Working together: a blended model for alcohol, other drugs and mental health services

Western Victoria Primary Health Network

June 2022

Supporting general practice, commissioning health services into gaps and driving service integration.

phn WESTERN VICTORIA

An Australian Government Initiative

Acknowledgement

Western Victoria Primary Health Network (WVPHN) acknowledges the Traditional Owners and custodians of the lands and waterways - the Wadda Wurrung, Gulidjan, Gadabanud, Keeray Wurrung, Peek Wurrung, Gunditjmara, Djab Wurrung, Wotjobaluk, Dja Dja Wurrung, Jadawadjarli, Wergaia, Jupagalk and Jaadwa peoples. We recognise their diversity, resilience, and the ongoing place that First Peoples hold in our communities. We pay our respects to the Elders, both past and present and commit to working together in the spirit of mutual understanding, respect, and reconciliation. We support self-determination for First Nations Peoples and organisations and commit to working together on Closing the Gap.

WVPHN acknowledges all people who have personal experience of living with a health condition. The voices of people with lived and living experience is essential in the development of our work.

Purpose

Western Victoria Primary Health Network (WVPHN) has created this updated version of the Commissioning Intent document, which incorporates feedback from providers who participated in the market sounding process conducted in May 2022

This document aims to provide information on an upcoming procurement process to assist applicants prepare responses to the Request for Proposal (RFP). It seeks to inform prospective applicants on the high-level requirements and expectations for the upcoming tender process as it relates to the commissioning of Alcohol and Other Drugs (AOD) and mild to severe mental health services under a blended service model, titled ***"Working together: a blended model for alcohol, other drugs and mental health services".*** Further details of the blended service model will be released through the RFP in August 2022.

Why work with WVPHN?

WVPHN is driven to become the 'commissioner of choice' for service providers in the western Victoria region. As a result, WVPHN intends to offer the following features to differentiate WVPHN as a commissioner of AOD and mental health services:

"Funding that enables a sustainable workforce during times of change"

Three-year program commitment which will include a cooperative evaluation with the service provider(s) to identify opportunities for service improvement and to inform a further three-year commitment to the program.

"Lead and design with the community"

Flexible service models that adapt with changing community needs and contract components that allow for continuous quality improvement. Services will be led by providers in collaboration with the community, and with support from WVPHN. Providers will have more autonomy in decision making and won't just be told what to do.

"Be in control of your data and performance"

On demand reporting and data visualisation that allow service providers to be on top of all trends and potential issues before they become concerns. That is to say, no surprise performance visits from WVPHN.

"Funds that adapt to your model"

Flexible funding with a focus on KPIs to allow funds to be used to best support the model.

"Separate evaluation funding"

WVPHN will fund a comprehensive evaluation of the new service model. This will be funded separately to the service agreement.

Introduction

WVPHN is committed to aligning the Alcohol and Other Drugs (AOD) and mental health services we commission with key Victorian state and Australian government recommendations including those from the Royal Commission into Victoria's Mental Health System and WVPHN's recent co-design process.

Evidence suggests that clients commonly present with a co-occurring mental health and/or alcohol or other drug issue and require integrated support to ensure both concerns and any other co-morbidities are treated holistically. Service delivery requires a flexible approach to facilitate and support evidence-based treatment tailored to individual needs. As such, WVPHN has developed a blended service model where AOD and mild to severe mental health services will work together to address co-occurring needs. This blended service model requires providers to demonstrate capabilities across AOD and mild to severe mental health services through formal or informal partnerships.

Note: a single provider can have partnerships on multiple applications (that is to say, partnerships do not have to be exclusive to one application).

In addition, partnerships must be formed to address holistic biopsychosocial needs where gaps exist in the provider organisation.

WVPHN has developed a set of **key guiding principles** to shape the blended service model. These principles were developed following the completion of the 2021 co-design, third-party evaluations of Psychological Therapy Services (PTS), Services and Treatment for Enduring and Persistent Mental Illness (STEPMI) and AOD programs, an internal review of key policy documents and feedback from the market sounding sessions.

The key guiding principles are:

- people are consumers of health care who are entitled to information that informs choice
- taking a person-centred approach to care, treatment, and management
- elevating the value of the voices and skills of people with lived experiences
- supporting service integration, care coordination and partnerships
- ensuring multidisciplinary workforces
- promoting collaborative practices and shared care arrangements to benefit consumers of health care
- ensuring services meet the needs of the people using them
- emphasising the importance of client, provider, and carer experiences
- focusing on outcomes and
- ensuring equitable access.

The new AOD and mental health blended service model commissioned by Western Victoria Primary Health Network and delivered by service providers will commence from 1 July 2023.

Guidelines

The blended model adheres to a combination of specific guidelines set by the Australian Government and other key documents. These include:

- National Ice Action Strategy
- Alcohol and other drug program guidelines
- Psychological therapies provided by mental health professionals for underserviced groups.
- Services for people with severe mental illness.

AOD and Mental Health Program Aim

The re-design of WVPHN commissioned mental health services includes the integration of two key mental health programs currently known as Psychological Therapy Services for underserviced groups (PTS) and Services and Treatment for Enduring and Persistent Mental Illness (STEPMI). AOD services will see the re-commissioning of two of WVPHN's core AOD funding streams – the Drug and Alcohol Program (DAP) and the National Ice Action Strategy (NIAS) program. The re-designed service model shifts focus from funding specific targeted AOD programs to funding broad AOD services across a spectrum of care that respond to the needs of clients.

Further, the integration of PTS and STEPMI offers a more flexible funding model to enhance service access and care coordination supporting the natural flow and experience of care by reducing delays, unnecessary disruptions, and address service gaps in response to community needs.

Overall, the new blended service model aims to commission providers with capacity and capability to deliver services in an integrated approach consisting of the mild to severe levels of the Stepped Care Framework prioritising the no wrong door approach.

The Combined Funding Model

Current programs that fund AOD and mental health models separately have created siloed programs. As a result, caps on service delivery have perpetuated job insecurity and hindered recruitment and retention of staff in an already overburdened workforce.

Our analysis of the market sounding sessions further supports the body of literature and validated the appetite of the market to integrate the delivery of AOD and mental health services, which will be supported through block funding approaches to better meet the needs of individuals with co-morbid AOD and MH issues across Levels 2 (mild), 3 (moderate) and 4 (severe) of the Stepped Care Framework (See Glossary for definition).

The combined funding model requires service providers partner with one another to support the service delivery within and/or across sub-regions and prioritises areas of greatest need. The model endeavours to reduce workforce shortages and improve workforce retention.

