepers', and** providing follow-up and support for adults who have self-harmed or attempted suicide.	Strengthen systemic and community capacity to identify suicide risk and deliver appropriate supports through training and partnership building. Provide workforce training to frontline primary mental health professionals and peer workers to strengthen systemic capacity to identify and reduce suicide risk. Develop and leverage cross-sectoral partnerships to provide training to the non-health workforce in contact with adults at risk of suicide, including those in the welfare, housing and justice sectors. The focus of training will be on systematically building capacity in alignment with current best-practice in suicide prevention. Training will have a practical, implementation focus. It will be initially prioritised to the cities of Port Phillip and Frankston. Training quality and effectiveness will be evaluated. Deliver well-coordinated follow-up support to people who have self-harmed or attempted suicide. Clear responsibilities for the coordination and delivery of timely follow-up support are agreed and documented at the regional level.	Rates of self-harm and suicide in at-risk groups are reduced Consumers access needs-appropriate mental health care in a timely way Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Downstream costs of care decrease through earlier intervention

Rationale

In addition to the premature loss of life, suicide can have a profound and lasting negative impact on families, workplaces and communities (Department of Health, 2016e). Port Phillip, Frankston, Cardinia, and Mornington Peninsula LGAs have higher than average rates of suicide deaths, attempts and/or ideation. These areas, particularly Port Philip SA3 which has the highest length of stay in hospital for intentional self-harm (7.2 days, 1.6 times greater than SEMPHN average) and Frankston SA3 which has high rates of hospitalisation for intentional self-harm (221 per 100,000 ASR, 1.9 times greater than SEMPHN average) are a focus for SEMPHN (South Eastern Melbourne PHN, 2016).

A range of community based suicide prevention activities currently operate within the SEMPHN region. These services range from prevention to postvention (i.e. prevention and support for family and friends following a suicide), to community and workforce development activities. SEMPHN has identified a need to complement existing services by coordinating services that focus on those who are at risk of attempting and/or have attempted suicide (South Eastern Melbourne PHN, 2016).

A 2016 report on evidence-based approaches to suicide prevention supports a multi-agency approach to suicide prevention that includes both designated gatekeepers (those who are formally trained such as GPs and psychiatrists etc.) and emergent gatekeepers who are part of the wider community and are not formally trained but still recognised by those with suicidal intent as gatekeepers, for example police, clergy, pharmacists, teachers, counsellors, family and friends, school and work peers, and crisis line staff. These people can be influential in a person's decision to access care and may reduce risk of suicide (The Black Dog Institute, 2016)

Key players

GPs, Mental health services, Community-based organisations

7.1.2. Self-directed digital MH services

Service Element	Key design parameters	Service element outcomes
Self-directed digital MH services The purpose of this service element is to provide online support services for adults experiencing, or at risk of, mild mental illness.	The Digital Gateway will provided access to online and mobile-based interactive websites and/or apps, using fully automated self-help programs, which can be accessed 24/7 by consumers. Material will be available to consumers in the region providing information about evidence-based, self-directed digital mental health services. Information will also be provided about alternatives within the stepped care model and how these are accessed. Information provided about the Digital Gateway will be made available in different languages, meet accessibility guidelines. Mental health and other service providers who are touchpoints for potentially at-risk groups will receive brief training and information about who benefits from self-directed digital MH services, and how they can support people to access these services.	Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Resources available to the system are deployed sustainably and efficiently

Rationale

Frankston and the Mornington Peninsula have high rates of self-reported mental health and behavioural problems and the SEMPHN 2016 modelled prevalence estimates that mild mental illness in SEMPHN region as 9% of the population (South Eastern Melbourne PHN, 2016).

Digital mental health and self-help services are most relevant for prevention and early intervention. Digital mental health services offer services that are low cost or no cost to the consumer, therefore E-mental health programs can assist people with socio-economic disadvantage by providing an effective accessible form of mental health care that may bridge the gap to care that is usually unaffordable and inaccessible (Harris, Meurk, & Reavley, 2016).These services may be particularly valuable for LGAs with high socio-economic disadvantage which in SEMPHN include Greater Dandenong, Frankston, Casey and Cardinia.

The PHNs will actively promote the use the *Digital Mental Health Gateway* which will act as a form of triage to assist people to access the most appropriate digital mental health services based on their specific needs (Department of Health, 2016g).

The most established evidence based e-mental health programs include Mental Health Online, This Way Up and the Mindspot Clinic. There is evidence of feasibility and effectiveness in reducing symptoms (Harris et al., 2016). The Black Dog Institute suggests that digital technology can support consumers to access services and engage in self-care (The Black Dog Institute, 2016).

Key players

SEMPHN

7.1.3. Low intensity peer-led interventions

Service Element	Key design parameters	Service element outcomes
Low intensity peer-led interventions The purpose of this service element is to provide low intensity interventions for adults with, or at risk of a mild mental illness.	Provides time-limited, goal directed psycho-education and CBT-based coaching interventions by telephone or face-to-face, including both individual or group programs. Access to the service is via self-referral, or referral from a health professional. The service targets people who are at risk of developing mental illness, or who have a mild mental illness. Initially, there will be a focus on women with/at risk of peri-natal depression and people identifying as LGBTI with/at risk of mild mental illness. Interventions are led by people with lived experience of mental illness, who have completed appropriate training and who have access to supervision, advice and support provided by an appropriately qualified clinician. Programs are delivered over a fixed number of sessions. The number of sessions will vary depending on the target group. Escalation pathways are established, and peer workers liaise with supporting clinicians where a consumer's needs are increasing. This may result in referral to additional services.	Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access appropriate mental health care in modalities aligned to their individual needs Consumers experience improved mental health and wellbeing outcomes Resources available to the system are deployed sustainably and efficiently

Rationale

Adults with, or at risk of mild mental illness reside in SEMPHN catchment, SEMPHN estimates 9% of the population experience mild mental illness (South Eastern Melbourne PHN, 2016). Entering and navigating through the mental health system is difficult for these consumers, especially for people experiencing socioeconomic disadvantage within the catchment.

People identifying as LGBTI experience barriers accessing the formal mental health system due to perceptions of stigma and discrimination (South Eastern Melbourne PHN, 2016). Women with or at risk of peri-natal depression are identified as a potential target group for low intensity services (Department of Health, 2016c).

There is significant evidence that a peer workforce can effectively support clinicians in low intensity service delivery for people at risk of, or experiencing mild mental illness (Department of Health, 2016c). Peer-led intervention or peer support models offer an opportunity for consumers to participate in the design, delivery and review of services (Department of Health, 2016c). There are also opportunities for people with lived experience of mental illness to deliver interventions (Department of Health, 2016b).

The PHN guide on consumer and carer participation notes that consumers will experience better outcomes where their participation is embedded in collaborative partnerships and co-design across the whole mental health system (Department of Health, 2016b) and an increase likelihood that consumers have a positive experience of their support, care and treatment (South Eastern Melbourne PHN, 2016). Engagement of peers also underpins a recovery oriented approach which emphasises self-determination, self-management, empowerment and advocacy (Department of Health, 2016b).

Key players

Mental health service providers, Peer workers

7.1.4. Clinician supported digital MH services

Service Element	Key design parameters	Service element outcomes
Clinician supported digital MH services The purpose of this service element is to provide clinician supported online mental health services for adults with moderate mental illness.	Provide psychological interventions through online modalities, supported by appropriately qualified primary mental health professionals. The target group is adults with moderate mental illness who have a sufficient level of technological literacy to benefit from online programs. The support role will include coaching occurring alongside consumers undertaking online programs, in the form of telephone contact, emails, or in-person support. Primary mental health professionals will play a role in motivating and enabling consumers to complete programs. Where additional supports re required, they may also refer consumers to other services within the stepped care model. Training and information will be provided to primary mental health professionals on effective approaches to supporting digital mental health services. Appropriate 'check-in' systems (e.g. call backs, text messages) will be established to support.	Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access appropriate mental health care in modalities aligned to their individual needs Consumers experience improved mental health and wellbeing outcomes Resources available to the system are deployed sustainably and efficiently

Rationale

The 2016 modelled prevalence estimates 9% of the population experience mild mental illness in the SEMPHN region (South Eastern Melbourne PHN, 2016). Digital mental health and self-help services are most relevant for prevention and early intervention. Digital services offer low cost or no cost to the consumer, therefore E-mental health programs can assist people with socio-economic disadvantage by providing an effective accessible form of mental health care that may bridge the gap to care that is usually unaffordable and inaccessible (Harris et al., 2016) Although digital mental health services can be self-directed by the consumer the consumer can also be assisted by clinicians, teachers, administrators or peers to use the digital services.

The most established evidence based e-mental health programs include Mental Health Online, This Way Up and the Mindspot Clinic. There is evidence of feasibility and effectiveness in reducing symptoms, including at longer term follow-up (Harris et al., 2016). There is also significant evidence that supporting good outcomes from mix digital and face-to-face support services. For consumers with mild to moderate depression it has been found that CBT web based with face-to-face therapist support is indicated to reduce depressive symptoms in the short term only (7 weeks post-treatment) (Mazza, O'Hare, & De Leon-Santiago). The Black Dog Institute suggests that digital technology can support consumers to access services and engage in self-care (The Black Dog Institute, 2016). A 2013 review found that "[b]ased on current evidence, we conclude that health systems implementing [computer assisted CBT] should include therapist support via email or brief telephone sessions, or both" (Dedert E, McDuffie JR, & Swinkels C, 2013)

Key players

GPs, Mental health services, SEMPHN

7.1.5. GP-led care coordination

Service Element	Key design parameters	Service element outcomes
GP-led care coordination The purpose of this element is to provide clinical care coordination for adults with a mild-moderate mental illness.	GP-led care coordination is delivered through implementation of Mental Health Plans under the MBS. Strengthened systemic capacity to deliver high quality care coordination will be enabled through training and information for GPs focused on: • understanding and accessing the regionally available services and supports, and • clinical knowledge and skills development relating to management of mental illness. Training and information will also be provided for other professional groups who may provide GP-referred services under a Mental Health Plan. Awareness raising activities focused on the availability of GP support for mental health issues, particularly in priority or low-uptake populations.	Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers with mental illness experience improvement in cultural, physical and social outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale
The Dandenong region of SEMPHN catchment has a low rate of MBS funded services for the preparation of mental health treatment plans by GPs, despite high need of mental health services (South Eastern Melbourne PHN, 2016). Collaborative and coordinated care involves GPs and mental health professionals working together (Harris et al., 2016). GPs are critical to ensuring people are referred to the right care at the right time as they are the gatekeepers to other services and usually the first point of critical contact for people seeking help for mental health problems and mental illness (Department of Health, 2016g). Access to most primary mental health services commissioned by PHNs will most likely continue to require a referral from a GP, psychiatrist or paediatrician therefore GPs are an important piece of the multidisciplinary approach to coordinated care (Department of Health, 2016g).
Key players
GPs, Other allied mental and physical health providers

7.1.6. Linkages to broader social supports

Service Element	Key design parameters	Service element outcomes
Linkages to broader social supports The purpose of this service element is to link adults experiencing mild-severe mental illness into the broader social supports necessary to live a meaningful life.	Provides a comprehensive and current resource directory of information about community resources and supports that can assist a person with mental illness to engage with protective social supports within their community. The directory will be available online and will seek to integrate rather than duplicate existing community directories. Areas of focus will include: • social groups and activities • wellbeing programs • sports, recreation, arts • education and training. Targets adults with mental illness, including those with severe mental illness who are ineligible for the NDIS. For people with mild-moderate mental illness, access to supports is primarily self-directed or undertaken with some assistance from their treating mental health professional as part of care planning. For people with severe mental illness who are ineligible for the NDIS, linkages to broader social supports will be supported within the context of complex-care coordination and recovery planning. For NDIS eligible consumers, the linkages function will be delivered by the Partners in Recovery program until transition to the NDIS.	Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience well-coordinated services as they move through the stepped care model Consumers with mental illness experience improvement in cultural, physical and social outcomes

Rationale

Severe mental illness is not just characterised by clinical symptoms but also the degree of disablement to social, personal, family and occupation functioning (Department of Health, 2016g). Currently, mental health support services are fragmented from broader social and community supports (South Eastern Melbourne PHN, 2016).

