RACGP submission:

Review of Primary Health Network Business Model and Mental Health Flexible Funding Model

January 2025

RACGP

Contents

Executive Summary

Specialist general Practitioners (GPs) have extremely variable experiences with their Primary Health Networks (PHNs). These range from positive engagement to pessimism and frustration at a lack of support and consultation. Whilst great potential for PHNs exists and has been achieved by some PHNs, the bulk of GPs do not have a good experience with their local PHNs. This speaks to the need to make PHNs more accountable to GPs and communities for the services they commission. **A recent RACGP newsGP poll with over 1,200 respondents identified that over 50% rate the value provided by their PHN as poor or very poor.**[1]

PHNs can play a key role in filling the gap between local needs and funded federal government priorities which to date has not been sufficiently realised. As regional bodies, PHNs have the potential to make significant improvements to integration between primary and secondary healthcare. However, not enough GPs currently trust their PHN to take on this role, necessitating increased transparency and accountability in PHNs before this potential can be realised. This must occur through collaboration with Local Hospital Networks (LHNs) or regional equivalents, especially if this is formalised through a clear place for PHNs in health governance structures.

Structural improvements within PHNs are necessary before specialist GPs will trust and engage with their local PHN. **The RACGP has made 22 recommendations to improve the governance and focus of PHNs to improve nationally consistent operations, but tailored to regional need.** There needs to be greater transparency in PHN decision-making. Incidents of unmanaged conflicts of interest and unclear decision-making have undermined GP trust in the capacity for PHNs to self-manage these issues. The governance processes for PHNs also need to be improved through mandatory standards to ensure GPs are properly represented and conflicts of interest are appropriately managed in all regions. PHNs need to be accountable to GPs, communities in their regions and the Australian taxpayer and demonstrate an accurate understanding of local needs and demonstrate value for money through targeted and improved service delivery. PHNs must be expected (and supported) to commission services in line with local needs, rather than personal or political interests, and the flexibility to fund evaluated and evidence-based initiatives over longer periods.

The RACGP also wishes to express its disappointment with holding such a significant consultation between December 2024 and January 2025, traditionally a time of annual leave and minimum office closure periods. The perception of such timing is that the Department of Health and Aged Care (DoHAC) doesn't want meaningful input from a key stakeholder, such as the RACGP. Significant consultations like this must be appropriately timed to allow for meaningful consultation and feedback.

Please contact Samantha Smorgon, National Manager – Funding and Health System Reform, on (03) 8699 0566 or via samantha.smorgon@racgp.org.au if you have any questions or comments regarding our submission.

Summary of RACGP recommendations

To ensure PHNs achieve their full potential for patients, communities and GPs, the RACGP makes the following recommendations.