In collaboration with various stakeholders, WVPHN has:

- built a new, combined funding model that will inform the commissioning of service providers that can deliver across AOD and MH programs
- developed a model that aligns with the Quadruple Aim in terms of cost effectiveness
- created a model that aligns with the WVPHN Place Based Commissioning strategy
- drawn upon WVPHN Needs Assessment data to inform the service model
- used HeadsUp Data
- consulted the National Mental Health Planning Support Tool and the Turning Point AOD Stats Tool.

Needs-based and outcomes-focused

The blended service model has been developed in line with the following needs-based and outcomes-focused strategies.

Place based commissioning

WVPHN is adopting a Place Based Commissioning approach, which aims to achieve optimal health and wellbeing outcomes responsive to local needs.

The Place Based Commissioning Strategy guided the development of this service model (see Glossary for full definition). The overall vision of this strategy is to work closely with local communities and system partners to achieve optimal health and wellbeing outcomes for our communities in the places where people live. The Placed Based Commissioning approach is:

- responsive to identified needs
- highly collaborative
- based on evidence and
- focused on measurable client and natural supporter outcomes.

WVPHN will deploy a staged approach to implementing the Place Based Commissioning Strategy that has been developed with a flexible vision to build the foundation across WVPHN, service providers and the broader community, as well as other organisations interested in the potential of co-commissioning across the next few years. The values of the Place Based Commissioning approach can be found in Figure 1 below.

Figure 1

1. Improve health and wellbeing outcomes through the delivery of services at the right place and the right time
2. Respond and adapt to the needs of specific places and communities with a tailored approach
3. Support, build and enable the capacity and capability of local workforces and provide markets
4. Partner with the community and where possible empower them to lead change.
5. Enable self-determination by First Nations people and communities
6. Partner with the community and where possible empower them to lead change
7. Integrate service delivery and priories responding to holistic needs of vulnerable people in place
8. Take a strategic approach to funding and maximise use of existing resources across the sector
9. Position ourselves as leaders in commissioning driving innovative approaches to meet need
10. Demonstrate the impact of evidence based commissioned responses on communities

Needs Assessment

In line with the WVPHN Place-Based Commissioning Strategy the blended service model will ensure services are targeted to Local Government Areas (LGAs – see Appendix A) where there is the greatest need. The WVPHN place-based approach will be data driven and will draw on data from the WVPHN Needs Assessment and other key sources, including the local expertise of commissioner providers and their partners.

Outcome Measures

A core element of the Place Based Commissioning Strategy is monitoring and reporting on the health and wellbeing of the western Victoria population through the measurement of outcomes.

WVPHN is improving how we measure outcomes that relate to health status and wellbeing to align with the needs of communities. Outcomes will be presented on a visual dashboard to effectively, accurately, consistently monitor and report progress of our commissioned programs in a timely manner. Enhancing how we measure outcomes will help us understand how we can improve the delivery of our commissioned services and the impact our services have on client experience and health outcomes.

The focus on measuring population health outcomes aligns with the Quadruple Aim Approach that strives to conceptualise and optimise performance in the health care system through the simultaneous pursuit of four dimensions (Figure 2). The blended service model will focus on the collection and measurement of outcomes measures across the four domains of the Quadruple Aim. While there are outcome measures mandated by the Australian Government, WVPHN will work with successful providers to co-design and implement meaningful outcome measures. Outcome measures will be consistent across AOD and MH where practical and will draw on existing tools that are validated and fit for purpose.

Figure 2 – Courtesy of North Western Melbourne Primary Health Network

Clear Focus Areas

The blended service model is shaped around six key focus areas built from the above guiding principles. They provide specific requirements for the service model as identified through the review of existing services and best practice literature and based on valuable feedback from lived experience, workforces, and stakeholder engagement. These focus areas form the key elements necessary for a successful service delivery system (See Figure 3).

Figure 3.

1 Streamlined Screening, Assessment and Referrals

The blended service model seeks to support coordination of care within and across sectors by promoting shared screening and assessment tools and clear referral pathways.

1.1 Screening and Assessment	Screening and referral processes in the blended service model will: • be person-centred, culturally safe and empathetic • determine the level of service and care coordination required • identify risk • assess for co-occurring AOD and Mental Health • escalate to appropriate acute services as required • provide warm transfer to local services that enable management of the co-occurring needs (if internal expertise is not present) • consider non-health factors that could impact client's health such as safe housing, trauma, stigma, domestic and family violence and • use the central intake system within Victorian PHNs (will be rolled out across all programs in 2023-24 (see Appendix B for more detail). ***Screening tools*** Every client with mental health needs must have had the IAR tool completed and a score recorded in Bridge CRM at the first point of contact. Please note: Where IARs have been completed prior to referral for the same presenting issue, completion should be tracked and recorded from other services to avoid repetition of the measure. Providers are responsible for following up on recent IARs with the referring provider. For clients seeking AOD support, the IAR tool must be completed if mental health needs are identified. Where possible, services should use universal or consistent screening and assessment tools to identify both mental health and AOD needs. Possible tools are listed under the Outcome Measures section below (Section 3.5).
1.2 Referral pathways	The blended service model will support: ***Warm transfers (see glossary for definition)*** The blended service model encompasses a 'how can we help – if not us, who?' approach. People who present to the service who are ineligible for care through the relevant service model are supported to find the care they need. ***Clear referral pathways*** Partnered services must build clear referral pathways within and between the mental health and AOD services. Partnered serviced must extend referral pathways to include services such as physical health and non-health services, for example, family violence, housing, child safety and local hospitals.
1.3 Data systems	To meet the requirements of the blended service model, providers must use the following data systems and processes to meet KPIs and to provide coordinated client care. 1. Bridge CRM (data reporting system provided by WVPHN). Access and training on this system will be provided by WVPHN 2. Commonwealth Central intake portal. Access and training on this system will be provided by WVPHN 3. Application Programming Interface (API) to allow for integration with providers'

	client management system(s). Providers client's management systems will be determined by the providers. WVPHN has ensured API interface is available for Bridge and the Central intake portal. Providers should consider the required IT systems and support to allow API integration into Bridge and the Central intake portal

2 Integrated Coordinated Care and Partnerships

The blended service model will have a strong focus on partnership approaches within sub-regions and across sectors.

2.1 Defining Partnerships

WVPHN defines partnerships based on the Royal Commission's final report which identified "three approaches for implementing integrated treatment, care and support for people living with mental illness, mental health issues and substance use or addiction in Mental Health and Wellbeing Services" (Royal Commission as stated by VAADA – See Appendix C).

Partnerships are established between AOD and mental health service providers. Partnership arrangements bring together the strength of individual service providers, fostering collaboration and driving service integration and coordination.

