# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Method</td>
<td>7</td>
</tr>
<tr>
<td>Phase One</td>
<td>7</td>
</tr>
<tr>
<td>Phase Two</td>
<td>7</td>
</tr>
<tr>
<td>Findings</td>
<td>9</td>
</tr>
<tr>
<td>Phase One</td>
<td>9</td>
</tr>
<tr>
<td>Phase Two</td>
<td>14</td>
</tr>
<tr>
<td>Discussion</td>
<td>22</td>
</tr>
<tr>
<td>Conclusion</td>
<td>25</td>
</tr>
<tr>
<td>Recommendations</td>
<td>26</td>
</tr>
<tr>
<td>References</td>
<td>27</td>
</tr>
</tbody>
</table>
Acknowledgements

Gippsland PHN gratefully acknowledges the National Mental Health Commission (NMHC) for funding this project.

Thank you to the Project Steering Committee members for their involvement and guidance:

- Ms Marianne Shearer, CEO, Gippsland PHN (Chair)
- Ms Liz Craig, Senior Project Manager, Gippsland PHN
- Ms Catherine Brown, Director, NMHC
- Ms Emily Clay, Director, NMHC
- Mr John Lawrence, mental health carer and PHN Community Advisory Committee representative
- Mr Warren Bartlett, mental health consumer
- Dr Daniel Rock, Western Australian Primary Health Alliance
- Mr Michael Struth, Western Victoria PHN
- Ms Lesley Maher, Gold Coast PHN

Finally, thank you to all project participants from across Australia, who volunteered their time, knowledge and experience.
Introduction

Primary care can be defined as the day to day care, first point of contact and principal point of continuing care within the health system, usually delivered within the community. A sustainable primary care system is underpinned by a number of ideologies, one of which views the individual and their family/carers as active partners at the centre of decision making about their health and wellbeing (Primary Health Care Advisory Group, 2015).

National policy reform saw the establishment of 31 Primary Health Networks (PHNs) on 1 July 2015 to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time. PHNs work with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for patients.

The PHN model represents a regional approach to analysis, planning, delivery and review of primary care services. This model offers flexibility to deliver place based primary care to improve health outcomes for individuals, communities and the regional population. Moreover, PHNs collectively have the opportunity to improve outcomes at a program and system level, uniting key elements of integration, accessibility and value, across six key priorities: Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth, aged care and mental health. Considering the definition of primary care above, the term ‘outcome’ and how to measure outcome, PHNs must stay clear about their role and purpose. Keeping the individual, families and populations in front of mind is crucial to developing a sustainable primary care system, inclusive of mental health.

Mental health is universally accepted as fundamental to the concept of health. The World Health Organisation (2013) has paved the way for global action on mental health, acknowledging the essential role of mental health in the wellbeing of people. It is based on a lifespan approach, seeks to achieve equity through access to universal health care, and highlights the importance of prevention strategies.

The Australian mental health system is in many ways illustrative of the global challenges faced in improving mental health. The 2014 National Review of Mental Health Programmes and Services identified the gaps, complexity and urgent need of reform (National Mental Health Commission: NMHC, 2014). The term ‘nothing about us, without us’ is a compelling phrase that touches the essence of the reform agenda.
The reform platform was outlined in the Government response to the review (Commonwealth Government, 2015), describing nine interconnected areas of reform:

- Locally planned and commissioned mental health services through Primary Health Networks (PHNs) and the establishment of a flexible primary health care funding pool.
- A new easy to access digital mental health gateway.
- Refocusing primary mental health care programmes and services to support a stepped care model.
- Joined up support for child mental health.
- An integrated and equitable approach to youth mental health.
- Integrating Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing services.
- A renewed approach to suicide prevention.
- Improving services and coordination of care for people with severe and complex mental illness.

Generational and transformational change to the mental health system requires structural support for evidence based care (McGorry & Hamilton, 2016), and must be accountable to consumers, carers, service providers and community as well as Government (Rosenberg et al., 2015). How to measure and monitor change is the timely question behind this project, especially within the context of the imminent release of the Fifth National Mental Health and Suicide Prevention Plan.