1) Require PHN Boards to have a strong GP presence through specific minimum Board composition requirements.
2) Require PHNs to have Aboriginal and/or Torres Strait Islander representation on their Board, Clinical Advisory Councils and Community and Consumer Councils.
3) Require PHNs to employ qualified Aboriginal and /or Torres Strait Islander staff to support relevant programs.
4) Require PHNs to report publicly on advice they have received from their Clinical Advisory Councils and Community and Consumer Councils which includes advice on how the PHN responded to the advice.
5) Nationally benchmark PHN performance with data provided at an individual PHN level made public and easily available.
6) Require PHNs to report on cultural safety within their organisation as part of their performance criteria and be able to demonstrate that the services they commission are culturally safe.
7) Mental health programs for Aboriginal and Torres Strait Islander people must be trauma-informed and competent in social and emotional wellbeing.
8) Create mandatory standards for consultation with ACCHOs and equitable involvement in commissioning.
9) Require PHNs to uphold the principle of Indigenous data sovereignty whenever they are handling data relating to Aboriginal and Torres Strait Islander people.
10) Develop criteria for when PHNs should be directed to implement nationally consistent programs or policies. PHNs must be focused on regional health priorities.
11) Implement mandatory governance processes within PHNs to ensure conflicts of interest are appropriately managed.
12) Ensure PHN initiatives across all health domains are developed via a joint process with LHNs and ACCHOs similar to Joint Regional Mental Health and Suicide Prevention Foundation Plans.
13) Require PHNs to conduct their regional needs assessment in collaboration with LHNs and ACCHOs
14) Require PHNs to publish their regional needs assessment.
15) Support PHNs to collaborate with key regional stakeholders including regional DoHAC representatives and other PHNs to identify and scale up successful programs.
16) Amend funding arrangements to allow for funding on a medium- and long-term basis.
17) Strengthen evaluation requirements to ensure minimum, evidence-based evaluation standards are used.
18) Implement a process to enable unspent funding to be used to continue cost-effective, high-value programs.
19) Allow for greater flexibility of funding arrangements outside the Mental Health Flexible Funding pool to enable innovative funding models.
20) Index PHN program funding to the Consumer Price Index (CPI).
21) Mental Health programs commissioned by PHNs should be well-integrated and as simple to refer to as existing mental health services.
22) PHNs must act as facilitators to engage a patient after a hospitalisation and support them to initiate treatment with their GP and support the GP to take over the patient's care.

Future state for PHNs

To achieve the potential of PHNs across Australia, there must be a re-examination of their underpinning goals and long-term intent. PHNs should operate according to the below principles:

- General practice must be at the heart of PHN decision-making, with specialist GPs in senior advisory and governance positions and chairing Clinical Advisory Groups.
- PHNs must operate independently from personal or political interests and be held accountable to their communities. They require mandatory governance and performance standards, independent auditing and transparency.
- PHNs should be assessed on the evidence-based outcomes they achieve rather than the volume of services they deliver. Funding priorities should demonstrate alignment with regional needs and account for social determinants of health and other factors that may impact the PHN's ability to achieve improved regional health outcomes.
- PHNs must aspire to be accurate and trusted representatives of specialist GPs and other primary care services within their regions. This trust can only be built on transparent decision-making, reporting and accountability.
- PHNs should be required to regularly collaborate with other regionally based organisations and key stakeholders that reflect their population including LHNs, Aboriginal Community Controlled Health Organisations (ACCHOs), primary care providers, aged care facilities and other PHNs to improve synergy and integration and help scale up successful programs.
- PHNs actively engage with stakeholder organisations that represent primary care professions and priority populations such as the RACGP and the National Aboriginal Community Controlled Health Organisation (NACCHO) to bring national expertise to local issues.
- PHNs can flexibly fund programs with short, medium and long-term funding arrangements. These funding decisions should be driven by the requirements of the programs rather than government funding cycles.

- PHN performance should be nationally benchmarked but their activity tailored to regional outcomes.

About the RACGP

Every year more than 22 million Australian choose to see a GP for their essential health care – making GPs the most accessed health professional in the country. The RACGP is the voice of GPs across our nation, representing more than 50,000 members in our growing cities and throughout rural and remote Australia.

For more than 60 years, the RACGP has supported the backbone of Australia's health system by setting the standards for education and practice and advocating for better health and wellbeing for all Australians. With the return of college-led training in 2023, the RACGP now trains more than 90% of Australia's GPs including those training in Aboriginal and Torres Strait Islander communities, remote, rural, regional, metro and outer metropolitan areas.

Our core commitment is to support GPs from across the entirety of general practice to address the primary healthcare needs of all Australians, because there is no substitute for the high-quality care provided by a GP who knows you and your history.

Detailed RACGP feedback to consultation questions

1. Program Objectives and Activities

Consultation Questions:

1. Are the roles of PHNs clear and understood by stakeholders, including your own organisation? How will the relative importance of the different roles need to evolve to meet broader changes in health policy and delivery?

1.1. What are the key roles played by PHNs, and how should the balance between local insight and national consistency be managed for each role?