Formalised partnerships

Partnerships are highly structured, formalised agreements that are monitored by WVPHN through contractual requirements such as deliverables and KPIs.

Within these formalised partnerships, integrated care should be guided by the following:

- Multidisciplinary teams: Workers from different disciplines employed by the same provider to work together to deliver integrated care in a single service setting.
- Care coordination: collaborative shared care based on best practice principles that enables the coordination of care. Providers must work together to co-ordinate care efficiently, effectively and work towards achieving the desired outcomes in a relevant timeframe.
- Service delivery: An AOD and/or mental health and wellbeing service partners with another care provider to deliver some aspects of the client's care within the service.

What it must include:

- formalised partnerships to address service gaps and specific needs within a sub-region (that is to say, with AOD or mental health providers where they do not hold expertise or services in a subregion)
- clear clinical governance in place and, where appropriate, shared governance.
- partner with organisations to collectively identify and address complex needs and co-occurring conditions, by leveraging their industry specific strengths
- expand upon existing partnerships, but also inviting new partnerships that prioritise the needs of the sub-regions, for example, subcontracting to appropriate providers to address service gaps identified by the provider organisation
- welcome and draw upon the knowledge and expertise of local service providers in WVPHN sub-regions
- identify provider strengths to meet the needs and enhance service capacity through a range of modalities to meet the needs of WVPHN sub-regions.
- partnerships and consortium arrangements, Memorandums of Understanding (MOUs) to demonstrate meaningful engagement between and across service providers and the community
- allocation of funds based on the agreed-upon services which might include in kind support, subcontractors and warm transfers.

	Collaborative agreements In addition to formalised partnerships, providers should also enter into collaborative agreements to strengthen service level engagement and additional pathways to care through other services. This will form part of the blended service model. Therefore, providers should strive to create collaborative relationships with other providers to support wrap-around care and to ensure biopsychosocial needs are met.
2.2. Elaborating on Partnerships	The blended service model will support stakeholder engagement and partnerships through: • formalised partnership arrangements (for example, terms of reference, MOUs, clear governance arrangements) • agreed and clear referral pathways between service providers in specific regions • developing partnerships strategically to meet the needs of the community • supporting combined contracts across AOD and mental health providers seeking to deliver both services where practical. Providers should bring together multidisciplinary and transdisciplinary providers (some of which may sit outside of the usual network) that include, but are not limited to: • service providers that collaborate and coordinate AOD and mental health services • local providers including emergency and hospital services and other health and community providers • providers of psychosocial and emotional wellbeing support • peer-led organisations, networks or forums where relevant • relevant, local services that support the specific needs of the communities being cared for • meaningful partnerships with priority populations.
2.3. Coordinated Care	The blended service model will facilitate care coordination through: • embedding the delivering of collaborative shared-cared plans • supporting improved referral pathways between sectors to achieve warm and seamless wrap-around care and coordination throughout the client's journey • regular, acute case meetings across disciplines as well as integrating natural supports (for example, family and friends) • collaboration of clinical and non-clinical services. As part of the collaborative partnerships and agreement process, providers should demonstrate evidence of engagement with a range of external organisations such as but not limited to: • General Practitioners • Aboriginal Controlled Community Health Organisations • Culturally and Linguistically Diverse (CALD) organisations • LGBTQIA+ support services • Refugee support services • WVPHN Low Intensity providers such as, Head to Health providers; National Psychosocial Support Measure providers; headspace providers; First Nations mental health and AOD providers; or other programs as relevant • Peer support services • Other relevant not-for-profit or Victorian State Government services.

3 Person Centred and Outcomes Focused Service Delivery

The blended service model will support person centred, recovery focused service delivery.

The blended service model is aligned with the Western Victoria Primary Health Network Outcomes Framework. Outcome measures and KPIs are intended to improve the transparency and accountability of service delivery and monitor for continuous improvement towards desired outcomes. In the blended service model, outcome measures will be implemented to monitor and report progress on the service model; provide a clear sense of direction; inform; and improve health service planning and development, program design and delivery. It also encourages a culture of continuous learning; drives performance improvement; and engages and mobilises health professionals in their collective efforts towards their shared goals.

3.1. Person centred service delivery	Person centred service delivery will include the following: • welcoming, wrap-around care that prioritises self-determination, choice and agency • the inclusion of natural supports, family, friends, and carers, and • flexibility in modality preferences within the current funding allocation including face-to-face, flexible hours and telehealth options that meets the needs of the client.
3.2. Quadruple aim framework and outcome focused	There are mandated tools necessary for measuring mental health and AOD KPIs as required by the Australian Government through the National Minimum Data Set (AODTS-NMDS and PMHC-MDS). These will form part of the outcome measures. The blended service model supports the development and standardisation of outcome measures across AOD and mental health programs aligned to the Quadruple Aim. The Quadruple Aim framework advocates for improving patient and provider experience, reducing cost, and advancing population health. WVPHN has developed new tools to assess patient and provider experience of AOD and mental health services as part of adhering to the Quadruple Aim Framework. Outcome and experience of care measures may include: • IAR (see Section 1.1 for details) • Program specific outcome measures* • Collaborative shared care plans • Indigenous Risk Impact Screen (IRIS) used where appropriate • Quality of life tools such as the WHOQoL • Your Experience Survey (YES) • Patient/client experience survey • Carer Experience Survey (CES) and family/carer involvement • Provider Satisfaction Survey • Partnership assessment *There is flexibility to work in partnership with WVPHN to determine the most appropriate outcome measure for use in specific programs.
3.3. Dual diagnosis tools.	WVPHN is in the process of exploring the possibility of implementing dual diagnosis tools and what this might look like in practice and will be guided by provider expertise. WVPHN will support service providers and their use of already implemented dual diagnosis tools as appropriate.