The PHN Mental Health Outcomes Project was funded by the NMHC to:

- Inform the NMHC’s approach to its monitoring and reporting of PHNs in relation to mental health and suicide prevention reforms and on outcomes for mental health consumers and carers.
- Review PHNs’ experiences of regional integration and reform implementation and processes concerning mental health and suicide prevention.
- Review PHNs’ consumer and carer participation in mental health and suicide prevention policy and practice.
- Identify options for how the NMHC can assist PHNs in relation to PHNs’ roles in mental health and suicide prevention.

This report is the project’s Phase Two deliverable, providing a final report of analysis and advice on options for the NMHC’s monitoring and reporting on PHNs in mental health and suicide prevention. Phase One brought
together a review of relevant frameworks and literature, with PHN engagement and consultation, in a thematic analysis. Phase Two tested the findings from Phase One against non-PHN data, and critically reviewed and cross-referenced all data to develop a set of project recommendations to the NMHC.

This report is designed to be a final report of progress against project objectives, and is structured accordingly. An overview of methodology is presented, followed by a description of key project findings. These findings are interpreted in light of project limitations, leading to a set of final project recommendations.
Method

Phase One
The Phase One methodology was three-fold:
- Rapid review
- Stakeholder engagement and consultation
- Thematic analysis

A desk top review was conducted to:
- Identify and review previous and current work regarding consumer and carer mental health outcomes.
- Identify and review other mental health outcomes frameworks that could be applicable to PHN context.
- Review developments in the measurement of consumer and carer experiences including quantitative and qualitative methodologies.

The consultation for Phase One involved activity related to stakeholder analysis, communication and engagement with stakeholders, definition of data domains and data collection tools, and implementing the data collection process. Thematic analysis offers an applied qualitative method more applicable for research in policy or practice arenas (Braun & Clarke, 2014). Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data. It organises and describes a data set in detail. It can also go further than this, interpreting various aspects of the research topic (Boyatzis, 1998). Full details of Phase One methodology are described in the Phase One project report (Gippsland PHN, 2017).

Phase Two
The Phase Two methodology was four-fold:
- Review of the Phase One preliminary report for lessons learned and additional consultation required
- Additional consultation
- Online survey
- Semi structured interviews with survey respondents who requested follow-up

The review of the preliminary report involved a meeting between project manager/sponsor and funder (Gippsland PHN and National Mental Health Commission). Feedback received at this meeting was incorporated
with the project manager’s review and critique of lessons learned, outstanding knowledge gaps, and critical follow up required to round out those gaps.

An Executive Summary of the preliminary report was prepared and circulated to all 31 PHNs (participants and non-participants). Furthermore, given that the project was designed to help inform the Commission’s development of a national monitoring and reporting framework to report to Government on mental health reform progress, follow up advice was sought on the following questions:

- Given the work of this project, what would be the key elements of a national mental health outcomes monitoring and reporting framework?
- What do you consider most important for the Commission to be monitoring and reporting to Government on?
- How could a national mental health outcomes monitoring and reporting framework be applied to measure reform across the sector?

An online survey targeted to peak bodies, community, people with a lived experience, carers and service providers was designed and implemented. The survey collected limited demographic information, ratings against a Likert scale for questions on the role of PHNs, the term mental health outcome, and how PHNs are measuring outcomes, involvement of consumers and carers, as well as open questions around what could be done differently and what measurement systems are needed. Recruitment to the online survey was via a snowball technique, where it was circulated to national and state peak bodies and service providers, and then to consumers and carers via those networks. The survey included an item offering respondents the opportunity to participate in a semi structured interview.
Findings

Phase One
The data corpus (collection of data sets for the entire project) included a range of stakeholders and two modes of data collection: semi-structured interview and survey. Phase One analysed the data set of PHN interview respondents only. A total of 28 interviews were conducted, across 25 PHNs, two State PHN Coordinators and 41 individuals. This represented a response rate of 80% (25 PHNs from possible total of 31). The representation across States and Territories is depicted in Figure 1.