The people of the SEMPHN catchment are diverse and complex. Some areas suffer greater social disadvantage than others. Greater Dandenong and Frankston in particular. There is low community strength and support in Greater Dandenong, high proportion of disability support pensioners in Greater Dandenong (7.9%), Frankston (6.7%), and Mornington Peninsula (6.1%). Port Phillip and Greater Dandenong have a high rate of homelessness and Frankston, Greater Dandenong, Cardinia and Casey have high rates of reported incidents of family violence. There are a high proportion of people reporting a poor work-life balance in Kingston (51.6%), Casey (49.5%), Stonington (49.1%) and Frankston (48.2%) compared to 46.9% in Victoria (South Eastern Melbourne PHN, 2016). These socioeconomic determinants contribute to the breakdown of social ties and social supports.

Key players

GPs, Primary mental health services, Peer workers, Community organisations

7.1.7. Higher intensity peer-led interventions

Service Element	Key design parameters	Service element outcomes
Higher intensity peer-led interventions The purpose of this service element is to provide additional support for adults experiencing a moderate-severe mental illness than is otherwise provided through GP/psychiatrist coordinated care, including the Better Access initiative.	Provides time-limited, goal directed psycho-education and CBT-based coaching interventions that complement and reinforce clinical supports. Delivered primarily through one-to-one sessions, with potential group interventions if appropriate. Access to the service is by referral from a GP or psychiatrist. The service targets people who have a moderate to severe mental illness. Interventions are led by people with lived experience of mental illness, who have completed appropriate training and who have access to supervision, advice and support provided by an appropriately qualified clinician. Programs are delivered over a fixed number of sessions. The number of sessions will vary depending on the target group. Escalation pathways are established, and peer workers liaise with supporting clinicians where a consumer's needs are increasing. This may result in referral to additional services.	Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access appropriate mental health care in modalities aligned to their individual needs Consumers experience improved mental health and wellbeing outcomes Resources available to the system are deployed sustainably and efficiently

Rationale

The SEMPHN mental health needs assessments 2016 modelled prevalence estimates moderate and severe mental illness in the catchment as 4.6% and 3.1% respectively (South Eastern Melbourne PHN, 2016). Entering and navigating through the mental health system is difficult for these consumers, especially for people experiencing socioeconomic disadvantage within the catchment.

There is significant evidence that a peer workforce can effectively support clinicians in low intensity service delivery for people at risk of, or experiencing mild mental illness (Department of Health, 2016c). Peer-led intervention or peer support models offer an opportunity for consumers to participate in the design, delivery and review of services (Department of Health, 2016c). There are also opportunities for people with lived experience of mental illness to deliver interventions (Department of Health, 2016b).

The PHN guide on consumer and carer participation notes that consumers will experience better outcomes where their participation is embedded in collaborative partnerships and co-design across the whole mental health system (Department of Health, 2016b) and an increase likelihood that consumers have a positive experience of their support, care and treatment (South Eastern Melbourne PHN, 2016). Engagement of peers also underpins a recovery oriented approach which emphasises self-determination, self-management, empowerment and advocacy (Department of Health, 2016b).

Key players

Mental health service providers, Peer workers

7.1.8. Complex care coordination packages

Service Element	Key design parameters	Service element outcomes
Complex care coordination packages The purpose of this service element is to provide packages of care coordination support for people with severe and complex mental illness, in community-based general practices, private psychiatrist services and other appropriate services.	Provide access to appropriately qualified mental health professional to provide clinical care coordination services to consumers with a severe and complex mental illness. Services may be based in general practices, private psychiatry or other appropriate settings. The mental health professional will be responsible for establishing a therapeutic relationship with the consumer; liaising closely with family and carers as appropriate; regularly reviewing the consumer's mental state; administering, monitoring and ensuring compliance by consumers with their medication; and, providing information on physical health care to consumers. Consumers are eligible for complex care coordination support if they have been identified by their GP or psychiatrist as eligible for the program, and that person will be the main person responsible for the consumer's clinical mental health care. Organisations, and contracted mental health professionals, must have appropriate insurance coverage. Appropriate reminder systems (e.g. call backs, text messages) will be established to minimise failures to attend.	Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers with mental illness experience improvement in cultural, physical and social outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale

It is estimated that 3.1% people in SEMPHN experience severe and complex mental illness (South Eastern Melbourne PHN, 2016). Navigating through the mental health system is difficult for these consumers, especially for people experiencing disadvantage within the catchment. A need for improved inter-connectedness and referral pathways has been identified.

Mental health nurses can increase resilience of people experiencing severe and complex mental health needs through assisting consumers to manage their own mental health and wellbeing (South Eastern Melbourne PHN, 2016). Mental health nurses encourage consumers to have a positive experience with care and minimise avoidable harm (South Eastern Melbourne PHN, 2016).

The Mental Health Nurse Incentive Program (MHNIP) utilisation is highest in the SA3 region of Frankston and lowest in Casey North and Dandenong. Reasons for high and low service utilisation should be investigated especially the high prevalence of mental illness in Dandenong and low MHNIP services utilisation (South Eastern Melbourne PHN, 2016).

From 2017-18, mental health nurse funding will operate solely within the PHN funding pool. MHNs implement a holistic and patient-centred approach to patients physical and mental health issues. Care can be provided in a range of settings, such as in clinics, patient's home or by telephone. Facilitating factors from a patient's perspective are: comfortable setting, service flexibility, holistic and affordable care and convenience and reduced stigma associated with services being available at GP practices. Evidence suggests that MHNIP improves care and patients to feel well and connected with their communities (Harris et al., 2016).

Key players

GPs, Psychiatrists, other allied mental health providers

7.2. Children and youth services

7.2.1. Youth targeted suicide risk identification and prevention

Service Element	Key design parameters	Service element outcomes
Youth targeted suicide risk identification and prevention The purpose of this element is to support existing community-based suicide risk identification and prevention targeted at children and young people, through workforce training and education, particularly for **system 'gatekeepers', and** providing follow-up and support for young people who have self-harmed or attempted suicide.	Strengthen systemic and community capacity to identify suicide risk and deliver appropriate supports through training and partnership building. Provide workforce training to frontline primary mental health professionals working with children and young people to strengthen systemic capacity to identify and reduce suicide risk. Develop and leverage cross-sectoral partnerships to provide training to the non-health workforce in contact with children and young people at risk of suicide, including those in the education, child protection, welfare, housing and justice sectors. The focus of training will be on systematically building capacity in alignment with current best-practice in suicide prevention. Training will have a practical, implementation focus. It will be initially prioritised to the cities of Port Phillip and Frankston. Training quality and effectiveness will be evaluated. Deliver well-coordinated follow-up support to children and young people who have self-harmed or attempted suicide. Clear responsibilities for the coordination and delivery of timely follow-up support are agreed and documented at the regional level.	Consumers access services that are culturally safe and age-appropriate Rates of self-harm and suicide in at-risk groups are reduced Consumers access needs-appropriate mental health care in a timely way Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Downstream costs of care decrease through earlier intervention

Rationale

Mental ill health is the leading cause of disability for 10-24 year old's (Orygen, 2016) and suicide is the leading cause of death among young Australians (South Eastern Melbourne PHN, 2016). In addition to the premature loss of life, suicide can have a profound and lasting negative impact on families, workplaces and communities (Department of Health, 2016e).

Port Phillip, Frankston, Cardinia and Mornington Peninsula LGAs have higher than average rates of suicide deaths, attempts and/or ideation. In particular Frankston and Mornington Peninsula have high mental health service needs - Frankston SA3s hospitalisation for intentional self-harm is 1.9 times greater than the SEMPHN average (South Eastern Melbourne PHN, 2016).

Building resilience through improving community and individual strength and capacity in suicide prevention is an objective of the Victorian Suicide Prevention Framework (Department of Health and Human Services, 2016). Young people face many challenges, particularly in relation to their identity (Department of Health and Human Services, 2016) - the framework acknowledges the importance of a safe and accepting community and personal environment that does not create stigma around sexuality, gender, or cultural identity (Department of Health and Human Services, 2016).

A range of community based suicide prevention activities currently operate within the SEMPHN region. These services range from prevention to postvention (i.e. prevention and support for family and friends following a suicide), to community and workforce development activities. SEMPHN has identified a need to complement existing services by coordinating services that focus on those who are at risk of attempting and/or have attempted suicide (South Eastern Melbourne PHN, 2016).

A 2016 report on evidence-based approaches to suicide prevention supports a multi-agency approach to suicide prevention that includes both designated gatekeepers (those who are formally trained such as GPs and psychiatrists etc.) and emergent gatekeepers who are part of the wider community and are not formally trained but still recognised by those with suicidal intent as gatekeepers, for example police, clergy, pharmacists, teachers, counsellors, family and friends, school and work peers, and crisis line staff. These people can be influential in a person's decision to access care and may reduce risk of suicide (The Black Dog Institute, 2016).

Key players

GPs, Mental health services, Community-based organisations

7.2.2. Age-appropriate digital MH services

Service Element	Key design parameters	Service element outcomes
Age-appropriate digital MH services The purpose of this service element is to provide online support services for children and young people experiencing, or at risk of, mild mental illness.	The Digital Gateway will provide access to online and mobile-based interactive websites and/or apps, using fully automated self-help programs, which can be accessed 24/7 by consumers, including young people. Material will be available to young people (and those working with them) in the region providing information about evidence-based, self-directed digital mental health services. Information will also be provided about alternatives within the stepped care model and how these are accessed. Information provided about the Digital Gateway will be made available in age-appropriate forms. Mental health and other service providers who are touchpoints for potentially at-risk children and young people will receive brief training and information about who benefits from self-directed digital MH services, and how they can support young people to appropriately access these services.	Consumers access services that are culturally safe and age-appropriate Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Resources available to the system are deployed sustainably and efficiently

Rationale

SEMPHN has identified a need for improved outreach to young people in need of mental health services (South Eastern Melbourne PHN, 2016). Three quarters of all mental illness manifests itself in people under the age of 25 (Department of Health, 2016f) and the onset of mental ill health peaks between the ages of 12 and 24 years (Orygen, 2016), which suggests a need to target youth who may be disconnected from traditional services.