3.4. AOD specific service delivery	The types of treatment activity and interventions used to treat the client's alcohol or other drug use supports care across the spectrum of service delivery includes but are not limited to: • assessment • brief Intervention • counselling • support and case management • home-based withdrawal management (detoxification) • Dual Diagnosis • treatment for families/carers.
3.6. Mental health specific service delivery	The blended service model will combine funding previously allocated separately for the PTS and STEPMI programs to allow for better continuity of client care. Treatment will be complemented by identifying and addressing broader social, physical, and emotional needs by taking a collaborative approach to care. This will include multidisciplinary approaches to ensuring holistic needs are met, through collaborative shared care and warm transfers through a service navigation function. The service will also focus on including natural supports in the client's care journey, as appropriate, and provided with support if needed. The blended service will support warm handovers with consent obtained from the client to carry care to another provider, enabling clients to more seamlessly move along the continuum of the Stepped Care Model (see Glossary for definition) and to other services (for example, physical health and social services).
3.8. Target population	The blended service model will target specific populations, places and priority populations. The Commonwealth Guidance for Primary Health Networks outlines priority areas and groups for the design and delivery of Mental Health and AOD programs. As such, the blended service model aligns with Commonwealth guidance and target priority populations who cannot access care through other services such as privately funded services and/or publicly funded services (for example, under the Medicare Benefits Scheme). Target populations are determined by WVPHN's research that supports the place-based commissioning approach focusing on specific priority areas of a place/region/LGA to support the needs of the community. These may include, but are not limited to: • Aboriginal and Torres Strait Islander people • People with co-morbid AOD/ mental health conditions • Young people – consider appropriate services and apply flexibility to age limits where appropriate. • Middle income, older people • People in contact with the criminal justice system • Culturally and linguistically diverse populations • People identifying as gay, lesbian, bisexual, transgender or intersex • People experiencing or at-risk of homelessness • People with a disability including people with intellectual disability • Childbearing population. • People with hearing and visual impairments. • People experiencing or at risk of experiencing domestic violence. • People facing barriers with literacy • People experiencing eating disorders • People who have experienced child sexual abuse
3.9. Evaluation	***Program evaluation*** WVPHN will fund a program evaluation over the initial contract term with an interim report after 12 months of continuous service delivery. The evaluation will be undertaken by an external evaluator and will be funded separately to the blended service model. Providers must participate in the evaluation and must implement quality improvement processes as identified by the evaluation, as well as take part in any other co-design or evaluation activities.

	Partnership assessment
	
	WVPHN will work with providers to develop partnership analysis tools and support the use of already existing best practice tools.
	
	Evaluations should consider:
	
	• Synergy
	  ○ Linkages between services
	  ○ How well partners leverage resources
	  ○ The extent to which they mobilise complementary knowledge and expertise of partners in the coordination of care and treatments
	• Partnership function:
	  ○ Roles and responsibilities
	  ○ Communication
	  ○ Decision making
	  ○ Leadership, including governance processes
	  ○ Resource utilisation

4 Inclusive and Culturally Safe Care

The blended service model will support the delivery of inclusive and culturally safe service provision across the spectrum of care.

4.1. First Nations population	The blended service model: • Enables self-determination by First Nations people and communities focus on delivering culturally safe care. • Mandates all staff and sub-contractors complete Indigenous Cultural Awareness and Safety Training. • Encourages meaningful collaboration with Aboriginal Community Controlled Health Organisations from the start • Supports the delivery of AOD and MH services tailored to the specific needs of First Nations people.
4.2. Equity, Diversity, and Inclusion Training	The blended service model encourages all staff (reception and administrators, clinical and non-clinical) to undertake meaningful and ongoing training to ensure mental health and AOD services deliver appropriate care that supports the diverse and intersectional needs of the people using them. This may include but is not limited to: • training on providing inclusive care for people with disability • workplace excursions and cultural immersion activities • LGBTQIA+ training • gender diversity training • multicultural training.

5 Workforce Development and Training

The blended service model supports a multidisciplinary, collaborative workforce by focusing on recruitment, retention, capacity, and capability with strong clinical governance in place.

In the tender application process, providers will be required to include an explanation of their proposed workforce profile, including how the profile will deliver on the blended service model and meet community needs. Please consider the following guidelines:

- National Ice Action Strategy
- Alcohol and other drug program guidelines
- Psychological therapies provided by mental health professionals for underserviced groups.
- Services for people with severe mental illness.

The workforce profile will be flexible and determined by community needs, provider expertise regarding best practice workforce profiles, and workforce availability in sub-regions.

There is an expectation that the workforce must hold the necessary minimum qualifications based on the nationally recognised standards required to ensure staff are appropriately and adequately trained to deliver high quality, responsive person-centred AOD and mild to severe mental health services. Credential audits of workforce qualifications are mandatory.

WVPHN will provide support to providers to understand the needs of their local communities through resources such as the WVPHN Needs Assessments and other applicable data sources. Providers must demonstrate a workforce profile that is clear in its focus and is capable of providing services across the functions of care within the scope of the blended service model and between the interfacing systems and services.

5.1. Workforce Development	The blended service model: • must include a multidisciplinary collaborative team approach supported by appropriate clinical governance within and across partnerships where there are shared care arrangements • mandates that all AOD and mental health workers have the skills to identify co-occurring needs and share skills across professions • should incorporate a Lived Experience Peer Workforce, where appropriate and feasible • focuses on supporting strategic workforce approaches that consider recruitment, relocation incentives, increased salary, retention, shared workforce models and skill development to uplift the existing AOD and mental health workforce • supports capacity building and professional development of the workforce to ensure all staff are appropriately skilled.
5.2. Dual Diagnosis	The blended service model supports the implementation of dual diagnosis assessment across AOD and mental health services including: • appropriate training for AOD and mental health workers in the assessment and identification of co-occurring AOD and mental health issues • a strong understanding of referral pathways to appropriately skilled specialists in local regions to support dual diagnosis management and facilitate warm transfer of care with the consent of the client. There will be an expectation that commissioned providers will work with WVPHN toward the development and implementation of dual diagnosis across both mental health and AOD.

5.3. Workforce	The blended service model requires: • the clinical workforce to meet mandatory qualifications and credentials • the clinical workforce to have degree qualifications in psychology, social work, occupational therapy, mental health nursing or other related discipline, including eligibility for membership with the appropriate professional body. • other AOD and mental health workers to hold qualifications that are equivalent to, or above the scope of their role such as a Certificate 3 (preferably Certificate 4) in mental health, AOD, addiction studies, peer work, community services or a related discipline. Qualifications must be in line with the Australian Qualifications Framework. • providers seeking to employ AOD and mental health workers who do not meet the above qualifications but hold equivalent experience and skills to fulfill the requirements of the role to check in with WVPHN before making an appointment.
5.3. Lived Experience Peer Workforce	Based on the Royal Commission into Mental Health recommendations and local co-design findings, the blended service model also encourages the deployment and development of the Lived Experience Peer Workforce. As part of the blended service model, if a Lived Experience Peer Workforce is employed it will be required to: • adhere to contemporary and best practice Lived Experience Peer Workforce models including but not limited to the Lived Experience Workforce Guidelines. • be culturally inclusive with experience in specific roles encouraged such as First Nations, LGBTQIA+ and carer specific peer support positions • be appropriately skilled and qualified (with flexibility for areas of need as approved by WVPHN) with the relevant tertiary qualifications (for example, Certificate 4 in Peer Work) Under clinical supervision, the role of the Lived Experience Peer Workforce may include: • support the service navigation function so people can receive coordinated care and warm transfers to other services • client advocacy work • provide additional support to service demands and workforce gaps.
5.5. Regional and Remote Workforce	The blended service model will support the development of the regional and remote workforce to ensure people across the WVPHN catchment have equitable, timely and ease of access to AOD and mental health services. The blended service model will support regional and remote workforces through: • rural loading • distribution of funds according to sub-regional needs • a block funded model that supports flexible resource allocation. Providers can also consider factors and strategies such as: • outreach services • telehealth/online • visiting or shared workforce models • AOD and mental health rotations/clinical placements WVPHN will also support rural and remote workforce development by collaborating with the WVPHN Workforce Development team, providers and other stakeholders to identify ongoing workforce development opportunities.