![Figure 1. State/Territory Representation in PHN Interviews.](image)

All levels of PHN work role were represented in the interviews (depicted in Figure 2), with the majority of respondents representing senior management.

![Figure 2. Work Role Representation among PHN Respondents.](image)
The method of thematic analysis was applied to the PHN interview data set. Notably, in the ‘defining and naming themes’ step, a quality check of the analysis was sought via respondent validation. This resulted in five responses, representing 20% of the data set, endorsing the coding and initial grouping of themes. Five overarching or organising themes emerged, each with its own set of sub-themes. A thematic map was developed to illustrate the themes, and is presented in Figure 3. The map shows that while the organising themes represented heterogeneous groups of sub-themes, there were also significant relationships between themes.

Figure 3. Thematic Map of Aspects of PHN Mental Health Outcomes.
Phase One of the PHN Mental Health Outcomes Project highlighted the strong passion and interest of many PHNs and their staff in contributing to implementing mental health reforms. The key findings revealed by the thematic analysis are summarised below, with most compelling extracts from PHN interviews included for each theme. Full details of Phase One findings are explained in the Phase One project report (Gippsland PHN, 2017).

Consumers and carers
The Consumers and Carers organising theme understandably resonated through other themes. All PHNs acknowledged the fundamental need for consumers and carers to participate in reform work, planning and outcome measurement, in order to uphold the ‘nothing about us, without us’ principle. The challenge of ‘hand-picking’ consumers and carers was raised. Many PHNs described the importance of consulting and involving a range of diverse groups and individuals. Plans to use an experience or feedback tool to obtain consumer and carer feedback on services and performance, and to build it into contracts as a performance measure were also reported. How to get good feedback to inform system improvement and monitoring was highlighted as crucial to measuring service system level outcomes. Attention to use of language by PHNs when engaging with consumers and carers was identified as important in not reinforcing the narrative of stigma or deficit.

“**We are about to commence someone in a mental health peer coordinator position to assist with modelling to our service providers that we want them to be consumer focused... and have more robust consultation.”** [PHN9]

“**We need the consumer and carer voice to help us understand what it is they need in a service, interpret that and provide information back to consumers. Also to listen to what’s going right and what’s delivered well, it’s not just about the negative experiences or the experiences from 20 years ago.”** [PHN16]

Commissioning
Most PHNs used the term ‘co-design’ when talking about commissioning mental health services and defining mental health outcomes. Difficulties in undertaking quality co-design with all stakeholders including service providers, community, consumers and carers were expressed. The use of regional planning processes to engage with service providers and communities, and commence discussions about outcome versus output, was a novel solution. Yet varied levels of progress were reported, due in part to the maturity and skill level within PHNs, but also the readiness of the sector within PHN regions. The use of the contracting process to elicit conversation and shared understanding of outcomes was indicated by PHNs. Finally, this theme captured concerns around 31
versions of stepped care. While acknowledging the importance of regional flexibility and localisation, PHNs saw a gap in a nationally consistent approach to how stepped care is understood and communicated across the country. The concept of a standardised decision tool to assist with stepped care assessment was raised as a potential solution to this dilemma.

“Another challenge is around the stepped care model – there is no footprint on how you buy that. We have the guidelines and workshops and training about what the model is, but not about how to commission it. We’ve never done it before, so we don’t know, and that’s frustrating.” [PHN10]

“I expect once we’re more comfortable with our approach to measurement of outcomes, we will look to include outcomes as a way to fund... If you’re not aligning your funding to outcomes, then it’s an uphill battle.” [PHN23]

Frameworks and models
A number of frameworks could be applied to inform the development, measurement, monitoring and reporting of mental health outcomes and experiences. Several PHNs were actively investigating and implementing a specific outcomes framework for their organisation. The value of the Partners in Recovery (PIR) service model to taking a recovery oriented approach to mental health care was described. Quality of life (QOL) was a concept discussed as more important than output or symptom measures. Particularly in considering population variation, QOL was proposed as a potential universal way of measuring improvement.