1.2. How have the roles of PHNs evolved over the past 9 years to align with changing objectives, and how are they expected to adapt in the next 5 years?

1.3. What key examples can you share of the key benefits delivered by PHNs?

1.4. What activities or programs does your PHN excel at delivering, or should be recognised as a national leader?

1.5. What additional roles, if any, should PHNs take on—either broadly or in specific circumstances—to better address community needs?

1.6. Are there roles currently performed by PHNs that might be more effectively managed by other organisations? If so, why and how?

Ten years into the operation of PHNs, the Australian health system continues to experience issues with fragmentation and patient access, issues PHNs were tasked with developing solutions for. While successful PHN-commissioned programs can be identified and should be rightly celebrated, PHNs overall have not had the desired or anticipated positive impact on Australia's health system.

The RACGP supports the PHN role in using local knowledge to address local needs which can overcome the gap between federal policy makers and local communities. There is also a need within our health system to bridge the communication, governance and service gap between low-intensity, community-based primary care services like general practice and high-intensity hospital-based services. Notwithstanding a small number of successful initiatives by PHNs and LHCs to proactively work together to support and integrate care transitions in regional communities, most often there continues to be insufficient integration between these services.

PHNs have the capacity to deliver significant improvements to care received by Aboriginal and Torres Strait Islander people. PHNs commissioning services through Aboriginal Community Controlled Health Organisations (ACCHOs) could contribute significantly to Closing the Gap Priority 2 (building the community-controlled sector). Unfortunately, ACCHOs have expressed that there are gaps in PHN consultation and that PHNs do not provide adequate resourcing to service their populations.[3] In some regions, PHNs have been seen as diverting funds away from Aboriginal and Torres Strait

Islander run services and towards mainstream services which undermines the community-controlled sector. The RACGP recommends mandatory standards be implemented to ensure PHNs are adequately and appropriately engaging with ACCHOs. These standards should be developed by Aboriginal and Torres Strait Islander Communities either through community liaison, local ACCHOs or the NACCHO.

PHNs must also ensure there is Aboriginal and/or Torres Strait Islander representation on their Board, Clinical Advisory Councils and Community and Consumer Councils and ensure Aboriginal and /or Torres Strait Islander staff are employed to support relevant programs. PHNs must report on cultural safety within their organisation as part of their performance criteria and be able to demonstrate that the services they commission are culturally safe. Mental health programs for Aboriginal and Torres Strait Islander people should be trauma-informed and competent in social and emotional wellbeing. PHNs must also be required to uphold the principle of Indigenous data sovereignty when handling data relating to Aboriginal and Torres Strait Islander people.

RACGP Recommendations:

- Require PHNs to have Aboriginal and/or Torres Strait Islander representation on their Board, Clinical Advisory Councils and Community and Consumer Councils.
- Require PHNs to employ qualified Aboriginal and /or Torres Strait Islander staff to support relevant programs
- Require PHNs to report on cultural safety within their organisation as part of their performance criteria and be able to demonstrate that the services they commission are culturally safe.
- Mental health programs for Aboriginal and Torres Strait Islander people must be trauma-informed and competent in social and emotional wellbeing
- Create mandatory standards for consultation with ACCHOs and equitable involvement in commissioning.
- Require PHNs to uphold the principle of Indigenous data sovereignty whenever they are handling data relating to Aboriginal and Torres Strait Islander people.

2. Program Governance

Consultation Questions:

2. Is the governance of PHNs and the broader PHN Program appropriate, efficient and effective?

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2.1. What challenges, if any, arise from PHNs operating as non-governmental organisations (NGOs)? Please provide examples and suggestions for addressing these challenges.

2.2. Are there specific issues or areas of concern related to PHN governance? What measures or improvements could be implemented to address these?

2.3. Are the processes currently used to measure and manage PHN performance sufficiently clear? Are there any challenges with these processes, and what potential improvements could be made?