Digital mental health and self-help services are most relevant for prevention and early intervention. Digital mental health services offer services that are low cost or no cost to the consumer, therefore E-mental health programs can assist people with socio-economic disadvantage by providing an effective accessible form of mental health care that may bridge the gap to care that is usually unaffordable and inaccessible (Harris et al., 2016).

Digital mental health and self-help services are most relevant for prevention and early intervention and can reduce the duration and impact of mental illness (Department of Health, 2016f). Early interventions emphasised in the stepped care system are lower in cost, evidence-based alternatives to face-to-face, and are targeted at those who have early symptoms and/or a previous illness (Harris et al., 2016).

E-mental health programs can assist young people with socio-economic disadvantage by providing an effective accessible form of mental health care that may bridge the gap to care that is usually unaffordable and inaccessible (Harris et al., 2016).These services may be particularly valuable for LGAs with high socio-economic disadvantage which in SEMPHN include: Greater Dandenong, Frankston, Casey and Cardinia, and also areas with higher than average rates of children on child protection orders and/or of children experiencing substantiated child abuse Frankston, Port Phillip and Greater Dandenong, and Frankston, Greater Dandenong and Mornington Peninsula respectively (South Eastern Melbourne PHN, 2016)The most established evidence based e-mental health programs include Mental Health Online, This Way Up and the Mindspot Clinic. There is evidence of feasibility and effectiveness in reducing symptoms (Harris et al., 2016). The Black Dog Institute suggests that digital technology can support consumers to access services and engage in self-care (The Black Dog Institute, 2016).

Key players

SEMPHN

7.2.3. Early intervention services for young people at risk of severe mental illness

Service Element	Key design parameters	Service element outcomes
Early intervention services for young people at risk of severe mental illness This service element will provide early intervention services designed for young people at risk of severe mental illness.	Provide workforce development designed at identifying risk factors and providing at-risk young people with support and referral pathways as necessary. Provide assertive outreach to young people, especially boys and young men, to support their engagement with early intervention mental health services.	Consumers access services that are culturally safe and age-appropriate Consumers experience improved mental health and wellbeing outcomes Rates of self-harm and suicide in at-risk groups are reduced Downstream costs of care decrease through earlier intervention Consumers access needs-appropriate mental health care in a timely way

Rationale

Frankston, Port Phillip and Greater Dandenong have higher than average rates of children on child protection orders and Frankston, Greater Dandenong and Mornington Peninsula have higher than average rates of substantiated child abuse (South Eastern Melbourne PHN, 2016). These children, as well as children from Indigenous or culturally diverse backgrounds and/or children transitioning from out-of-home care experience, or are at risk of, mental illness (Department of Social Services, 2015)

Intervention during childhood or adolescent years can reduce the duration and impact of mental illness (Department of Health, 2016f). For example early intervention may alter the course of eating disorders and/or prevent more severe illnesses (Mazza, O'Hare, & Hawes, 2016). Early intervention is emphasised in the stepped care system are those which are lower in cost, evidence-based alternatives to face-to-face, targeted at those who have early symptoms and/or a previous illness (Harris et al., 2016) . A one size fits all approach is unlikely to be appropriate as young people may need diverse clinical needs (Department of Health, 2016f).

Evidence based early intervention reduces the prevalence and impact of mental illness and can have a significant impact on a wide range of outcomes (Department of Health, 2016f).

Key players

GPs, Mental health services

7.2.4. Clinician supported age-appropriate digital MH services

Service Element	Key design parameters	Service element outcomes
Clinician supported age-appropriate digital MH services The purpose of this service element is to provide clinician supported online mental health services for children and young people with moderate mental illness.	Provide psychological interventions through online modalities, supported by appropriately qualified primary mental health professionals. The target group is children and young people with mild-moderate mental illness who have a sufficient level of technological literacy to benefit from online programs. The support role will include coaching occurring alongside young people undertaking online programs, in the form of telephone contact, emails, or in-person support. Primary mental health professionals will play a role in motivating and enabling consumers to complete programs. Where additional supports are required, they may also refer consumers to other services within the stepped care model. Training and information will be provided to primary mental health professionals on effective approaches to supporting digital mental health services. Appropriate 'check-in' systems (e.g. call backs, text messages) will be established to support.	Consumers access services that are culturally safe and age-appropriate Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access appropriate mental health care in modalities aligned to their individual needs Consumers experience improved mental health and wellbeing outcomes Resources available to the system are deployed sustainably and efficiently

Rationale

SEMPHN has identified a need for improved outreach to young people in need of mental health services (South Eastern Melbourne PHN, 2016). Three quarters of all mental illness manifests itself in people under the age of 25 (Department of Health, 2016f) and the onset of mental ill health peaks between the ages of 12 and 24 years (Orygen, 2016), which suggests a need to target youth who may be disconnected from traditional services

Digital mental health offers services that are low cost or no cost to the consumer and can assist young people with socio-economic disadvantage that may be disconnected from traditional services. This accessible service may bridge the gap to care that is usually unaffordable (Harris et al., 2016). These services may be particularly valuable for LGAs with high socio-economic disadvantage which in SEMPHN include: Greater Dandenong, Frankston, Casey and Cardinia, and also areas with higher than average rates of children on child protection orders and/or of children experiencing substantiated child abuse such as Frankston, Port Phillip and Greater Dandenong, and Frankston, Greater Dandenong and Mornington Peninsula respectively (South Eastern Melbourne PHN, 2016) Digital mental health and self-help services are most relevant for prevention and early intervention and can be self-directed by the consumer or offered with guidance from clinicians, teachers, administrators or peer self-health programs. It can be delivered via a range of media and settings. SEMPHN will actively promote the use the *Digital Mental Health Gateway* which will act as a form of triage to assist people to access the most appropriate digital mental health services based on their specific needs

The Black Dog Institute suggests that digital technology can support consumers to access services and engage in self-care (The Black Dog Institute, 2016).The most established evidence based e-mental health programs include Mental Health Online, This Way Up and the Mindspot Clinic. There is also significant evidence that supporting good outcomes from mix digital and face-to-face support services. For consumers with mild to moderate depression it has been found that CBT web based with face-to-face therapist support is indicated to reduce depressive symptoms in the short term only (7 weeks post-treatment) (Mazza et al.). A 2013 review found that "[b]ased on current evidence, we conclude that health systems implementing [computer assisted CBT] should include therapist support via email or brief telephone sessions, or both" (Dedert E et al., 2013)

Key players

GPs, Mental health services, SEMPHN

7.2.5. Children and youth focused accessible psychological interventions

Service Element	Key design parameters	Service element outcomes
Children and youth focused accessible psychological interventions Accessible Psychological Interventions are flexible services that are intended to support children and young people with a mental illness who will benefit from individual, family and/or group provision of psychological services from allied health professionals.	Provide access to flexible services that are intended to support young people with a mental illness who will benefit from individual, family and/or group provision of psychological services from allied health professionals. The range of interventions that can be delivered is consistent with those available privately under the Commonwealth Better Access to Mental Health Care program. Accessible at no cost by young people living in the SEMPHN catchment, with a diagnosed mental illness. Health professionals providing services must be appropriately trained in working with young people. At least one available professional must provide services from premises no more than one hour by public transport or 20 minutes drive from a consumer's usual place of residence. Services are to be available outside of traditional business hours to support accessibility for consumer with other commitments.	Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access services that are culturally safe and age-appropriate Consumers experience improved mental health and wellbeing outcomes Consumers access flexible services at times and places that meet their needs Services are available consistently and equitably across the catchment Consumers experience well-coordinated services as they move through the stepped care model

Rationale

Frankston, Port Phillip and Greater Dandenong have higher than average rates of children on child protection orders, and Frankston, Greater Dandenong and Mornington Peninsula have higher than average rates of substantiated child abuse. These children as well as children from Indigenous or culturally diverse backgrounds, or children transitioning from out-of-home care experience, or are at risk of, mental illness (Department of Social Services, 2015)

The SEMPHN catchment covers areas of significant disadvantage, notably the LGAs of Frankton and Greater Dandenong, with pockets of disadvantage in other suburbs. This suggests that there are cohorts of young primary health consumers who would struggle to access allied psychological services through an MBS rebate. In particular in a low proportion of young people accessing MBS funded mental health services in Dandenong despite a high service need (South Eastern Melbourne PHN, 2016).

Currently, this service element is provided through the *Access to Allied Psychological Services* (ATAPS) program. The ten-year evaluation of ATAPS (conducted in 2013) found that consumer outcomes improved significantly and were indicative of clinical improvement, and that the program "continues to be an integral part of the primary mental health care system in Australia."

Together this suggests ongoing demand for brief focused psychological interventions for adults experiencing mild mental illness, where financial hardship is a barrier to accessing alternative programs.

Key players

GPs, Psychiatrists, Private allied health providers

7.2.6. GP-led care coordination (e.g. Doctors in Schools)

Service Element	Key design parameters	Service element outcomes
GP-led care coordination (e.g. Doctors in Schools) The purpose of this element is to provide clinical care coordination for young people aged 12-25 with a mild-moderate mental illness.	GP-led care coordination is delivered for children and young people through implementation of Mental Health Plans under the MBS. GP service provision in educational settings will be explored (e.g. the Doctors in Schools) Strengthened systemic capacity to deliver high quality care coordination will be enabled through training and information for GPs focused on: • understanding and accessing the regionally available services and supports relevant to children and young people, and • clinical knowledge and skills development relating to management of mental illness in children and young people Training and information will also be provided for other professional groups who may provide GP-referred services under a Mental Health Plan. Awareness raising activities focused on the availability of GP support for mental health issues in children and young people, particularly in priority or low-uptake populations.	Consumers access services that are culturally safe and age-appropriate Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers with mental illness experience improvement in cultural, physical and social outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale

Areas within SEMPHN catchment have low rates of MBS funded services for the preparation of mental health treatment plans by GPs. Dandenong has especially low rates despite high need of mental health services (South Eastern Melbourne PHN, 2016).

Collaborative and coordinated care involves GPs and mental health professionals working together (Harris et al., 2016). For example outpatients with anorexia require a multidisciplinary approach that involves medical, dietetic and psychological services (Russell & Wasiak, 2016). GPs are critical to ensuring people are referred to the right care at the right time as they are the gatekeepers to other services and usually the first point of critical contact for people seeking help for mental health problems and mental illness (Department of Health, 2016g).

The Victorian suicide prevention framework recognises the need for building resilience within school communities which includes creating a safe environment where children and youth are supported and not discriminated against because of their sexuality, gender, or cultural identity. The Victorian government is committed to supporting programs within schools that improve the mental health and wellbeing of children through influencing attitudes towards identity (Department of Health and Human Services, 2015). Access to most primary mental health services commissioned by PHNs will most likely continue to require a referral from a GP, psychiatrist or paediatrician, which suggests that GPs are an important piece of the multidisciplinary approach to coordinated care for people in SEMPHN catchment (Department of Health, 2016g).