“We need an evidence based outcomes framework with a variety of suggestions around monitoring – individual, organisation, client, provider, system, and having a set of guidelines that each PHN can draw on.... the best ways to look at how to measure that and draw on research and expertise.” [PHN11]

“We’ve been looking at the National Mental Health Service Planning Framework which does set some targets around access to services... but the challenge is it’s not broken down... the responsibility of provision of services (to a cohort) doesn’t sit solely with primary care. So we need to figure out where our portion of that is.” [PHN24]

Systems and data
Reporting was raised as an important consideration in outcome measurement and monitoring, in terms of the requirements and expectations of the sector, community and funder. Challenges in reporting against multiple program funding areas while simultaneously applying a flexible, regional approach to service commissioning were
highlighted. Most PHNs cited difficulties with the new Primary Mental Health Care – Minimum Data Set (PMHC-MDS). While a need for a national system and regularity was agreed, there was parallel unease around the inflexibility of the PMHC-MDS to apply to local priority communities. A desire to see an efficient and streamlined monitoring system was observed, not only for PHN, provider and regional needs, but also for alignment with Department reporting requirements. The use of technology to enable data access and sharing was strongly linked with the notion of collaboration between jurisdictions.

“We don’t (want to) just submit numbers, that we can put annotation on context around the numbers. The MDS (Minimum Data Set) – we just submit the numbers and that might be interpreted in Canberra, and the devil is in the detail. We need the opportunity to give the context.” [PHN4]

“The patients that are shared between state and federal funded services – how do we track their progress and outcomes? Surely there needs to be a better way to do that... hospital networks have been around for a long time, have lots of outcome measures and indicators and systems and infrastructure... It would be nice to have access to that and learn from it and not re-invent the wheel.” [PHN8]

Integration and partnership

Consistency in order to improve integration was one of the most frequently cited themes. An appeal was made by all PHNs for increased reliability in how they are guided to implement the mental health reforms, as well as clarity around roles and responsibilities across all sectors. The importance of building an internal organisational capacity within PHNs was evident. Moreover, successful results were indicated where PHNs described working with other PHNs on joint initiatives. This method could be particularly useful for rural and remote PHNs. Maintaining PHN objectives at the forefront of any activity was encouraged. Good communication was frequently expressed as necessary to helping PHNs achieve their objectives. Conversely, PHNs reported frustration at the lack of understanding of the PHN role in the sector, and pointed to a need for standardised communication at state and national level.

“I don’t know whether PHNs have been actively involved in reform development. Question is, is that a product of a lack of collective voice? So the model becomes ad hoc. We don’t have the mechanism to represent state wide voice, and then clearly articulate across the country. So in some ways the Government are realising the benefits of pushing down, but not realising the benefits of pulling those learnings up.” [PHN18]

“The implementation (of reforms) is tough, and we’ve inherited a system that is not in a future state... We don’t have the benefit of an integrated system, we have lots of silos and we’ve got to point them all to that point on the horizon to mobilise people in the direction we’re all conceptually heading towards.” [PHN1]
Phase Two

Phase Two analysed three data sets:
- survey respondents;
- semi-structured interviews with non-PHN participants; and
- follow up consultation with PHN participants.

A total of 44 survey responses were received, with 17 (38%) from mental health and/or suicide prevention service providers, 13 (30%) across consumers and carer groups, 12 (28%) government and community support agencies and two (4%) peak bodies (Figure 4). The majority (n=29) of respondents were from Victoria (66%), nine (20%) from New South Wales, and the remainder (14%) from other states and territories (Figure 5).

Figure 4. Stakeholder group representation among survey responses.
Figure 5. Geographic location of survey respondents.

A total of 39 survey respondents rated how well PHNs are measuring mental health outcomes and experiences now, with 24 (over 60%) responding ‘unknown’ or ‘poor’, and only 6 (15%) applying the ‘good’ or ‘very good’ rating (Figure 6).