2.4. How could the Department support PHNs in enhancing capability and performance? What alternative bodies (whether current or conceptual) could further contribute to achieving these objectives?

PHNs largely establish their own governance structures and self-report on many areas for their performance assessments. Some PHNs have established robust structures and are held in high regard by the general practices in their regions. Others have been mired with controversy due to poorly managed conflicts of interest, unclear decision making and a reluctance to engage with general practice. Specialist GPs report consistent concerns that their PHN is insufficiently transparent and are not accountable in their decision-making.

The National Health Reform Agreement (NHRA) Mid-Term Review Final Report recommended an expanded role for PHNs within the governance structures Australia's health system, acting as representatives of the general practices in their area.[2] Governance changes to PHNs and stronger requirements to build relationships with local general practices will be vital if PHNs are to take on this regional representative role. RACGP members have reported some PHNs have shown insufficient interest in or understanding of general practice. The RACGP is concerned this is due to insufficient prominence of the GP-led Clinical Advisory Councils within PHNs. This can be rectified by mandatory GP representation on PHN Boards. The RACGP recommends the chair of the Clinical Advisory Council (or a GP from the council where the

chair is not a GP) of a PHN have a seat on the PHN's Board. General practice must be at the heart of PHN decision-making. PHNs must also be required to report publicly about the advice they have received from their Clinical Advisory Council and Community and Consumer Council and how they've acted on it.

The RACGP is aware of instances where PHNs have not adequately managed conflicts of interest within their organisation or made questionable funding decisions without explanation. These instances have undermined the trust of GPs and overshadowed PHN achievements. Mandatory and consistent governance requirements are necessary to ensure conflicts of interest are being appropriately managed in all PHNs and so GP and community trust can be restored.

Increasingly, PHNs are required to locally implement policies that have been designed at a federal level.[4] PHNs have limited capacity to adapt these programs to the local context. While there are circumstances where a national approach is ideal, such as the role of PHNs in the federal government's response to COVID-19, the focus of PHNs should generally be on regional health priorities. The RACGP recommends the DoHAC develop strict criteria for when PHNs are directed to implement of nationally based programs or policy.

Any national program PHNs are directed to implement should be paired with or inclusive of appropriate administrative and flexible funding so the associated workload does not impact other PHN programs. If PHNs have the capacity to address regional needs as their clear focus and priority while also implementing national programs, this will result in increased trust and good will amongst general practices.

The RACGP made a range of specific recommendations regarding how PHNs are performance managed in its submission to the Effectiveness of the Department of Health and Aged Care's performance management of the Primary Health Network program audit. These included:

- PHN performance data at an individual PHN level must be made public and easily available.
- Moving away from using metrics that measure the volume of services delivered and adopting measures that are outcomes-based.
- Move beyond optional guidelines on how PHNs and ACCHOs work together and create mandatory standards for Aboriginal consultation and equitable involvement in commissioning.

The RACGP is also aware that PHNs, GPs and communities are frustrated at the difficulty PHNs have scaling up successful programs. The RACGP recommends PHNs be supported to collaborate with stakeholders including DoHAC and other PHNs to identify and scale up successful programs.

RACGP Recommendations

- Require PHN Boards to have a strong GP presence through specific minimum Board composition requirements.
- Develop criteria for when PHNs should be directed to implement nationally consistent programs or policies.
- Require PHNs to report publicly on advice they have received from their Clinical Advisory Councils and Community and Consumer Councils that includes advice on how the PHN responded to the advice.
- Nationally benchmark PHN performance with data provided at an individual PHN level made public and easily available.
- Require PHNs to conduct their regional needs assessment in collaboration with LHNs and ACCHOs.
- Require PHNs to publish these needs assessments.
- Support PHNs to collaborate with key regional stakeholders including regional DoHAC representatives and other PHNs to identify, share learnings from, and scale up successful programs.
- Implement mandatory governance processes within PHNs to ensure conflicts of interest are appropriately managed.