6 Targeted Funding Model

The blended service model will be supported through block funding that considers allocation of a proportion of funding to support the delivery of care in rural areas, the development and maintenance of partnership approaches and standardised cost structures that are evidence based.

The blended funding model strictly relates to the integration of AOD with mild to severe mental health service (level 3 and 4 of the stepped care) funds.

The blended service model will be block funded and aligns with WVPHN's Place Based Commissioning strategy.

The strengths of a block funding model are that it supports flexibility for service providers to reallocate funds based on the needs of the community and supports partnership development.

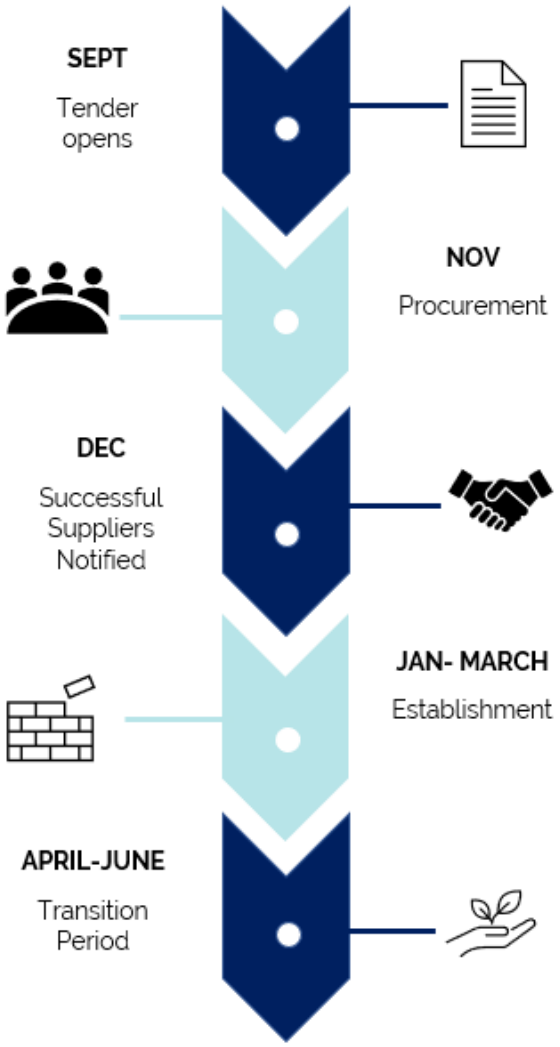
The allocation of funds under the block funding model will be underpinned by Australian Government KPIs, as well as factors such as community needs, industry standards, external pricing schedules, evaluation of previous AOD and mental health programs.

The block funding model will clearly articulate how funding allocation and incentives (such as rural loading) will be used.

6.1. Allocation of funding across Western Victoria	The combined funding WVPHN received from the Australian Government for the currently commissioned PTS, STEPMI, DAP, NIAS will be reallocated across each of the four sub-regions within the catchment and calculated using three key factors: • Rurality (using the Modified Monash Model classification) • Population • Prevalence of AOD and MH issues. • Socio-Economic Indexes for Areas SEIFA (for AOD only*) *Evidence suggests lower socioeconomic groups typically suffer more alcohol-related harm than higher socioeconomic ones. Additionally, disparities in alcohol-related harm are made worse by those experiencing many types of socioeconomic disadvantage at the same time (Ann Roche, 2015). ***Approximate Amount Allocated per subregion per annum**** Ballarat Goldfields: $1,822,454 Geelong Otway: $3,475,469 Wimmera Grampians: $1,147,322 Great South Coast: $1,288,810 *Final funding value may alter on tender release depending on confirmed Australian Government funding.
6.2. Evidence	***Evidence to support allocation of funding*** Allocation of funding is supported by analysis of the most recent data available that measures local and regional needs across the WVPHN catchment. These sources included the WVPHN 2121 Needs Assessment and contextualising data sources include AIHW and PHN Exchange, Victorian Population Health Survey, Public Health Information Development Unit (PHIDU), Turning Point AODStats Australian Bureau of Statistics - Socio-Economic Indexes for Areas (SEIFA) and the Modified Monash Model.

	AOD prevalence is calculated per LGA based on: • Alcohol and drug-related hospitalisations (Victorian Admitted Episodes Dataset) ***Mental Health prevalence is calculated per LGA based on:*** • Percentage of adults with high or very high psychological distress (Victorian Population Health Survey, 2017) • Percentage of adults with lifetime prevalence of depression or anxiety The prevalence of AOD and mental health needs across each LGA were prioritised and can be viewed in detail in Appendix D and E. ***Local Expertise*** In addition to population health, WVPHN recognises service providers bring their own expertise of local communities that will help direct funding allocation and adjustments to the right place, at the right time. Successful providers can expect that WVPHN will support service delivery to priority areas and groups by highlighting these areas in service contracts. Providers will also have access to real time, easy-to-access, visual data to inform how service delivery is tracking.
6.3. Allocation of funding within contracts	**Flexible allocation** Successful providers will receive blocked funding from WVPHN that can be flexibly allocated according to the following factors in consideration of service delivery targets and key performance indicators as determined by WVPHN: • priority LGAs (for example, where service gaps exist and to meet the needs of priority populations) • incentives to encourage rural and remote workforce • partnerships, collaboration with other sectors, shared-cared plans, stakeholder engagement (for example, GPs, health professionals, clinicians, peer workers). **Australian Government requirements** • Australian Government program guidance documents and funding deeds provided to WVPHN • appropriate allocation of resources required to meet key Australian Government KPIs. **High value KPIs** Contracts will include high value KPIs which financially incentivise providers to meet certain KPIs. For example, data reporting and data quality will be incentivised
6.6 Funding that supports partnerships	Intent for a three-year program commitment which will include a cooperative evaluation with the service provider(s) to identify opportunities for service improvement and to inform a further three-year commitment to the program.

Timeline 2022-2023



Probity and Transparency

WVPHN has probity at the forefront of procurers' minds when planning and conducting early market engagement activities. All activities undertaken are done so openly, transparently, and fairly. WVPHN plans and manages early market engagement to ensure probity is maintained throughout the whole process.