Key players

GPs, Other allied mental and physical health providers

7.2.7. Linkages to broader social supports

Service Element	Key design parameters	Service element outcomes
Linkages to broader social supports The purpose of this service element is to link children and young people experiencing mild-severe into the broader social supports necessary to lead a meaningful life, including vocational support and AOD services.	Provides a comprehensive and current resource directory of information about community resources and supports that can assist young people with mental illness and their families to engage with protective social supports within their community. The directory will be available online and will seek to integrate rather than duplicate existing community directories. Areas of focus will include: • social groups and activities • wellbeing programs • sports, recreation, arts • education and training. Targets children and young people with mental illness and their families, including those with severe mental illness who are ineligible for the NDIS. For children and young people with mild-moderate mental illness, access to supports is primarily self-directed or undertaken with some assistance from family support services and/or their treating mental health professional as part of care planning. For children and young people with severe mental illness who are ineligible for the NDIS, linkages to broader social supports will be supported within the context of complex-care coordination and recovery planning. For NDIS eligible consumers, the linkages function will be delivered by the Partners in Recovery program until transition to the NDIS.	Consumers access services that are culturally safe and age-appropriate Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience well-coordinated services as they move through the stepped care model Consumers with mental illness experience improvement in cultural, physical and social outcomes

Rationale

Severe mental illness is not just characterised by clinical symptoms but also the degree of disablement to social, personal, family and occupation functioning (Department of Health, 2016g). Currently mental health support services are fragmented from broader social supports (South Eastern Melbourne PHN, 2016). This coupled with higher than average rates of children on protection orders and substantiated child abuse in some regions contributes to the need for linkages to social supports.

A coordinated and linked approach would bring together organisations in health, policing, employment, housing, justice, education and the community to plan prevention initiatives, interventions and crisis responses (Department of Health and Human Services, 2016).This approach includes professionals, people with lived experience, and people from organisations putting in place a coordinated approach for local communities (Department of Health and Human Services, 2016).

This suggests a demand for the coordination of programs to encouraged active linkages and referral pathways. SEMPHN will facilitate proactive engagement with disengaged children and young people who are isolated from services, and support their path through the local service system.

Key players

GPs, Primary mental health services, Peer workers, Community organisations

7.2.8. Family Mental Health Support Services

Service Element	Key design parameters	Service element outcomes
Family Mental Health Support Services The purpose of this service element is to improve mental health outcomes for children and young people by supporting families and young people who are at risk of, or experiencing mental illness.	Provide interventions for children under the age of 18 experiencing, or at risk of, mental illness, and their families. Highest priority is given to vulnerable children, young people and their families including those from Aboriginal or culturally and linguistically diverse backgrounds, children and families in contact with the child protection system, and young people transitioning from out-of-home care. Services will accept referrals of children and young people from any source, including self-referrals, and conduct an initial brief screening process to ensure Family Mental Health Support Services is the appropriate service for them. A formal diagnosis of mental illness is not required to access FMHSS. Interventions may include intensive, long-term support as well as short-term assistance for families.	Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access appropriate mental health care in modalities aligned to their individual needs Consumers experience improved mental health and wellbeing outcomes

Rationale
Frankston, Port Phillip and Greater Dandenong have higher than average rates of children on child protection orders and Frankston, Greater Dandenong and Mornington Peninsula have higher than average rates of substantiated child abuse. These children as well as children from Indigenous or culturally diverse backgrounds, or children transitioning from out-of-home care experience, or are at risk of, mental illness (Department of Social Services, 2015)The support provided by families, friends, and carers is essential to preventing suicide in young people, therefore it is important these support networks are included by services (Department of Health and Human Services, 2016). Family Mental Health Support Services aim to provide flexible and responsive interventions that increase access for children and their families to mental health services. These services aim to improve emotional health and wellbeing, give children and young people the tools to better manage different aspects of their lives, provide families and carers support in helping their children and young people and increase the communities understanding and response to mental health issues (Department of Social Services, 2015).
Key players
FMHSS providers

7.2.9. Early intervention services for young people with severe mental illness

Service Element	Key design parameters	Service element outcomes
Early intervention services for young people with severe mental illness This service element will provide early intervention services designed for young people experiencing the early stages of severe mental illness.	Support the transition of existing services previously funded under the Early Psychosis Youth Services program. Provide workforce development designed at identifying risk factors and providing at-risk young people with support and referral pathways as necessary. Provide assertive outreach to young people, especially boys and young men, to support their engagement with early intervention mental health services.	Consumers access services that are culturally safe and age-appropriate Consumers experience improved mental health and wellbeing outcomes Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale
Frankston, Port Phillip and Greater Dandenong have higher than average rates of children on child protection orders and Frankston, Greater Dandenong and Mornington Peninsula have higher than average rates of substantiated child abuse (South Eastern Melbourne PHN, 2016). These children as well as children from Indigenous or culturally diverse backgrounds, or children transitioning from out-of-home care experience, or are at risk of mental illness (Department of Social Services, 2015). Frankston has high prescribing rates for all psychotropic medicines and the highest proportion of young people accessing MBS funded mental health services in the SEMPHN region(South Eastern Melbourne PHN, 2016). Dandenong however, although has similar determinants of mental illness for young people, has a low proportion of young people accessing MBS-funded mental health services and low prescribing rates of psychotropic medicines (South Eastern Melbourne PHN, 2016). Evidence based early intervention reduces the prevalence and impact of mental illness and can have a significant impact on a wide range of outcomes (Department of Health, 2016f).
Key players
GPs, Mental health services

7.2.10. Specialised complex care coordination packages

Service Element	Key design parameters	Service element outcomes
Specialised complex care coordination packages The purpose of this service element is to provide packages of care coordination support to young people aged 12-25 with severe and complex mental illness, in community-based general practices, private psychiatrist services, and other appropriate services.	Provide access to appropriately qualified mental health professional specialised in working with children and young people to provide clinical care coordination services to children and young people with severe and complex mental illness. Services may be based in general practices, private psychiatry or other appropriate settings. The mental health professional will be responsible for establishing a therapeutic relationship with the consumer; liaising closely with family and carers as appropriate; regularly reviewing the consumer's mental state; administering, monitoring and ensuring compliance by consumers with their medication; and, providing information on physical health care to consumers. Consumers are eligible for complex care coordination support if they have been identified by their GP or psychiatrist as eligible for the program, and that person will be the main person responsible for the consumer's clinical mental health care. Eligible organisations, and contracted mental health professionals, must have appropriate insurance coverage. Appropriate reminder systems (e.g. call backs, text messages) will be established to minimise failures to attend.	Consumers access services that are culturally safe and age-appropriate Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers with mental illness experience improvement in cultural, physical and social outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale

It is estimated that 3.1% people in SEMPHN experience severe and complex mental illness (South Eastern Melbourne PHN, 2016). Navigating through the mental health system is difficult for these consumers, especially for people experiencing disadvantage within the catchment. Young people who experience disadvantage are represented highly in Frankston, Port Phillip and Greater Dandenong where there are higher than average rates of on child protection orders (South Eastern Melbourne PHN, 2016). There is also higher than average rates of substantiated child abuse in Frankston, Greater Dandenong. These children, as well as children from Indigenous or culturally diverse backgrounds and/or children transitioning from out-of-home care experience, or are at risk of mental illness (Department of Social Services, 2015). A specific component of the Mental Health Nurse Incentive Program (MHNIP) is to provide clients with severe mental illness access to a mental health nurse. MHNs coordinate treatment and provide services that are client focused, recovery-oriented and responsive to the needs of people across ages, cultures and settings (The Australian College of Mental Health Nurses inc., 2016).

A need for improved inter-connectedness and referral pathways has been identified to improve the way young people with severe and complex mental illness enter and navigate through the mental health system (South Eastern Melbourne PHN, 2016).

MHNIP utilisation is highest in the SA3 region of Frankston and lowest in Casey North and Dandenong. Reasons for high and low service utilisation should be investigated especially the high prevalence of mental illness in Dandenong and low MHNIP services utilisation (South Eastern Melbourne PHN, 2016).

From 2017-18, mental health nurse funding will operate solely within the PHN funding pool. MHNs implement a holistic and patient-centred approach to patients physical and mental health issues. Care can be provided in a range of settings, such as in clinics, patient's home or by telephone. Facilitating factors from a patient's perspective are: comfortable setting, service flexibility, holistic and affordable care and convenience and reduced stigma associated with services being available at GP practices. Evidence suggests that MHNIP improves care and encourages patients to feel well and connected with their communities (Harris et al., 2016).

Key players

GPs, Psychiatrists, Other allied mental health providers

7.3. Services targeting priority populations

7.3.1. Targeted resilience building and mental health literacy programs

Service Element	Key design parameters	Service element outcomes
Targeted resilience building and mental health literacy programs The purpose of this service element is to provide targeted health promotion to support resilience building and mental health literacy within key cohorts.	Provide evidence-based information and resources focused on mental health literacy and resilience building targeted to at-risk disadvantaged communities. Information will focus on navigating the primary health (and mental health) system. As a focus will be on priority communities (CALD, refugee populations), information and resources will be in-language where appropriate, and available in a range of modalities (including printed materials and community information sessions). Provide evidence-based training on simple resilience building interventions to non-mental health professionals who regularly work with at-risk cohorts.	Consumers access services that are culturally safe and age-appropriate Rates of self-harm and suicide in at-risk groups are reduced Consumers access needs-appropriate mental health care in a timely way Downstream costs of care decrease through earlier intervention

Rationale

The SEMPHN catchment health literacy survey results suggest 40% of residents have difficulty navigating the health system. This is unsurprising as between 2006 and 2016 12,128 humanitarian entrants have settled in the SEMPHN catchment area, mostly in Dandenong (54%) and Casey (38%), and in the last 5 years 74% of those entrants have had very poor or no proficiency in English (PHN Needs Assessment). This population has contributed to the diversity of the SEMPHN catchment area in which 33% of people were born overseas. This percentage is higher in the City of Greater Dandenong (60%), City of Glen Eira (37%), and the City of Casey (37%).

Low proficiency in English is a contributing factor to mental health issues, therefore building mental health literacy is important. Building social resilience is equally important as disconnect from family and friends, uncertainty about the future including visa status, stress of migration, racism and discrimination, trauma, limited occupational opportunity, food insecurity, lack of meaningful activity, and lack of or poor use of interpreter services are determinants that affect the CALD and/or asylum and refugee population in the catchment. The CALD population's poor health literacy levels decrease their health literacy by decreasing their ability to find good health information and navigate the health system. Another group that is socially disadvantaged is older people. Factors that contribute to their increased risk of mental health issues include loss of ability to live independently, drop in socioeconomic status, feeling isolated, loneliness, elder abuse and age discrimination (South Eastern Melbourne PHN, 2016).

This suggests that there is benefit in targeted resilience building to improve engagement that is appropriate and effective.