3. Regional Planning, Communication and Engagement

Consultation Questions:

3. Does the PHN Program support regional planning, effective communication and engagement between relevant stakeholders?

3.1. How do PHNs engage with stakeholders across primary and acute care sectors, including GPs, allied health providers, Local Hospital Networks (LHNs), state departments, and community services? What aspects of these engagement processes work well, and where could improvements be made?

3.2. What are the expectations of different stakeholder groups of PHN regional planning, engagement, and communication? Are these expectations currently met, and should there be minimum requirements to guide these activities?

3.3. Are current PHN boundaries appropriately aligned with service delivery boundaries? Are there opportunities to adjust these boundaries to better support stakeholder consultation and engagement?

3.4. How do PHNs establish and use Clinical Committees and Community Advisory Councils? What factors contribute to their effectiveness, and are there areas for improvement?

3.5. How should PHNs assess whether their collaborations with stakeholders are effective and result in measurable improvements in health outcomes and other key performance indicators? What tools, metrics, or approaches could support this evaluation?

The lack of primary care representation in the governance and planning structures of Australia's health system(s) is a structural flaw PHNs are well-placed to address. While this is a space PHNs are already active in, the RACGP argues much more can be achieved. The Joint Regional Mental Health and Suicide Prevention Foundation Plans present an example of PHNs taking on this role to develop initiatives to address mental health and suicide prevention in collaboration with LHNs (or regional equivalents). This joint planning process allows services to be developed with PHNs and LHNs using the same needs assessment data and promotes integration between services. The RACGP recommends this model should be expanded beyond mental health and PHN initiatives across all health domains should be developed via a joint process with LHNs. ACCHOs must also be invited to collaborate to ensure the unique needs of this sector are considered.

Joint regional planning is effective for mental health as treatment often involves a patient receiving care from multiple providers with varying intensities, with the specialist GP acting as a consistent provider and care coordinator. Similarly, treatment for many other health conditions require a patient to interact with multiple health services such as an initial hospitalisation before progressing to outpatient care, then to GP care supported by allied health services. Integration between general practice and hospitals is vital in these instances to facilitate collaborative care and ensure the patient is receiving the right care at the right time in the right place. Joint regional planning will support the integration of general practices and hospitals and streamline the journey between hospital and general practice. Collaboration should be embedded from the start of these processes.

The patient care facilitator program currently being run by the West Moreton PHN presents an example of how the PHNs can support integration. PHN commissioned services can connect hospitalised patients with GPs where they do not already have one to set the patient up for a stable recovery in the community and establish a primary care relationship to reduce the likelihood of future hospitalisations. Evidence suggests that seeing patients who experience a unexpected hospital stay have a 32% reduced likelihood of readmission if they see their GP within two days of discharge.[5] The RACGP argues patients should be at the heart of measuring the effectiveness of integration programs such as these. Patient-reported outcome measures and patient-reported experience measures should be used to assess their journey between hospital and their general practice.

RACGP Recommendations

- Ensure PHN initiatives across all health domains are developed via a joint process with LHNs and ACCHOs similar to Joint Regional Mental Health and Suicide Prevention Foundation Plans.

4. PHN Program Funding Arrangements

Consultation Questions:

4. Do the current PHN Program funding arrangements support effective delivery of the objectives?

4.1. Does the current level of flexibility in PHN funding effectively support the delivery of locally relevant solutions? What changes, if any, could enhance this flexibility while ensuring alignment with nationally consistent health priorities?

4.2. Are there opportunities to streamline core activities or deliver them more efficiently, such as through shared service arrangements or similar models?

4.3. Do current funding arrangements create challenges for service delivery? If so, what changes could be made to address these issues and improve outcomes?

The current short-term nature of PHN funding cycles is consistently reported as problematic and a limiting factor for the type and scope of programs/services PHNs can commission. Short-term funding means programs have a very limited lifespan. Established relationships end and need to be redeveloped in any new program. Specialist GPs experience this short-term funding as a never-ending turnover of available programs. This funding instability and uncertainty means GPs are unclear about what services are available for patients and whether they will be available long enough for the patient to receive sufficient benefits, so generally disengage.