Considerations for attendees:

- Please understand that you are not bidding or providing any formal expression of interest.
- All information received in the market sounding can be recorded and communicated to other companies participating in the market sounding except for intellectual property and commercially confident material.
- The purpose of the market sounding is not selecting solutions or suppliers. Selection will occur during procurement.
- No legal relationship is created by the issue of this AOD and mental health Commissioning Intent Document, nor the submission of any proposal in response to it.
- WVPHN is under no obligation to award a contract to any respondent as a result of this market sounding process.
- WVPHN has taken reasonable steps to ensure that all information presented in this AOD and mental health Commissioning Intent Document is accurate at the time of issue.

Glossary

Alcohol and Other Drugs (AOD) – this term most often refers to excess use of alcohol and misuse of illicit or prescribed drugs.

Best practice – includes:

- evidenced care models that have been peer-reviewed and broadly accepted by the sector as the 'gold standard' based on the best available evidence from current research.
- emerging practices that are developing an evidence base over time and are underpinned by evidence-based principles that are broadly accepted and/or prescribed by the sector.

Care navigator – a person who works collaboratively with clients and carers to assist them in finding the most appropriate treatment, care or supports.

Clinical governance – the system by which the governing body (bodies), managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for clients/patients/residents. It includes workforce credentialling and scope of practice determinations.

Co-morbidity – other conditions that occur at the same time as mental illness or mental health issues. This is often physical illness or poor health but can also include use of alcohol and other drugs. Both are very common in those with mental illness or mental health issues.

Dual diagnosis - when someone has a mental health issue and an alcohol or drug use issue at the same time.

Intersectionality/intersectional - the ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation (State Government of Victoria, 2021).

Lived Experience Peer Workforce - a form of support provided by individuals with a personal lived experience of mental ill health and recovery, who are trained to use their experiences to support others in their recovery (Slade et al, 2014) as cited by Mind Australia.

LGA – Local Government Area.

Market sounding- a structured conversation with the provider market to gather insights and test assumptions to support successful commissioning outcomes. Market soundings occur outside of a procurement process and are typically used as an important planning activity and can involve getting feedback from the market regarding the structure of key elements of the service model or the procurement approach.

Memorandum of Understanding (MOU)- a nonbinding agreement that states each party's intentions to take action, conduct a business transaction, or form a new partnership.

Multiple modalities- the place or platform where a service delivered. For example, face-to-face, telehealth, group settings and/or over the phone.

Formal partnerships - formal agreements that are highly structured and formalised and are monitored by WVPHN through contractual agreements such as deliverables and Key Performance Indicators (KPIs).

Collaborative partnerships - formalised letters of support and MOUs

Collaborative agreements - informal agreements and relationships between providers that support wrap-around care and clear referral pathways.

Peer support worker – workers who have a lived experience of mental health issues and/or suicide and who provide valuable contributions by sharing their experience of mental health issues and/or suicide and recovery with others. Peer workers may have lived experience as a client or as a carer. In general, peer support workers don't have clinical or medical qualifications or backgrounds, but generally hold a minimum Certificate 4 qualification in mental health or peer work.

Place-based commissioning – WVPHN's strategy ensuring that services across the mental health and alcohol and other drugs are accessible for the community at the right place and at the right time.

Priority populations - groups in the region with disproportionately high rates of chronic disease and poorer overall health. They include but are not limited to culturally and linguistically diverse groups, LGBTQIA+ people, those experiencing homelessness, and First Nations peoples. Each priority population has additional and complex needs that are not necessarily met by the current service system.

PTS – Psychological Therapy Services.

STEPMI – Services and Treatment for Enduring and Persistent Mental Illness.

Stepped Care- an approach that provides a continuum of primary mental health services. Mental health services are defined in terms of a hierarchy of interventions that are matched to individuals' needs. Low intensity services (self-management) are delivered at Level 1 of the continuum with services that provide care for severe and enduring mental health delivered at Level 5. The stepped care approach relies on the service system to work together to integrate care and offer a suite of service interventions.

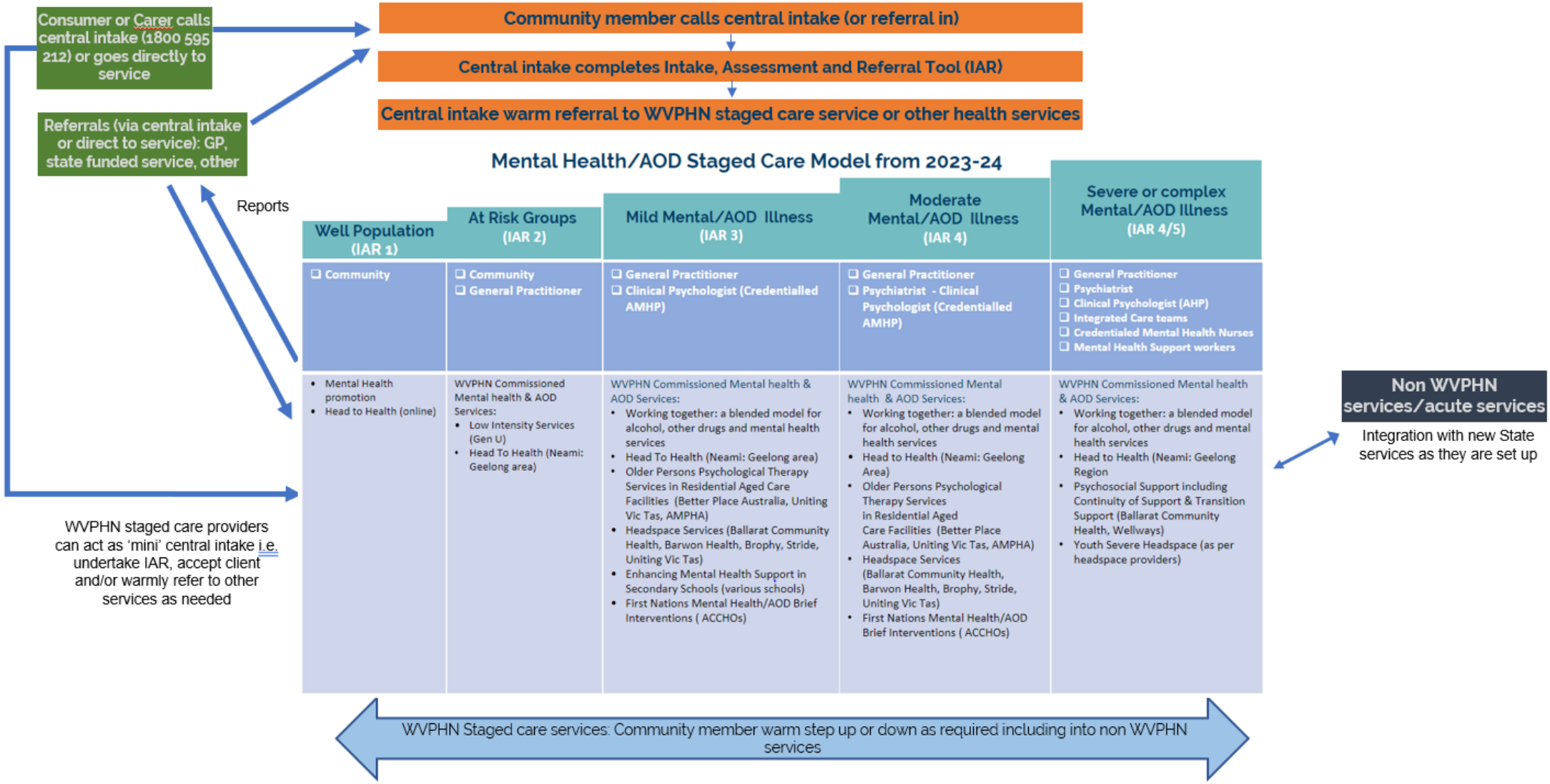
Figure 1 - Schematic representation of levels of care[5]