Key players

Community-based organisations

7.3.2. Cohort-targeted suicide risk identification and prevention programs

Service Element	Key design parameters	Service element outcomes
Cohort-targeted suicide risk identification and prevention programs The purpose of this element is to support and supplement existing community-based suicide risk identification and prevention (with a focus on priority cohorts) through workforce training and education, particularly for **system 'gatekeepers', and** providing follow-up and support for adults who have self-harmed or attempted suicide.	Strengthen systemic and community capacity to identify suicide risk and deliver appropriate supports through training and partnership building. Initial priority will be given to the cities of Port Phillip and Frankston, and in communities with identified high-needs, especially people identifying as LGBTI and CALD communities. Provide workforce training to frontline primary mental health professionals and peer workers to strengthen systemic capacity to identify and reduce suicide risk among socially disadvantaged cohorts. Develop and leverage cross-sectoral partnerships to provide training to the non-health workforce in contact with adults at risk of suicide, including those in the welfare, housing and justice sectors, and within agencies that have regular engagement with the target cohorts. The focus of training will be on systematically building capacity in alignment with current best-practice in suicide prevention. Training will have a practical, implementation focus. It will be initially prioritised to the cities of Port Phillip and Frankston. Training quality and effectiveness will be evaluated. Deliver well-coordinated follow-up support to people who have self-harmed or attempted suicide. Clear responsibilities for the coordination and delivery of timely follow-up support are agreed and documented at the regional level.	Consumers access services that are culturally safe and age-appropriate Rates of self-harm and suicide in at-risk groups are reduced Consumers access needs-appropriate mental health care in a timely way Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Downstream costs of care decrease through earlier intervention

Rationale

In addition to the premature loss of life, suicide can have a profound and lasting negative impact on families, workplaces and communities (Department of Health, 2016e). Port Phillip, Frankston, Cardinia and Mornington Peninsula LGAs have higher than average rates of suicide deaths, attempts and or ideation. These areas, particularly Port Philip SA3, which has the highest length of stay in hospital for intentional self-harm (7.2 days, 1.6 times greater than SEMPHN average), and Frankston SA3 which has high rates of hospitalisation for intentional self-harm (221 per 100,000 ASR, 1.9 times greater than SEMPHN average) are a focus for SEMPHN (South Eastern Melbourne PHN, 2016).

Suicide issues and risk factors affecting each socially disadvantaged community are unique (The Black Dog Institute, 2016). Socially disadvantaged populations within SEMPHN include LGBTI people, older Australians, CALD communities refugee and asylum seekers and people experiencing homelessness.

Homosexual/bisexual Australians are twice as likely to have high/very high levels of psychological distress and experience anxiety disorders compared to heterosexual Australians (South Eastern Melbourne PHN, 2016). Compared to the general population LGBTI people are more likely to attempt suicide and more likely to have suicidal thoughts and delay seeking treatment as they expect they will face discrimination and reduced quality of care (South Eastern Melbourne PHN, 2016). Similarly CALD, refugee and asylum seeker communities may not have access to services that respond to different cultural perceptions of mental health (South Eastern Melbourne PHN, 2016)The CALD cohort in particular has a relatively low mental health service use compared to Australian born populations with similar mental health needs, and may be more likely to access care when they become acutely and seriously unwell (South Eastern Melbourne PHN, 2016), therefore targeted prevention that improves access at early onset of mental ill health before they reach crisis point is a priority.

A 2016 report on evidence-based approaches to suicide prevention supports a multi-agency approach to suicide prevention that includes both designated gatekeepers (those who are formally trained such as GPs and psychiatrists etc.) and emergent gatekeepers who are part of the wider community and are not formally trained but still recognised by those with suicidal intent as gatekeepers, for example police, clergy, pharmacists, teachers, counsellors, family and friends, school and work peers, and crisis line staff. These people can be influential in a person's decision to access care and may reduce risk of suicide (The Black Dog Institute, 2016)

Key players

GPs, Mental health services, Community-based organisations

7.3.3. Accessible psychological interventions

Service Element	Key design parameters	Service element outcomes
Accessible psychological interventions Accessible Psychological Interventions are flexible services that are intended to support consumers with a mental illness who will benefit from individual, family and/or group provision of psychological services from allied health professionals.	Provide access to flexible services that are intended to support consumers with a mental illness who will benefit from individual, family and/or group provision of psychological services from allied health professionals. The range of interventions that can be delivered is consistent with those available privately under the Commonwealth Better Access to Mental Health Care program. Accessible at no cost by adult consumers in the SEMPHN catchment, with a diagnosed mental illness, experiencing demonstrable financial hardship or who belong to traditionally underserviced priority groups. Health professionals providing services must be appropriately trained in working with the socially disadvantaged cohort they are treating (e.g. trauma-informed approaches when working with refugee populations). At least one available professional must provide services from premises no more than one hour by public transport or 20 minutes drive from a consumer's usual place of residence. Services are to be available outside of traditional business hours to support accessibility for consumer with other commitments.	Consumers access services that are culturally safe and age-appropriate Consumers experiencing social disadvantage access care on an equitable basis Consumers experience improved mental health and wellbeing outcomes Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale

The SEMPHN catchment has higher rates of psychological distress and suicide, when compared to the Victorian and Australian averages. The catchment covers areas of significant disadvantage, notably the LGAs of Frankton and Greater Dandenong, with pockets of disadvantage in other suburbs. This suggests that there are cohorts of primary health consumers who would struggle to access allied psychological services through an MBS rebate.

Currently, this service element is provided through the *Access to Allied Psychological Services* (ATAPS) program. The ten-year evaluation of ATAPS (conducted in 2013) found that consumer outcomes improved significantly and were indicative of clinical improvement, and that the program "continues to be an integral part of the primary mental health care system in Australia."

Together this suggests ongoing demand for, and evidence of value to, brief, focused psychological interventions for adults experiencing mild mental illness, where financial hardship is a barrier to accessing alternative programs.

Key players

GPs, Psychiatrists, Private allied health providers

7.3.4. Cohort-specialised GP-led care coordination

Service Element	Key design parameters	Service element outcomes
Cohort-specialised GP-led care coordination The purpose of this element is to provide clinical care coordination for adults with a mild-moderate mental illness.	GP-led care coordination is delivered for socially disadvantaged cohorts through implementation of Mental Health Plans under the MBS. Strengthened systemic capacity to deliver high quality care coordination will be enabled through training and information for GPs focused on: • understanding and accessing the regionally available services and supports relevant to socially disadvantaged cohorts, and • clinical knowledge and skills development relating to management of mental illness in specific socially disadvantaged cohorts (e.g. refugees). Training and information will also be provided for other professional groups who may provide GP-referred services under a Mental Health Plan. Awareness raising activities focused on the availability of GP support for mental health issues in specific socially disadvantaged cohorts.	Consumers access services that are culturally safe and age-appropriate Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers with mental illness experience improvement in cultural, physical and social outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale

Collaborative and coordinated care involves GPs and mental health professionals working together (Harris et al., 2016). GPs are critical to ensuring people are referred to the right care at the right time as they are the gatekeepers to other services and usually the first point of critical contact for people seeking health for mental health problems and mental illness (Department of Health, 2016g).

The Dandenong region of SEMPHN catchment has a low rate of MBS funded services for the preparation of mental health treatment plans by GPs, despite high need of mental health services (South Eastern Melbourne PHN, 2016).Socially disadvantaged populations are more likely to be misunderstood and misdiagnosed, for example the CALD population this is often due to language and cultural barriers (South Eastern Melbourne PHN, 2016)

Access to most primary mental health services commissioned by PHNs will most likely continue to require a referral from a GP, psychiatrist or paediatrician. GPs are an important piece of the multidisciplinary approach to coordinated care for people in SEMPHN catchment (Department of Health, 2016g), therefore it is important they are responsive to the needs of socially disadvantaged populations

Key players

GPs, Other allied mental and physical health providers

7.3.5. Active outreach and engagement services for hard-to-reach populations

Service Element	Key design parameters	Service element outcomes
Active outreach and engagement services for hard-to-reach populations The purpose of this service element is to provide additional support for engagement activities and outreach services for hard-to-reach populations.	Provide support to GP practices and primary mental health services to develop and pursue outreach and engagement activities with hard-to-reach populations. Grants will be assessed on their merit for reaching the following identified populations: Afghan women; people with a CALD background in the Cities of Dandenong and Casey; LGBTI people; and people experiencing homelessness. This service element will involve coordination activities and service delivery in partnership with key community services in target cohorts.	Consumers access services that are culturally safe and age-appropriate Consumers experiencing social disadvantage access care on an equitable basis Consumers access appropriate mental health care in modalities aligned to their individual needs Consumers and those supporting them have a good experience when accessing support, care and treatment Downstream costs of care decrease through earlier intervention

Rationale

Between 2006 and 2016, 12,128 humanitarian entrants have settled in the SEMPHN catchment area, mostly in Dandenong (54%) and Casey (38%), and in the last 5 years 74% of those entrants have had very poor or no proficiency in English (PHN Needs Assessment). Other socially disadvantaged populations within SEMPHN include Afghan women, LGBTI people, older Australians, and people experiencing homelessness. Outreach and engagement services are necessary to break down the barriers preventing and limiting these hard-to-reach populations from accessing mental health services.

Some areas suffer greater social disadvantage than others, in particular, Greater Dandenong and Frankston. There is low community strength and support in Greater Dandenong, high proportion of disability support pensioners in Greater Dandenong (7.9%), Frankston (6.7%), and Mornington Peninsula (6.1%) compared to 5.4% in Victoria. Port Phillip and Greater Dandenong have a high rate of homelessness and Frankston, Greater Dandenong, Cardinia and Casey have high rates of reported incidents of family violence. High proportion of people reporting a poor work-life balance in Kingston (51.6%), Casey (49.5%), Stonington (49.1%) and Frankston (48.2%) compared to 46.9% in Victoria (South Eastern Melbourne PHN, 2016).

SEMPHN will facilitate proactive engagement with disadvantaged people who are socially isolated and disengaged and support their path through the local service system.

Key players

GPs, Mental health services, Community-based organisations

7.3.6. Linkages to cohort-appropriate social supports

Service Element	Key design parameters	Service element outcomes
Linkages to cohort-appropriate social supports The purpose of this service element is to link priority people experiencing mild-severe into the broader social supports necessary to lead a meaningful life, including vocational support and AOD services.	Provides a comprehensive and current resource directory of information about community resources and supports that can assist socially disadvantaged people with mental illness and their families to engage with protective social supports within their community. Initially the priority focus will be on people who are homeless, people who are socially isolated, and people who have been victims of family violence. The directory will be available online and will seek to integrate rather than duplicate existing community directories. Areas of focus will include: social groups and activities; wellbeing programs; sports, recreation, arts; and education and training. Targets socially disadvantaged people and their families, including those with severe mental illness who are ineligible for the NDIS. For people with mild-moderate mental illness, access to supports is primarily self-directed or undertaken with some assistance from support services and/or their treating mental health professional as part of care planning. For people with severe mental illness who are ineligible for the NDIS, linkages to broader social supports will be supported within the context of complex-care coordination and recovery planning. For NDIS eligible consumers, the linkages function will be delivered by the Partners in Recovery program until transition to the NDIS.	Consumers access services that are culturally safe and age-appropriate Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experiencing social disadvantage access care on an equitable basis Consumers experience well-coordinated services as they move through the stepped care model Consumers with mental illness experience improvement in cultural, physical and social outcomes

Rationale

SEMPHN is a catchment area that is diverse and complex. Some areas suffer greater social disadvantage than others. Greater Dandenong and Frankston in particular. There is low community strength and support in Greater Dandenong, high proportion of disability support pensioners in Greater Dandenong (7.9%), Frankston (6.7%), and Mornington Peninsula (6.1%) compared to 5.4% in Victoria. Port Phillip and Greater Dandenong have a high rate of homelessness and Frankston, Greater Dandenong, Cardinia and Casey have high rates of reported incidents of family violence. High proportion of people reporting a poor work-life balance in Kingston (51.6%), Casey (49.5%), Stonington (49.1%) and Frankston (48.2%) compared to 46.9% in Victoria (South Eastern Melbourne PHN, 2016).