Figure 6. Survey respondent ratings of how PHNs are measuring mental health outcomes.
Open text responses to the question “What could be done differently to measure mental health outcomes and experiences?” echoed PHN views around involvement of consumers and carers and consistency in measurement.

“There should be consistent measures across all PHNs in order to be able to benchmark in the future.” [Community support agency, NSW]

“Continuous, regular contact with carers and consumers.” [Carer, NSW]

“Method of following ‘users and their carers’ of mental health services to understand effectiveness.” [Government agency, VIC]

“Use client’s perception of what they see as positive outcomes.” [Mental health service provider, VIC]

“Research needs to be consumer carer relevant not service provider.” [Mental health service provider, VIC]

“We need to engage more closely with those people with mental illness.” [Person with lived experience, VIC]

A total of 39 survey respondents rated current PHN capacity and capability to measure mental health outcomes and experiences now, with 21 (over 50%) responding ‘unknown’ or ‘poor’, and only 5 (12%) applying the ‘good’, ‘very good’ or ‘excellent’ rating (Figure 7).

![Ratings regarding current PHN capacity and capability](image)

**Figure 7.** Survey respondent ratings of current PHN capacity and capability to measure mental health outcomes.
Open text responses to the question “What information and systems are needed to measure mental health outcomes and experiences?” mirrored PHN views and frustrations related to data collection methods and sharing, as well as recognition of carers’ roles in mental health outcomes.

“Online data collection rather than relying on paper based forms.”
[Mental health service provider, WA]

“ED (Emergency Department) & PHN & psych. inpatients sharing more information.”
[Person with lived experience, VIC]

“Can GPs (general practitioners) record anywhere if they have identified the individual’s carer? Can inpatient services record the instances of where the individual does or does not have a carer? Are there any existing data linkages between individuals and carers in various settings?”
[Mental health service provider, WA]

A total of 37 survey respondents rated how PHNs are working towards regional integration, with 23 (over 50%) responding ‘fair’, ‘good’ or ‘very good’ (Figure 8).

![Ratings regarding PHN progress towards regional integration](image)

**Figure 8.** Survey respondent ratings of PHN progress towards regional integration.

A total of 36 survey respondents rated how PHNs are involving people with a lived experience in implementing the mental health reform, with 22 (over 60%) responding ‘unknown’ or ‘poor’ (Figure 9). Open text responses to
this question highlighted the complexity for PHNs in balancing effective consumer participation with the need to avoid burden on consumers and service providers.

Figure 9. Survey respondent ratings of how PHNs are involving consumers in mental health reform.

“Many people who live with mental illness or have a family member with mental illness are too busy dealing with the illness to have time to be involved. It is all consuming and for families it is highly emotional.” [Person with lived experience, VIC]

“Often it depends on the service provider relationship with consumers and their willingness to put in energy in co-ordinating contact between PHN and consumer base.” [Mental health service provider, VIC]

“A total of 37 survey respondents rated how PHNs are involving carers of people with a lived experience in implementing the mental health reform, with 25 (67%) responding ‘unknown’ or ‘poor’ (Figure 10). Open text responses to this question suggested that involving carers is an achievable and warranted action.”

“Can’t speak about all 31 PHNs, but my local has engaged people with a lived experience of suicide.” [Carer, NSW]

“Too soon to tell and there is a lack of architecture in mental health.” [Mental health service provider, ACT]
Figure 10. Survey respondent ratings of how PHNs are involving carers in mental health reform.

“Carers have autonomy and resources to contribute and be involved in service and system research and reform.”
[Mental health service provider, VIC]

“Very difficult to achieve without carer understanding of how vital their information is.”
[Government agency, VIC]

Open text responses to the question “What could be done differently to involve consumers and carers in PHN mental health reform?” were unanimous in suggesting that PHNs could do more, with varied ideas.