Warm transfer – the site actively communicates with the service to which the individual is connected to provide essential information about their needs before transferring them. Support is maintained for the individual by the site until they are received by the service.

Appendix A - LGAs within sub-regions

Subregion	LGA
Geelong Otway	Borough of Queenscliffe
	City of Greater Geelong
	Colac-Otway Shire
	Golden Plains Shire
Ballarat Goldfields	City of Ballarat
	Central Goldfields Shire
	Hepburn Shire
	Moorabool Shire
	Pyrenees Shire
Great South Coast	Warrnambool City Council
	Corangamite Shire
	Glenelg Shire
	Moyne Shire
	Southern Grampians Shire
Wimmera Grampians	Horsham Rural City
	Ararat Rural City
	Hindmarsh Shire
	Northern Grampians Shire
	West Wimmera Shire
	Yarriambiack Shire

Appendix B – Central Intake process mapped against Stepped Care Model



Appendix C

DH navy factsheet (vaada.org.au)

Proposed principle	What does this mean in practice for Mental Health and Wellbeing Services?
Partnerships are established between Mental Health and Wellbeing Services and AOD service providers. Partnership arrangements bring together the strength of individual service providers, fostering collaboration and driving service integration and coordination to meet a persons' whole needs.	Mental Health and Wellbeing Services: • may explore collaborative partnership arrangements with AOD service providers, including care coordination partnerships, service delivery partnerships and consortium arrangements. • explore governance arrangements to facilitate genuine partnerships and accountability for the delivery of effective integrated AOD and mental health treatment, care and support.

Appendix D

Mental Health Prevalence Data Only

**Disclaimer: Within LGAs there are discrepancies. The score does not take into account discrepancies in socio economic score across post codes.*

Rank	LGA	LGA Pop	Percentage of adult population ever diagnosed with anxiety or depression	Vic Average	Rank	LGA	Percentage of adults high or very high psychological distress (K10 22+)	Vic Average
1st	Central Goldfields	13,186	42.8	**27.4**	1st	Colac-Otway	20.3	**10.6**
2nd	Hepburn	16,157	37.6	**27.4**	2nd	Central Goldfields	19.4	**10.6**
3rd	Ballarat	111,361	36.2	**27.4**	3rd	Northern Grampians	18.8	**10.6**
4th	Ararat	11,965	36.0	**27.4**	4th	Greater Geelong	18.0	**10.6**
5th	Yarriambiack	6588	35.9	**27.4**	5th	Ballarat	17.9	**10.6**
6th	Horsham	20018	33.5	**27.4**	6th	Yarriambiack	17.6	**10.6**
7th	Warrnambool	35,533	32.5	**27.4**	7th	Warrnambool	16.7	**10.6**
8th	Moorabool	12,953	32.5	**27.4**	8th	Moorabool	16.4	**10.6**
9th	Corangamite	15929	32.0	**27.4**	9th	Glenelg	15.5	**10.6**
10th	Colac Otway	21,662	31.6	**27.4**	10th	Moyne	15.3	**10.6**
11th	Greater Geelong	264,866	30.8	**27.4**	11th	Corangamite	15.0	**10.6**
12th	Hindmarsh	5592	29.7	**27.4**	12th	Ararat	14.7	**10.6**
13th	Queenscliffe	3008	29.5	**27.4**	13th	Queenscliffe	14.2	**10.6**
14th	Northern Grampians	11,403	28.5	**27.4**	14th	Hindmarsh	13.8	**10.6**

15th	West Wimmera	3810	27.9	**27.4**	15th	Horsham	13.6	**10.6**
16th	Glenelg	19,621	27.8	**27.4**	16th	Hepburn	12.0	**10.6**
17th	Golden Plains	24249	26.3	**27.4**	17th	West Wimmera	11.6	**10.6**
18th	Moyne	17027	26.1	**27.4**	18th	Golden Plains	10.6	**10.6**
19th	Pyrenees	7555	23.9	**27.4**	19th	Pyrenees	9.8	**10.6**
20th	Southern Grampians	16134	19.7	**27.4**	20th	Surf Coast	9.1	**10.6**
21st	Surf Coast	34771	18.7	**27.4**	21st	Southern Grampians	8.0	**10.6**

Legend
Well above State average
Slightly above State average
At or below State average

Subregion Population		**Data**	**Source**
Geelong Otway	340,616	Ranking	*To identify the most affected LGAs, scores were either summed (if all indicators used the same units) or ranked from highest to lowest and assigned a score of 21 to 1, respectively.*
Ballarat Goldfields	153,446	Prevalence Data	*PHN Exchange | Priority Areas*, *Victorian Population Health Survey*
Great South Coast	130,928	Population Data	WVPHN Needs Assessment 2021
Wimmera Grampians	59,233		

Appendix E

AOD Prevalence Data Only

Disclaimer: Within LGAs there are discrepancies. The score does not take into account discrepancies in socioeconomic score across postcodes.