Severe mental illness is not just characterised by clinical symptoms but also the degree of disablement to social, personal, family and occupation functioning (Department of Health, 2016g). Currently mental health support services are fragmented from broader social supports within the SEMPHN catchment (South Eastern Melbourne PHN, 2016). A coordinated and linked approach would bring together organisations in health, policing, employment, housing, justice, education and the community to plan prevention initiatives, interventions and crisis responses (Department of Health and Human Services, 2016).This approach includes professionals, people with lived experience, and people from organisations putting in place a coordinated approach for local communities (Department of Health and Human Services, 2016).

This suggests a demand for the coordination of programs to encouraged active linkages and referral pathways. SEMPHN will facilitate proactive engagement with disadvantaged people who are socially isolated and disengaged and support their path through the local service system.

Key players

GPs, Primary mental health services, Peer workers, Community organisations

7.3.7. Cohort-specialised complex care coordination

Service Element	Key design parameters	Service element outcomes
Cohort-specialised complex care coordination The purpose of this service element is to provide packages of care coordination support for people from targeted cohorts with severe and complex mental illness, in community-based general practices, private psychiatrist services, and other appropriate services.	Provide access to appropriately qualified mental health professional specialised in working with defined target cohorts (e.g. homeless, CALD groups) to provide clinical care coordination services people with severe and complex mental illness. Services may be based in general practices, private psychiatry or other appropriate settings. The mental health professional will be responsible for establishing a therapeutic relationship with the consumer; liaising closely with family and carers as appropriate; regularly reviewing the consumer's mental state; administering, monitoring and ensuring compliance by consumers with their medication; and, providing information on physical health care to consumers. Consumers are eligible for complex care coordination support if they have been identified by their GP or psychiatrist as eligible for the program, and that person will be the main person responsible for the consumer's clinical mental health care. Eligible organisations, and contracted mental health professionals, must have appropriate insurance coverage. Appropriate reminder systems (e.g. call backs, text messages) will be established to minimise failures to attend.	Consumers access services that are culturally safe and age-appropriate Consumers experiencing social disadvantage access care on an equitable basis Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers with mental illness experience improvement in cultural, physical and social outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale

People with severe and complex mental illness reside in SEMPHN. Navigating through the mental health system is difficult for these consumers, especially for people experiencing disadvantage within the catchment. A need for improved inter-connectedness and referral pathways has been identified by SEMPHN (PHN Needs Assessment). A specific component of the Mental Health Nurse Incentive Program (MHNIP) is to provide clients with severe mental illness access to a mental health nurse. MHNs coordinate treatment and provide services that are client focused, recovery-oriented and responsive to the needs of people across ages, cultures and settings (The Australian College of Mental Health Nurses inc., 2016).

The Mental Health Nurse Incentive Program (MHNIP) utilisation is highest in the SA3 region of Frankston and lowest in Casey North and Dandenong. Reasons for high and low service utilisation should be investigated especially the high prevalence of mental illness in Dandenong and low MHNIP services utilisation (South Eastern Melbourne PHN, 2016).

From 2017-18, mental health nurse funding will operate solely within the PHN funding pool. MHNs implement a holistic and patient-centred approach to patients physical and mental health issues. Care can be provided in a range of settings, such as in clinics, patient's home or by telephone. Facilitating factors from a patient's perspective are: comfortable setting, service flexibility, holistic and affordable care and convenience and reduced stigma associated with services being available at GP practices. Evidence suggests that MHNIP improves care and encourages patients to feel well and connected with their communities (Harris et al., 2016).

Key players

GPs, Psychiatrists, Other allied mental health providers

7.4. Aboriginal and Torres Strait Islander services

7.4.1. Aboriginal and Torres Strait Islander targeted cultural strengthening and social and emotional wellbeing programs

Service Element	Key design parameters	Service element outcomes
Aboriginal and Torres Strait Islander targeted cultural strengthening and social and emotional wellbeing programs The purpose of this service element is to provide social and emotional wellbeing programs. These programs are designed to engage Aboriginal people in developing resilience and protective factors through cultural strengthening.	Strengthen systemic and community capacity identify and deliver appropriate cultural strengthening programs through training and partnership building with the Aboriginal Community in the region. Strengthen pathways to available cultural strengthening programs for Aboriginal and Torres Strait Islander people who come into contact with primary health services in the region. Provide workforce training to frontline primary mental health professionals and peer workers to strengthen systemic capacity to work within the SEWB model. Develop and leverage cross-sectoral partnerships that engage with the Aboriginal community and provide training on holistic approaches to social and emotional wellbeing, focused on building capacity in the non-health workforce in contact with Aboriginal and Torres Strait Islander.	Consumers experiencing social disadvantage access care on an equitable basis Consumers access services that are culturally safe and age-appropriate Consumers experience improved mental health and wellbeing outcomes Rates of self-harm and suicide in at-risk groups are reduced Consumers with mental illness experience improvement in cultural, physical and social outcomes

Rationale

An estimated 7,000 people of Aboriginal and/or Torres Strait Islander origin live in the SEMPHN catchment area, of which 27% live in Casey, followed by 19% in Frankston, and 17% in the Mornington Peninsula (South Eastern Melbourne PHN, 2016). High rates of suicide among Aboriginal and Torres Strait Islander peoples can be attributed to complex factors of social, economic, and historic determinants that can lead to poor social and emotional wellbeing and mental health (Department of Health and Ageing, 2013). SEMPHN recognises that damage to traditional culture, spirituality, and language, contribute to increased risk of mental health issues within their catchment (South Eastern Melbourne PHN, 2016).

Services/programs that are culturally shaped understand that health is holistic and connected to the individual, family and kin, community, culture, country and the spiritual dimension of existence (Department of Health, 2016b). Services/programs that target cultural strengthening should acknowledge this as well as cultural differences between Aboriginal and Torres Strait Islander communities such as groupings, languages, kinships and tribes, and ways of living (The Black Dog Institute, 2016) (Department of Health and Ageing, 2013).

Key players

GPs, Aboriginal Community Controlled Organisations, Aboriginal Community Controlled Health Organisations, Non-health sector stakeholders

7.4.2. Aboriginal and Torres Strait Islander targeted suicide risk identification and prevention programs

Service Element	Key design parameters	Service element outcomes
Aboriginal and Torres Strait Islander targeted suicide risk identification and prevention programs The purpose of this element is to support and supplement existing community-based suicide risk identification and prevention for Aboriginal and Torres Strait Islander people through workforce training and education, particularly for **system 'gatekeepers', and** providing follow-up and support for adults who have self-harmed or attempted suicide.	Strengthen systemic and community capacity to identify suicide risk and deliver appropriate supports through training and partnership building with the Aboriginal Community in the region. Provide workforce training to frontline primary mental health professionals and peer workers to strengthen systemic capacity to identify and reduce suicide risk in Aboriginal and Torres Strait Islander people, with specific emphasis on the SEWB model. Develop and leverage cross-sectoral partnerships that engage with the Aboriginal community and provide training to the non-health workforce in contact with Aboriginal and Torres Strait Islander people at risk of suicide, including those in the welfare, housing and justice sectors, and within agencies that have regular engagement with the target cohorts. The focus of training will be on systematically building capacity in alignment with current best-practice in suicide prevention. Training will have a practical, implementation focus. Training quality and effectiveness will be evaluated. Deliver well-coordinated follow-up support to Aboriginal and Torres Strait Islander people who have self-harmed or attempted suicide. Clear responsibilities for the coordination and delivery of timely follow-up support are agreed and documented at the regional level.	Consumers access services that are culturally safe and age-appropriate Rates of self-harm and suicide in at-risk groups are reduced Consumers access needs-appropriate mental health care in a timely way Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Downstream costs of care decrease through earlier intervention

Rationale

Intentional self-harm was the leading cause of death from 2011-2015 for Indigenous Australians between 15 and 34 years of age (South Eastern Melbourne PHN, 2016). In addition to the premature loss of life, suicide can have a profound and lasting negative impact on families, workplaces and communities (Department of Health, 2016e). Port Phillip, Frankston, Cardinia and Mornington Peninsula LGAs have higher than average rates of suicide deaths, attempts and or ideation. Of the Aboriginal and Torres Strait Islander population living in SEMPHN, 19% live in Frankston and 17% om the Mornington Peninsula. These LGAs also have high mental health service needs (South Eastern Melbourne PHN, 2016). Frankston SA3 has high rates of hospitalisation for intentional self-harm - 1.9 times greater than SEMPHN average (South Eastern Melbourne PHN, 2016). Aboriginal and Torres Strait Islander suicide prevention initiatives need to account for the cultural differences between diverse Aboriginal and Torres Strait Islander communities and the general population (The Black Dog Institute, 2016).Differences include cultural groupings, languages, kinships and tribes, and ways of living (Department of Health and Ageing, 2013). .

The same report notes the importance of designated gatekeepers (those who are formally trained such as GPs and psychiatrists etc.) and emergent gatekeepers who are part of the wider community and are not formally trained but still recognised by those with suicidal intent as gatekeepers, for example police, clergy, pharmacists, teachers, counsellors, family and friends, school and work peers, and crisis line staff. These people can be influential in a person's decision to access care and may reduce risk of suicide (The Black Dog Institute, 2016).