“More co-design with consumers and carers before the service providers are involved.”
[Mental health service provider, WA]

“More education about the PHN so people know there is an avenue for feedback.”
[Carer, WA]

“…carers are treated as partners in care and invited to seminars, promotions and forums which are offered to professionals.”
[Carer, NSW]

“A clear and publicly accessibly engagement strategy.”
[Peak body, ACT]

“Increased access to training for consumers and carers to be able to fulfil the role of advocate.”
[Mental health service provider, WA]

“Appointment of PHN regional Consumer Advocate.”
[Government agency, VIC]
A total of eight semi structured interviews with non-PHNs were conducted: three with carers, three with peak bodies, and two with service providers. The non-PHN interview transcripts were tested against the thematic template from the PHN interviews to analyse and test themes from Phase One against Phase Two data.

Peak body interviews reflected closely the thematic map from PHN data. In particular, a strong message of improved integration, consistency and leadership was clear. Furthermore, the theme of consumer and carer participation in co-design and planning activities was advocated by the peak bodies interviewed. The three peak bodies commented on minimal engagement with them by PHNs, and noted that for the mental health reform agenda to move forward, inclusion of all stakeholders in the co-design space is required.

“There’s enormous potential for co-design in this space. The really important thing about co-design in mental health is ensuring that you have people in the room who have a really broad range of experiences... PHNs could benefit from the support of the NGO (Non-Government Sector) to do that.... There’s a real need to make sure we listen to people who have added complexity in their lives, whether it’s diversity or complex mental illness.” [National peak body]

Carer interviews reflected two of the five PHN data themes: consumer and carer, and integration and partnership. Carers who were interviewewed spoke about the importance of continuity of care as a measure of integration, and building on community infrastructure and fabric to help facilitate integration with mental health, primary health, and the system more broadly. The strongest consumer and carer sub-theme related to stigma, and the need for diagnosis and labelling to be accurate and clearly communicated. Furthermore, carers spoke about access to services and that this remained a barrier for not only treatment but for becoming more involved in advocating for service system improvement.

“I think consumers and carers need to be involved much more. They’ll see the roadblocks better, and where things need to be improved. They know where things get stuck and what needs to change. Sometimes the change needs to come the other way – bottom up rather than top down. It’s not until you get to the other end to see it.” [Carer, VIC]
The service provider interviews reflected all five of the PHN data themes in a broad way. Interestingly, service providers echoed carer interviews in emphasising the importance of access to services and how rural/remote location impacts on access, as well as the notion of employing community networks to influence integration and improved mental health outcomes.

“I think we should start trying to measure continuity of care because it’s already started to show cost savings... And that’s what governments will listen to. But we’ve got to be careful we don’t just make it look good on paper.” [Service provider, VIC]

Two responses were received from PHNs following an invitation to comment on the Phase One findings, a response rate of 8% (two from 25 PHN participants), as below.

“Thank you for your efforts in compiling the responses into a rich yet concise summary. The message of duplication of effort by the 31 PHNs has been expressed so I am satisfied and feel confident now that our views regarding determinants of success and base definitions (e.g., stepped care) are in line with those of other PHNs.” [PHN13]

“A monitoring and reporting framework needs to:
1. Be flexible enough to allow for localised approaches
2. Consider the size of the PHN in progressing with the mental health reform and broader sector reform i.e., larger PHNs have access to greater resources on current DoH (Department of Health) operational funding model
3. The maturity of the sector that we work within – for some regions undertaking reform will be more successful based on the sector and its readiness for change.” [PHN16]
Discussion

The PHN Mental Health Outcomes Project highlighted the strong passion and interest of many stakeholders in implementing mental health reforms. It investigated what PHNs perceive to be the most important aspects of mental health outcomes in the context of major mental health and suicide prevention reform. Five emergent themes revealed how PHNs are approaching the definition, measurement, monitoring and reporting of mental health outcomes.