Short-term funding, coupled with the need for project/program evaluations within these short timeframes, limits the kind of programs that can be run to those that can demonstrate measurable results quickly. Within mental health this has resulted in PHNs commissioning many interventionist services. While these types of services have their place, the conditions GPs spend most of their time addressing are long term in nature, as is preventive health. These needs are better addressed with medium- and long-term programs that can realise the intervention benefits over a longer period. Evaluation requirements need to be revised to better enable programs supporting mental health, chronic disease and preventive health. The nature of conditions being treated or goals of these programs means they are unlikely to yield clear quantitative results within a few months. Appropriately evaluating these programs often requires larger data sets, qualitative or mixed methods evaluations, all of which require longer timeframes to demonstrate outcomes than two-year funding cycles allow.

Current funding cycles also lead towards inefficiencies. Low intensity programs are quickly commissioned at the end of a funding cycle to avoid funding being 'lost'. The nature of the current funding cycle means that unspent funding cannot be carried over into the next cycle. This encourages the PHN to commission quickly to ensure the money is spent. In some instances, this involves less than ideal procurement practices where specific providers are approached and asked to submit a very specific funding request the commissioner knows will get approved and will expend any remaining funding. These practices do not reflect high value or cost effectiveness. The RACGP recommends a portion of unspent funding be allowed to be carried forward to ensure it is going towards cost effective, high value programs. If unspent funding is due to insufficient service provision by a PHN, this should be a matter that is identified and addressed via the performance management framework.

Funding for PHN's is not indexed according to the CPI, with the DoHAC expecting efficiency gains to cover the shortfall. While efficiency gains can be realised, this is difficult when programs are being funded for such short periods of time. Indexation that does not meet CPI results in a gradual loss of funding with the gap between the real cost of programs and the funding provided growing over time. The current state of general practice with the national bulk billing rate dropping to 77.4% in 2024 from 83% in 2014,[6] and the ever-increasing out of pocket costs (the national average gap payment for a Level B consultation is $43.38)[7] demonstrates what can happen when the investment is not supported appropriately. PHN program funding must be indexed according to CPI at a minimum to ensure ongoing program viability.

The Mental Health Flexible Funding Pool (MHFFP) has shown what PHNs can achieve when given autonomy in how they use their funding. The flexibility of the MHFFP has allowed PHNs to develop innovative services, pooling funding from other sources such as hospital funding to scale services that are better integrated with other areas of the health system. The MHFFP also allows funding to scale with the growth of the program as providers become interested. This is a key strength of the Mental Health Nurse Incentive program. Being funded through the MHFFP allows additional funding to quickly be available when practices seek to employ a mental health nurse without making funding unavailable for other

programs. The RACGP recommends PHNs be given greater overall flexibility with how they spend the commissioning resources to enable scalability, innovation and collaboration with other areas of the health system.

The RACGP supports collaboration between PHNs to share resources, knowledge and scale up successful programs. Such arrangements would need to be well coordinated and managed to ensure that PHNs don't lose the independence to respond to the needs of their region.

RACGP Recommendations

- Require PHNs to collaborate with key regional stakeholders including regional DoHAC representatives and other PHNs to identify, learn from and scale up successful programs.
- Amend funding arrangements to allow for funding on a medium- and long-term basis.
- Strengthen evaluation requirements to ensure minimum, evidence-based evaluation standards are used.
- Implement a process to enable unspent funding to be used to continue cost-effective, high-value programs.
- Allow for greater flexibility of funding arrangements outside the Mental Health Flexible Funding pool to enable innovative funding models.
- Index PHN program funding to the Consumer Price Index (CPI).