Key players

Aboriginal Community Controlled Health Organisations, GPs, Mental health services, Community-based organisations

7.4.3. Culturally appropriate, self-directed digital MH services

Service Element	Key design parameters	Service element outcomes
Culturally appropriate, self-directed digital MH services The purpose of this service element is to provide online support services for Aboriginal and Torres Strait Islander people experiencing, or at risk of, mild mental illness.	The Digital Gateway will provide access to online and mobile-based interactive websites and/or apps, using fully automated self-help programs, which can be accessed 24/7 by consumers, including Aboriginal and Torres Strait Islander people. Material will be available to young people (and those working with them) in the region providing information about evidence-based, self-directed digital mental health services. Information will also be provided about alternatives within the stepped care model and how these are accessed. Information provided about the Digital Gateway will be made available in culturally appropriate forms. Mental health and other service providers who are touchpoints for potentially at-risk Aboriginal and Torres Strait Islander people will receive brief training and information about who benefits from self-directed digital MH services, and how they can support young people to appropriately access these services.	Consumers access services that are culturally safe and age-appropriate Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Resources available to the system are deployed sustainably and efficiently

Rationale

Digital mental health and self-help services are most relevant for prevention and early intervention. Digital mental health services offer services that are low cost or no cost to the consumer. These services may be particularly valuable for Aboriginal and/or Torres Strait Islander population of SEMPHN catchment where culturally appropriate low intensity digital mental health services may bridge the gap to care that is usually inaccessible, unaffordable or unacceptable (Harris et al., 2016). Culturally appropriate services respond to the linguistic, cultural, social-economic and historical differences between communities and respect local cultures to strengthen mental health and wellbeing services (Department of Health and Ageing, 2013).

The digital health services, like other health services targeted towards Aboriginal and Torres Strait Islander population should ensure the service accounts for the differences between cultures and does not create a barrier for service delivery (The Black Dog Institute, 2016).

The most established evidence based e-mental health programs include Mental Health Online, This Way Up and the Mindspot Clinic. There is evidence of feasibility and effectiveness in reducing symptoms,(Harris et al., 2016). The Black Dog Institute suggests that digital technology can support consumers to access services and engage in self-care (The Black Dog Institute, 2016).

Key players

SEMPHN, Aboriginal Community Controlled Health Organisations

7.4.4. Culturally appropriate Family Mental Health Support Services for young people

Service Element	Key design parameters	Service element outcomes
Culturally appropriate Family Mental Health Support Services for young people The purpose of this service element is to improve mental health outcomes for Aboriginal and Torres Strait Islander children and young people by supporting families and young people who are at risk of, or experiencing mental illness.	Provide interventions for Aboriginal children under the age of 18 experiencing, or at risk of, mental illness, and their families. Highest priority is given to vulnerable children, young people and their families including those from Aboriginal or culturally and linguistically diverse backgrounds, children and families in contact with the child protection system, and young people transitioning from out-of-home care. Services will accept referrals of children and young people from any source, including self-referrals, and conduct an initial brief screening process to ensure Family Mental Health Support Services is the appropriate service for them. A formal diagnosis of mental illness is not required to access FMHSS. Interventions may include intensive, long term support as well as short term assistance for families. Services are delivered in a culturally safe context.	Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access appropriate mental health care in modalities aligned to their individual needs Consumers experience improved mental health and wellbeing outcomes

Rationale

Aboriginal and Torres Strait Islander population living in SEMPHN, 27% live in Casey, 19% in Frankston and 17% in the Mornington Peninsula. Frankston, Port Phillip and Greater Dandenong have higher than average rates of children on child protection orders, and Frankston, Greater Dandenong and Mornington Peninsula have higher than average rates of substantiated child abuse. These, who may also be from Aboriginal and Torres Strait Islander communities, and/or transitioning from out-of-home care experience, or are at risk of, mental illness(Department of Social Services, 2015).

Family Mental Health Support Services aim to provide flexible and responsive interventions that increase access for these children and their families to mental health services that will improve emotional health and wellbeing, give children and young people the tools to better manage different aspects of their lives, provide families and carers support in helping their children and young people, and increase the communities understanding and response to mental health issues (Department of Social Services, 2015).

Key players

FMHSS providers, Aboriginal Community Controlled Health Organisations

7.4.5. Clinician/AHW supported culturally appropriate digital MH services

Service Element	Key design parameters	Service element outcomes
Clinician/AHW supported culturally appropriate digital MH services The purpose of this service element is to provide supported online mental health services for Aboriginal and Torres Strait Islander people with mild-moderate mental illness.	Provide psychological interventions through online modalities, supported by appropriately qualified primary mental health professionals or AHWs. The target group is Aboriginal and Torres Strait Islander people with mild-moderate mental illness who have a sufficient level of technological literacy to benefit from online programs. The support role will include coaching occurring alongside young people undertaking online programs, in the form of telephone contact, emails, or in-person support. Primary mental health professionals or AHWs will play a role in motivating and enabling Aboriginal and Torres Strait Islander people to complete programs. Where additional supports re required, they may also refer consumers to other services within the stepped care model. Training and information will be provided to primary mental health professionals and AHWs on effective approaches to supporting digital mental health services. Appropriate 'check-in' systems (e.g. call backs, text messages) will be established to support.	Consumers access services that are culturally safe and age-appropriate Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access appropriate mental health care in modalities aligned to their individual needs Consumers experience improved mental health and wellbeing outcomes Resources available to the system are deployed sustainably and efficiently

Rationale

Digital mental health and self-help services are most relevant for prevention and early intervention. Digital mental health services can be self-directed by the consumer or offered with guidance from clinicians, teachers, administrators or peers self-health programs.

Culturally appropriate services respond to the linguistic, cultural, social-economic and historical differences between communities and respect local cultures to strengthen mental health and wellbeing services (Department of Health and Ageing, 2013).

The digital health services, like other health services targeted towards Aboriginal and Torres Strait Islander population should ensure the service accounts for the differences between cultures and does not create a barrier for service delivery (The Black Dog Institute, 2016).

Digital mental health includes phone, online, interactive website, apps, sensor-based monitoring devices and computers. Can be delivered through home, school, workplace and clinicians' workplaces. The PHN will actively promote the use the Digital Mental Health Gateway which will act as a form of triage to assist people to access the most appropriate digital mental health services based on their specific needs

The most established evidence based e-mental health programs include Mental Health Online, This Way Up and the Mindspot Clinic. There is evidence of feasibility and effectiveness in reducing symptoms, including at longer term follow-up (Harris et al., 2016). There is also significant evidence that supporting good outcomes from mix digital and face-to-face support services. For consumer with mild to moderate depression it has been found that CBT web based with face-to-face therapist support is indicated to reduce depressive symptoms in the short term only (7 weeks post-treatment) (Mazza et al.).

SEMPHN will facilitate proactive engagement between Aboriginal and Torres Strait Islander people and online mental health services to support their path through the local mental health service system.

Key players

Aboriginal Community Controlled Health Organisations, GPs, Mental health services, SEMPHN

7.4.6. Culturally appropriate accessible psychological interventions

Service Element	Key design parameters	Service element outcomes
Culturally appropriate brief psychological interventions The purpose of this service elements is to provide culturally appropriate Accessible Psychological Interventions to support Aboriginal and Torres Strait Islander people with a mental illness who will benefit from individual, family and/or group provision of psychological services from allied health professionals.	Provide access to flexible services that are intended to support Aboriginal and Torres Strait Islander people with a mental illness who will benefit from individual, family and/or group provision of psychological services from allied health professionals. The range of interventions that can be delivered is consistent with those available privately under the Commonwealth Better Access to Mental Health Care program, extending to evidence based approaches known to be effective for Indigenous people. Accessible at no cost by Aboriginal and Torres Strait Islander people living or working in the SEMPHN catchment. Health professionals providing services must be appropriately trained in working with Aboriginal and Torres Strait Islander people, including the provision of culturally appropriate and culturally safe services. At least one available professional must provide services from premises no more than one hour by public transport or 20 minutes drive from a consumer's usual place of residence. Services are to be available outside of traditional business hours to support accessibility for consumer with other commitments.	Consumers access services that are culturally safe and age-appropriate Consumers experience improved mental health and wellbeing outcomes Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale

The SEMPHN catchment has higher rates of psychological distress and suicide, when compared to the Victorian and Australian averages. The Aboriginal and Torres Strait Islander population within SEMPHN is not exempt from this statistic. It is important that brief psychological interventions are culturally appropriate which includes the cultural competency of staff. Culturally appropriate services respond to the linguistic, cultural, social-economic and historical differences between communities and respect local cultures to strengthen mental health and wellbeing services (Department of Health and Ageing, 2013).

The catchment covers areas of significant disadvantage, notably the LGAs of Frankton and Greater Dandenong, with pockets of disadvantage in other suburbs. This suggests that there are cohorts of primary health consumers who would struggle to access allied psychological services through an MBS rebate.

Currently, this service element is provided through the *Access to Allied Psychological Services* (ATAPS) program. The ten-year evaluation of ATAPS (conducted in 2013) found that consumer outcomes improved significantly and were indicative of clinical improvement, and that the program "continues to be an integral part of the primary mental health care system in Australia."

Together this suggests ongoing demand for, and evidence of value to, brief, focused psychological interventions for adults experiencing mild mental illness, where financial hardship is a barrier to accessing alternative programs.

Key players

Aboriginal Community Controlled Health Organisations, GPs, Psychiatrists, Private allied health providers

7.4.7. Culturally appropriate GP-led care coordination

Service Element	Key design parameters	Service element outcomes
Culturally appropriate GP-led care coordination The purpose of this element is to provide clinical care coordination for Aboriginal and Torres Strait Islander adults with a mild-moderate mental illness. This service element will provide additional support for workforce development to enable GPs to provide effective care coordination across multiple morbidities and services.	GP-led care coordination is delivered for Aboriginal and Torres Strait Islander people through implementation of Mental Health Plans under the MBS. Strengthened systemic capacity to deliver high quality care coordination will be enabled through training and information for GPs focused on: • strengthening cultural competence and culturally safe practises, including the SEWB model • understanding and accessing the regionally available services and supports relevant to Aboriginal and Torres Strait Islander people, and • clinical knowledge and skills development relating to management of mental illness in Aboriginal and Torres Strait Islander people Training and information will also be provided for other professional groups who may provide GP-referred services under a Mental Health Plan. Awareness raising activities focused on the availability of GP support for mental health issues for Aboriginal and Torres Strait Islander people.	Consumers access services that are culturally safe and age-appropriate Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers with mental illness experience improvement in cultural, physical and social outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale

An estimated 7000 people of Aboriginal and Torres Strait Islander originlive in the SEMPHN catchment therefore GPs should be trained and provide culturally appropriate services especially because navigating through the mental health system can be more difficult for Aboriginal and Torres Strait Islander individuals than other community members (The Black Dog Institute, 2016). GPs are critical to ensuring people are referred to the right care at the right time as they are the gatekeepers to other services and usually the first point of critical contact for people seeking health for mental health problems and mental illness (Department of Health, 2016g). Access to most primary mental health services commissioned by PHNs will likely continue to require a referral from a GP, psychiatrist or paediatrician therefore culturally appropriate service is a priority.

The Dandenong region of SEMPHN catchment has a low rate of MBS funded services for the preparation of mental health treatment plans by GPs, despite high need of mental health services (South Eastern Melbourne PHN, 2016). Collaborative and coordinated care involves GPs and mental health professionals working together (Harris et al., 2016). GPs are an important piece of the multidisciplinary approach to coordinated care for people in SEMPHN catchment (Department of Health, 2016g).