There is a strong policy focus on increasing opportunities for people with a lived experience, and their carers and families, to contribute to the design, implementation and evaluation of mental health services (e.g., Council of Australian Governments, 2012; NMHC, 2014). The findings emphasised that PHNs view consumer and carer participation in the reform implementation as fundamental to success. However, non-PHN stakeholders see current PHN engagement with consumers and carers as either inadequate or not visible. Although dependent on the maturity of the PHN, this engagement could largely be improved. All PHNs need to work with peak bodies, advocacy groups, communities and individuals, especially to ensure participation of diverse and specialised communities. Where possible, this could be done more effectively and efficiently via state or national mechanisms. There must be careful consideration of how to close the feedback loop when involving consumers and carers in co-design, defining outcomes, or monitoring and evaluating outcomes and experiences. Moreover, communicating learnings and successes will be crucial to building stakeholder confidence in PHN capability to involve, listen to, and respond to the views of consumers and carers.

The PHN model is still developing and PHNs are growing rapidly in capacity and capability to commission effective and efficient mental health services. Much has been achieved in a short space of time, managing complex change while building capacity within PHNs and in the sector. There is strong interest from PHNs in building expertise in outcomes based commissioning, a view supported by the literature (Gardner et al., 2016; Schwartzkoff & Sturgess, 2015). A high proportion of diversity within and between PHNs reinforces the policy of a regional approach to stepped care, yet building inter-jurisdictional governance should be a planned exercise rather than afterthought to influence effective commissioning (Addicott, 2014). There could be increased inter-PHN learning and sharing of commissioning resources and tools, to avoid duplication and build efficiency.

One of the most prominent PHN themes was frameworks and models, with a number of existing recommended indicators, frameworks and models of care available to inform the development of a mental health outcomes
framework (e.g., Australian Mental Health Outcomes Classification Network, 2015; Bodenheimer & Sinsky, 2014; Expert Reference Group on Mental Health Reform, 2013; Porter, 2010). Outcomes definition, measurement, monitoring and reporting should occur at the individual or clinical level, the service level, and the system or population level, a view echoed by the literature (Brown & Oliver-Baxter, 2016; Bywood, Brown & Raven, 2015; Rosenberg et al., 2015). Peak bodies, carers, consumers and service providers support the PHN view that domains beyond disorder specific, such as goal setting, quality of life, and functional recovery could add value to how outcomes and experiences are measured. Engaging with all relevant parties in co-design and joint planning activities could provide PHNs with the opening to explore this notion further.

Mental health outcomes measurement, monitoring and reporting requires efficient and interconnected technology in order to meet PHN and sector needs. There is great opportunity to align data sets into one system that can provide a fuller picture across national, state services and private mental health services, allowing for more effective monitoring of outcomes. The PHN themes reinforced literature calling for innovative approaches to outcome measurement (Griffiths et al., 2015) and strong national leadership in data collection (McGorry & Hamilton, 2016). Data access and sharing agreements could be addressed at state/national levels to avoid duplicated effort by each PHN. Peak bodies and service providers underlined PHN observations that the burden of data collection and reporting must be weighed against the nature and context of the intended outcomes. This suggests that PHNs, peak bodies and service providers are in agreement, and yet have not come together in a uniform way to discuss solutions.

Achieving integration within a PHN region could be influenced and assisted by national and state functions to break down silos between levels of government, and between public and private services, a view echoed by the literature (Brown & Oliver-Baxter, 2016; Bywood et al., 2015). Greater definition is needed of roles and responsibilities across all stakeholders in the mental health reform platform. Achieving the intended bold reform is dependent on appropriate time, governance, and all parts of the system working in tandem, with PHNs only one component. As Robinson et al. (2016) aptly noted, “If rushed, there is a risk that this ‘new agenda’ might not deliver anything very different at all”. There could be greater uptake and implementation of the National Standards for Mental Health Services (Commonwealth of Australia, 2010), through the commissioning of primary mental health services, and specifically in contracting for quality outcomes. This requires investment to build capacity and capability in workforces within PHNs, in general practice, within the mental health sector, Aboriginal health, and within other sectors, and also to build enabling mechanisms for communication and coordination across those workforces.
The consumer and carer voice has the potential to point PHNs and the broader system to integration solutions. The issue of ‘territory and ego’ within the mental and primary health sectors was alluded to by PHNs, peak bodies and service providers alike. Local and regional approaches that come from the ‘bottom-up’ could well overcome the integration barriers put up by organisations, government and historical arrangements. However, this will only be successful if consumers, carers and community are positioned appropriately to not only inform and guide solutions, but also to test and critique progress against those solutions. In essence, the system must do better to understand that real improvements rely on the power of people. Technology, data, tools, processes and policy are mechanisms that will be made or broken by the people involved – consumers, carers, community, peak bodies and advocacy groups, service providers, commissioning agents, and governments. Shared planning and co-design is a fundamental avenue to, and facilitator of integration, yet will count on the sentiment of all parties. If consumers, carers and community are the first and crucial party involved at all levels of planning and co-design, integration success may be realised.