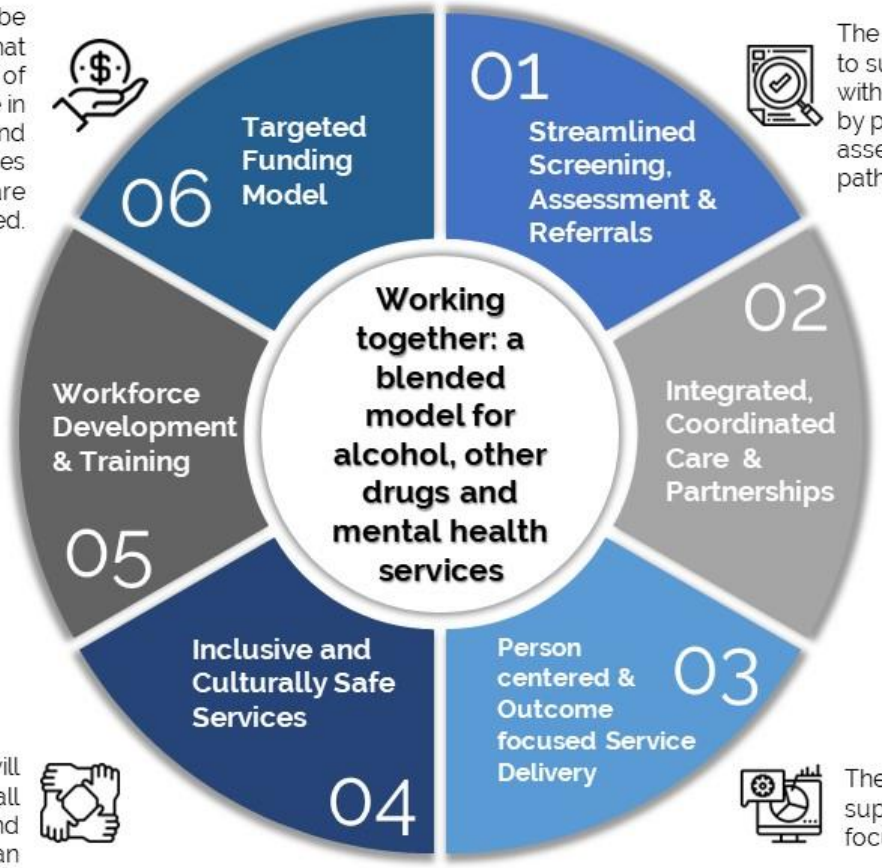
Rank	LGA	LGA Pop	Alcohol and drug related hospitalisation (per 100,000 population)	Vic Average
1st	Central Goldfields	13,186	1004	845.1
2nd	Greater Geelong	264,866	946	845.1
3rd	Glenelg	19.621	926	845.1
4th	Queenscliffe	3,008	910	845.1
5th	Warrnambool	35,533	906	845.1
6th	Corangamite	15,929	814	845.1
7th	Ballarat	111,361	805	845.1
8th	Southern Grampians	16,134	803	845.1
9th	Hindmarsh	5,592	787	845.1
10th	Pyrenees	7,555	777	845.1
11th	Moyne	17,027	752	845.1
12th	Yarriambiack	6,588	748	845.1
13th	Northern Grampians	11,403	739	845.1
14th	Hepburn	16,157	734	845.1
15th	Horsham	20,018	694	845.1
16th	Moorabool	12,953	687	845.1
17th	Colac-Otway	21,662	682	845.1
18th	Ararat	11,965	671	845.1

19th	Surf Coast	34,771	654	845.1
20th	West Wimmera	3,810	610	845.1
21st	Golden Plains	24,249	460	845.1

Legend
Well above State average
At or below State average

Subregion Population		Data	Source
Geelong Otway	340,616	Ranking	To identify the most affected LGAs, scores were either summed (if all indicators used the same units) or ranked from highest to lowest and assigned a score of 21 to 1, respectively.
Great South Coast	103,928	Population	WVPHN Needs Assessment 2021
Wimmera Grampians	59,233		PHN Exchange/ Victorian Population Health Survey 2017
Ballarat Goldfields	153,446		PHN Exchange/Victorian Population Health Survey 2017
Great South Coast	103,928		WVPHN Needs Assessment 2021
		Alcohol and drug related hospitalisation (per 100,000 population)	AODStats by Turning In (Victoria Admitted Episodes Dataset)

Service Model Priority Areas



The proposed service model will be supported through block funding that considers allocation of a proportion of funding to support the delivery of care in rural areas, the development and maintenance of partnership approaches and standardised cost structures that are evidence based.

The proposed service model seeks to support coordination of care within and across sectors by promoting shared screening & assessment tools and clear referral pathways.

The proposed service model supports a multidisciplinary, collaborative workforce by focusing on recruitment, retention, capacity and capability with strong clinical governance in place.

The proposed service model will have a strong focus on partnership approaches within sub-regions & across sectors.

Developing the proposed service will focus on ensuring that all commissioned programs and services are being delivered in an inclusive and culturally safe way.

The proposed service models will support person centred, recovery focused service delivery.

01

Streamlined Screening, Assessment & Referrals

Initial Assessment and Referral (IAR) – will be mandated where there are mental needs. The most appropriate tool must be used based on a person-centered approach for AOD. Consistent use of the K10 or K5 for mental health. Utilise universal use of screening and assessment tools where appropriate. Referral pathways within and between AOD, MH and other sectors including warm transfers across and between services.

02

Integrated, Coordinated Care & Partnerships

Embedding, encouraging & supporting collaborative shared-cared plans, partnerships and engagement that addresses biopsychosocial needs. Demonstrating ways to formalise partnership arrangements such as a Memorandum of Understanding (MOU) and stakeholder engagement & partnerships to be better supported.

03

Person centered & Outcomes focused Service Delivery

Commissioned programs are targeted to priority groups who cannot access care, targeting specific priority areas/regions/LGAs. The model will also support the social constructs of specific communities to improve service availability through flexibility in modality preference, stepped-care model, and targeted multidisciplinary approaches. Combined with ongoing consumer and carer engagement with providers in the development of services, this will ensure holistic needs are met.

04

Inclusive and Culturally Safe Care

Delivering appropriate care that supports diverse groups including First Nations people, LGBTQIA+ communities, gender diverse people and multicultural groups, providing services that are equitable, accessible and meet the diverse needs of the community and deliver safe and inclusive services.

05

Workforce Development & Training

Increasing the diversity of the workforce through the integration of peer and cultural specific roles, and supporting rural and remote areas where shortages exist. The workforce will be supported by strong clinical governance and will focus on building skills across both AOD and Mental Health, with upskilling and additional training, professional development plans, volunteers and partnerships.

06

Targeted Funding Model

Rural Loading and financial incentives to support rural and remote workforce to encourage recruitment and retention through salary and relocation incentives/stimulus, placed-based commissioning, funding allocations based on disadvantaged and priority needs. WVPHN will provide data reports.

Priority Areas in Practice

phn WESTERN VICTORIA

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