Key players

Aboriginal Community Controlled Health Organisations, GPs, Other allied mental and physical health providers

7.4.8. ACCHO-led care coordination

Service Element	Key design parameters	Service element outcomes
ACCHO-led care coordination The purpose of this element is to provide clinical care coordination for Aboriginal and Torres Strait Islander adults with a mild-moderate mental illness.	Provide additional support for workforce development to enable ACCHOs to extend capacity to provide effective care coordination across multiple morbidities and services. Provide support for ACCHOs to expand service capacity to deliver integrated, SEWB informed care coordination services.	Consumers access services that are culturally safe and age-appropriate Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes

Rationale

An estimated 7000 people of Aboriginal and/or Torres Strait Islander origin live in the SEMPHN catchment area, of which 27% live in Casey, followed by 19% in Frankston and 17% in the Mornington Peninsula. This population has experienced damage to traditional culture, spirituality and language, all of which contribute to increased risk of mental health issues (South Eastern Melbourne PHN, 2016).

Discrimination, racism, inter-generational trauma, child removals, and damage to traditional culture, spirituality and language contribute to increased mental health issues of Aboriginal and Torres Strait Islander people. ACCHO services are supported by clinical evidence and are delivered by an appropriately skilled workforce that is culturally aware, respectful, safe, and which understands the cultural determinants of health. Collaborative and coordinated care involves ACCHO, PHNs working and mental health professionals working together (Harris et al., 2016).

The Victorian government recognises the leadership role the ACCHO has in supporting resilience and addressing risk factors for poor mental health (Department of Health and Human Services, 2015). ACHHO are critical in engaging Aboriginal and Torres Strait Islander people and ensuring the right care is received at the right time.

Key players

Aboriginal Community Controlled Health Organisations, GPs, Other allied mental and physical health providers

7.4.9. Linkages to cultural and social supports

Service Element	Key design parameters	Service element outcomes
Linkages to cultural and social supports The purpose of this service element is to link Aboriginal and Torres Strait Islander people experiencing mild-severe into the broader social supports necessary to lead a meaningful life, including cultural and social and emotional wellbeing services.	Provides a comprehensive and current resource directory of information about community resources and supports that can assist Aboriginal and Torres Strait Islander people with mental illness and their families to engage with protective social supports within their community. The directory will be available online and will seek to integrate rather than duplicate existing community directories. Areas of focus will include: • social groups and activities • social and emotional wellbeing • sports, recreation, arts and cultural strengthening • education and training. Targets Aboriginal and Torres Strait Islander people and their families, including those with severe mental illness who are ineligible for the NDIS. For Aboriginal and Torres Strait Islander people with mild-moderate mental illness, access to supports is primarily self-directed or undertaken with some assistance from support services and/or their treating mental health professional as part of care planning. For Aboriginal and Torres Strait Islander people with severe mental illness who are ineligible for the NDIS, linkages to broader social supports will be supported within the context of complex-care coordination and recovery planning. For NDIS eligible consumers, the linkages function will be delivered by the Partners in Recovery program until transition to the NDIS.	Consumers access services that are culturally safe and age-appropriate Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience well-coordinated services as they move through the stepped care model Consumers with mental illness experience improvement in cultural, physical and social outcomes

Rationale

Severe mental illness is not just characterised by clinical symptoms but also the degree of disablement to social, personal, family and occupation functioning (Department of Health, 2016g). These factors are present among Aboriginal and Torres Strait Islander people who experience increased risk of mental health issues because of social disadvantage and damage to traditional culture, spirituality and language (South Eastern Melbourne PHN, 2016).

An estimated 7000 people of Aboriginal and/or Torres Strait Islander origin live in the SEMPHN catchment area, of which 27% live in Casey, followed by 19% in Frankston, and 17% in the Mornington Peninsula (South Eastern Melbourne PHN, 2016). Greater Dandenong and Frankston in particular suffer greater disadvantage within the SEMPHN catchment. There is low community strength and support in Greater Dandenong, high proportion of disability support pensioners in Greater Dandenong (7.9%), Frankston (6.7%), and Mornington Peninsula (6.1%) compared to 5.4% in Victoria. Port Phillip and Greater Dandenong have a high rate of homelessness and Frankston, Greater Dandenong, Cardinia and Casey have high rates of reported incidents of family violence. A highproportion of people report a poor work-life balance in Kingston (51.6%), Casey (49.5%), Stonington (49.1%) and Frankston (48.2%) compared to 46.9% in Victoria (South Eastern Melbourne PHN, 2016).

SEMPHN will facilitate proactive engagement with Aboriginal and Torres Strait Islander people who are socially isolated and disengaged and support their path through the local service system.

Key players

Aboriginal Community Controlled Health Organisations, Aboriginal Community Controlled Organisations, GPs, Primary mental health services, Peer workers, Community organisations

7.4.10. Culturally appropriate complex care coordination packages

Service Element	Key design parameters	Service element outcomes
Culturally appropriate complex care coordination packages The purpose of this service element is to provide packages of care coordination support for Aboriginal and Torres Strait Islander people with severe and complex mental illness, in community-based general practices, private psychiatrist services, ACCHOs, and other appropriate services.	Provide access to appropriately qualified mental health professional specialised in working with Aboriginal and Torres Strait Islander people to provide culturally appropriate clinical care coordination services people with severe and complex mental illness. Services may be based in ACCHOs, general practices, private psychiatry or other appropriate settings. The mental health professional will be responsible for establishing a therapeutic relationship with the consumer; liaising closely with family and carers as appropriate; regularly reviewing the consumer's mental state; administering, monitoring and ensuring compliance by consumers with their medication; and, providing information on physical health care to consumers. Health professionals providing services must be appropriately trained in working in a culturally safe way and in culturally appropriate modalities with Aboriginal and Torres Strait Islander people. Consumers are eligible for complex care coordination support if they have been identified by their GP or psychiatrist as eligible for the program, and that person will be the main person responsible for the consumer's clinical mental health care. Eligible organisations, and contracted mental health professionals, must have appropriate insurance coverage. Appropriate reminder systems (e.g. call backs, text messages) will be established to minimise failures to attend.	Consumers access services that are culturally safe and age-appropriate Consumers experience well-coordinated services as they move through the stepped care model Consumers and those supporting them have a good experience when accessing support, care and treatment Consumers experience improved mental health and wellbeing outcomes Consumers with mental illness experience improvement in physical health and social outcomes Consumers access appropriate mental health care in modalities aligned to their individual needs Services are available consistently and equitably across the catchment

Rationale
Aboriginal and Torres Strait Islander people experience severe and complex mental illness. Navigating through the mental health system can be more difficult for Aboriginal and Torres Strait Islander individuals than other community members (The Black Dog Institute, 2016). A need for improved inter-connectedness and referral pathways has been identified (South Eastern Melbourne PHN, 2016). A specific component of the Mental Health Nurse Incentive Program (MHNIP) is to provide clients with severe mental illness access to a mental health nurse through Aboriginal Medical Centres. MHNs coordinate treatment and provide services that are provided within a holistic and clinical framework that is client focused and tailored to different ages, cultures, and settings. MHNIP utilisation is highest in the SA3 region of Frankston and lowest in Casey North and Dandenong. Reasons for high and low service utilisation should be investigated especially the high prevalence of mental illness in Dandenong and low MHNIP services utilisation (South Eastern Melbourne PHN, 2016). Mental health nurse funding will operate solely within the PHN funding pool. Facilitating factors from a patient's perspective are: comfortable setting, service flexibility, holistic and affordable care and convenience and reduced stigma associated with services being available at GP practices. Evidence suggests that MHNIP improves care and encourages patients to feel well and connected with their communities (Harris et al., 2016).
Key players
Aboriginal Community Controlled Health Organisations, GPs, Psychiatrists, Other allied mental health providers

Appendix A: References

Commonwealth of Australia. (2010). *National Standards for Mental Health Services*. Retrieved from
Dedert E, McDuffie JR, & Swinkels C. (2013). *Computerized Cognitive Behavioral Therapy for Adults with Depressive or Anxiety Disorders*. Retrieved from Washington DC: https://www.ncbi.nlm.nih.gov/books/NBK269005/
Department of Health. (2015). *Australian Government Response to Contributing Lives, Thriving Communities: Review of Mental Health Programmes and Services* Retrieved from
Department of Health. (2016a). *PHN Mental Health Guidance: Aboriginal and Torres Strait Islander Mental Health Services* Retrieved from
Department of Health. (2016b). *PHN Mental Health Guidance: Consumer and Carer Engagement and Participation* Retrieved from
Department of Health. (2016c). *PHN Mental Health Guidance: Low Intensity Mental Health Services* Retrieved from
Department of Health. (2016d). *PHN Mental Health Guidance: Psychological Therapies Provided by Mental Health Professionals to Underserviced Groups* Retrieved from
Department of Health. (2016e). *PHN Mental Health Guidance: Regional Approach to Suicide Prevention* Retrieved from
Department of Health. (2016f). *PHN Mental Health Guide: Child and Youth Mental Health Services*. Retrieved from
Department of Health. (2016g). *PHN Primary Mental Health Care Guidance: Stepped Care* Retrieved from
Department of Health. (2016h). *PHN Primary Mental Health Care: People with Severe Mental Illness*. Retrieved from
Department of Health. (2016i). *Primary Health Network: Grant Programme Guidelines - Annexure A1 Primary Mental Health Care* Retrieved from
Department of Health. (2016j). *Primary Health Networks: Grant Programme Guidelines* Retrieved from
Department of Health and Ageing. (2013). *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*. Retrieved from
Department of Health and Human Services. (2015). *Victoria's 10-year Mental health Plan* Retrieved from
Department of Health and Human Services. (2016). *Victoria's 10-Year Mental Health Plan: Victorian Suicide Prevention Framework 2016-25*. Retrieved from
Department of Social Services. (2015). Family Mental Health Support Services Retrieved from https://www.dss.gov.au/our-responsibilities/mental-health/programmes-services/family-mental-health-support-service-fmhss
Harris, M., Meurk, C., & Reavley, N. (2016). *Rapid Literature Review: Primary Mental Health Care Models* Retrieved from
Mazza, D., O'Hare, M., & De Leon-Santiago, M. *Identifying the Most Effective Models of Care for the Management of Mild to Moderate Depression in Primary Care: A rapid review*. Retrieved from
Mazza, D., O'Hare, M., & Hawes, L. (2016). *Identifying the Most Effective Models of Care for the Management of Eating Disorders in Primary Care: A Rapid REview* Retrieved from
National Disability Insurance Agency. (2015). *Final Project Scope: Outcome Measures and Reference Packages for Psychosocial Disability* Retrieved from
Orygen. (2016). *Commissioning and Youth Mental Health*. Retrieved from
Russell, S., & Wasiak, J. (2016). *A Rapid Literature Review of Binge Eating Disorder and Other Specified Feeding or Eating Disorder* Retrieved from
South Eastern Melbourne PHN. (2016). *South Eastern Melbourne PHN: Needs Assessment Reporting Template - Mental health* Retrieved from
The Australian College of Mental Health Nurses inc. (2016). *Mental Health Nursing Services in Australia: A How to Guide for Primary Health Networks* Retrieved from
The Black Dog Institute. (2016). *An Evidence-based System Approach to Suicide Prevention: Guidance on Planning, Commissioning and Monitoring* Retrieved from