5. Mental Health Flexible Funding Stream (MHFFS)

Consultation Questions:

5. What is the role of PHNs in commissioning services through the mental health flexible funding stream within the mental health and suicide prevention system, and how effective has it been? How could that role evolve to be more efficient and effective?

5.1. How has the landscape of mental health and suicide prevention system changed since the introduction of the Mental Health Flexible Funding Stream (MHFFS) in 2016? Please provide the key changes based on evidence or policy changes relevant to your organisation.

5.2. What further changes in mental health and suicide prevention system do you predict, and how could the role of the MHFFS adapt to support these changes effectively?

5.3. What challenges do PHNs face in delivering their role within the mental health and suicide prevention system? How can these challenges be addressed to improve outcomes?

5.4. How does your PHN currently coordinate services and referral pathways across the stepped care continuum? How could this evolve in the future?

5.5. Does the current funding allocation under the MHFFS support PHNs in meeting the objectives of the program? Have any challenges appeared over time as community needs and priorities have evolved?

5.6. What changes to the funding allocation under the MHFFS could better support PHNs in addressing evolving needs and achieving program objectives effectively?

5.7. Do service providers experience challenges in delivering mental health services under the MHFFS? If so, what are these challenges, and how could they be resolved?

As previously identified, the short-term nature of PHN funding cycles has meant that many programs commissioned under the MHFFS have been interventionist in nature. The Health of the Nation Report has found that 71% of specialist GPs report psychological issues in their top three reasons for presentations.[8] GPs need support to treat mental health at all levels of severity and with a variety of approaches. The RACGP recommends enabling longer funding cycles under the MHFFS to enable a greater variety of services to be funded. Amendments should also be made to the evaluation criteria for these programs. Mental health conditions are often long term, and episodic or variable. Patients may make significant progress but still be experiencing symptoms. Evaluation for mental health programs should place less emphasis on quantitative data regarding reduction of symptoms and the number of services attended and place a greater emphasis on how patients feel able to manage their condition and how they feel the program supported them.

An area where the MHFFS should play a larger role is to support GPs to understand what services are available for their mental health patients. Navigating the mental health system is difficult, with many psychologists and psychiatrists having

long waiting lists, if they are still accepting patients. Public and community services exist but often have limited capacity and strict admission criteria. There are also a host of digital mental health supports, social prescribing and diet and exercise services which could assist mental health patients. Navigating these channels of support can be challenging when GPs are trying to adequately listen to a patient's concerns and develop a mental health treatment plan within a brief consultation.

The ways PHN can play a larger role in supporting specialist GPs is by communicating wait times, what services the patient is eligible for and how each one could support their treatment. PHNs should also be able to indicate which programs are appropriate for patients with low English proficiency or technological literacy. They should be aware of the cultural and language groups in their service area and be able to let GPs know what services are available in the patient's preferred language. The RACGP has received member feedback that PHNs' mental health services often have referral criteria that is overly administratively burdensome. Mental Health programs commissioned by PHNs should aim to be as simple to refer to as existing mental health services.

Integrating hospital psychiatric wards and general practice is an opportunity for PHNs to deliver significant improvements to service coordination and efficiency, improving outcomes for people experiencing severe mental health issues. Hospital psychiatric wards often have limited capacity to do anything more than bring down a patient's level of acuity to a point where they can be discharged back to the community. Mental health hospitals rely on GPs to take over care and keep the patient stable and out of hospital. Unfortunately, mental health conditions make it challenging for patients to initiate treatment with their GP. Existing issues around discharge and clinical handover mean a patient's GP may be unaware they were even hospitalised. PHNs should act as facilitators to engage a patient after a hospitalisation and support them to initiate treatment with their GP and support the GP to take over the patient's care.

RACGP Recommendations

- Mental health programs commissioned by PHNs should be well integrated and as simple to refer to as existing mental health services.
- PHNs must act as facilitators to engage a patient after a hospitalisation and support them to initiate treatment with their GP and support the GP to take over the patient's care.

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