The key findings should be interpreted with study limitations in mind. Thematic analysis relies on coding and interpretation of transcripts against those codes, and could be subject to researcher interpretation (Braun & Clarke, 2014). Furthermore, while the response rate from PHNs was high, it is not clear whether the findings can be generalised across all 31 PHNs. The small sample sizes in Phase Two data collection (survey and non-PHN interviews) allowed for testing against PHN themes, however limit the generalisability of findings. Furthermore, it is unclear the reason behind minimal PHN response to Phase One findings feedback and the request for additional information, and there was no added value to this action.

Nevertheless, the findings provide a relevant conversation piece about future work to improve mental health outcomes. Recent developments that support responses to the findings from this project include the commencement of the PHN SharePoint facility. The purpose of the PHN SharePoint site is to support PHNs to collaborate and share information. If used to its full potential, the SharePoint site could partially resolve some of the communication issues highlighted by PHNs in this project, as well as reducing duplicated effort and resources. A Departmental document on peer workforce is in draft form, and once released will provide PHNs with guidance on how to support better outcomes in mental health by promoting and guiding the employment of peer workers. It is timely to also consider how the forthcoming Fifth National Mental Health and Suicide Prevention Plan may provide PHNs and their key stakeholders with directions to achieve better integration within and beyond the mental health and primary health sectors. Converging paths will need to align so that PHNs have a clear and consistent road forward in mental health reform.
Conclusion

The PHN Mental Health Outcomes Project has provided a critical insight into how PHNs are approaching their role in mental health outcomes. The semantic themes point to key areas of focus as the reform agenda continues. These themes have been reinforced by other stakeholders in the reform, including people with a lived experience, carers, service providers, and peak bodies. Notably, keeping consumers and carers front and centre of mental health commissioning, systems, data and framework implementation can facilitate better integration and partnership across the PHN region, and contribute to quality, equitable mental health outcomes.
Recommendations

The National Mental Health Commission has been tasked by the Commonwealth Government to develop a national mental health monitoring and reporting framework. In light of the key findings from the project, it is recommended that in the development of this framework, the Commission considers the following actions.

**Recommendation 1** To help keep consumers, carers and community at the front and centre in all mental health reform activities, the Commission’s framework includes parameters for PHNs and other organisations tasked with mental health reform. This could include minimum expectations for consumer and carer involvement as well as mandatory and aspirational targets for consumer, carer and community participation across mental health planning, design, procurement, and review activities.

**Recommendation 2** To facilitate improved collaboration and integration, the Commission advocates for the Department of Health to resource a collective PHN voice mechanism. This mechanism will provide opportunity for bottom up as well as top down communication about PHN role, programs and issues. It will enable PHN information to be collated and used in a uniform way. It will also develop and actively promote links, shared data and systems between PHNs, levels of government and peak bodies to reduce duplicated effort.

**Recommendation 3** To encourage a nationally consistent approach to the commissioning of mental health services, the Commission produces a detailed definition of stepped care. This model and its component parts could help to provide structure for the Commission’s monitoring and reporting framework, such as the inclusion of minimum standards for service delivery and mandatory and aspirational targets within the stepped care model.

**Recommendation 4** To encourage flexibility and diversity in the definition of outcome, the Commission’s monitoring and reporting framework allows for measurement of outcomes on different levels including individual, program, system, population. The application of specific tools and models could be PHN choice to maintain regional appropriateness.
References


