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An Australian Government Initiative

DISCUSSION PAPER

Towards a Regional Mental Health and Suicide Prevention Plan in Western NSW

July 2019

Purpose

The purpose of this discussion paper to share what we've learnt in prior consultation workshops and presentations in Western NSW PHN's footprint. We welcome further feedback from those who have yet to contribute. Specifically – we would like to hear more from consumers, carers, GPs and Aboriginal people (both consumers, carers and service providers).

We have already heard much about ***what*** should be done through comprehensive needs assessments and consumer consultations undertaken throughout 2018. This discussion paper seeks input into the ***how*** the Western NSW PHN should work together with local health districts, service providers, consumers, carers and the wider community to provide better mental health care and suicide prevention activities. It has incorporated the feedback we have already received from community, health professionals and the Aboriginal Health Council in 2018 and 2019.

You can help us by taking the time to read this discussion paper and making any comments that might help us improve the mental service and suicide prevention system in our region, particularly in how we can and should work together. The Western NSW PHN has engaged the Centre for Rural and Remote Mental Health to facilitate the development of this foundation plan, to give feedback or discuss or request to be updated on progress, please email: CRRMHresearch@newcastle.edu.au

We invite you to share this discussion paper with others and encourage them to respond, especially consumers and carers.

Acknowledgements:

We would like to thank staff from the Western NSW Primary Health Network, the stakeholders from Western and Far West regions of NSW representing communities, consumers, clinicians, service providers across local health district and Aboriginal Community Controlled Health Services and Aboriginal Medical Services who attended the workshops, listened to presentations and provided feedback either directly or via review of early drafts of this discussion paper. This paper has built upon prior engagement work in health needs and suicide prevention.

Consultation and engagement process:

We would like to outline the consultation and engagement process that has led to this discussion paper, which serves as a primer in the development of our foundational joint regional mental health, drug and alcohol and suicide prevention plan. The Western NSW PHN has worked with a team from the Centre for Rural and Remote Mental Health (CRRMH) in this process.

- Broken Hill, December 2018 –
  workshop with Far West Local Health District
  community workshop.
- Orange, February 2019 –
  workshop with Western NSW Local Health District
  community workshop.
- January – February 2019 – four presentation and discussions with the WNSW PHN clinical and community councils in Western and Far West areas.
- March 2019 – Draft Discussion paper shared with WNSW PHN.
  NB – draft not shared at this point due to need to engage with and draw upon the experience of the WNSW PHN Aboriginal Health Council.
- April 2019 – presentation and discussions with the WNSW PHN Aboriginal Health Council.
- May - June 2019 – additional feedback from Aboriginal Health Council and PHN incorporated into discussion paper

Suggested citation:

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What’s in this paper?

Purpose 1

Acknowledgements: 2

Consultation and engagement process: 2

Scope 4

Why a regional plan? 4

A note about primary health care 5

A note about stepped care 6

How are we going about it? 7

What have we learnt so far? 8

Principles 8

Processes 9

Feedback – other themes 10

What does the current service system look like? 12

How has all this shaped our thinking for the plan so far? 14

How will the plan be implemented? 15

Scope

This discussion paper will inform the *foundational* regional mental health plan that lays out the ground we need to cover including the way we will work together to build a more *comprehensive* plan by 2022. Moreover, the foundation plan is focused on primary care and the comprehensive plan across the mental health service spectrum. Feedback will thus inform both plans, now with the foundational plan and into the future with the comprehensive plan. So we are investing time, effort and research to collaboratively build these plans. Done properly, the two plans will provide a rich and detailed picture of the development of western NSW mental health and suicide prevention care for the next decade.

Why a regional plan?

The concept of a regional plan arises from the **Fifth National Mental Health and Suicide Prevention Plan**[1] agreed by Council of Australian Government's Health Council in 2017. Importantly, Primary Health Networks and Local Health Districts[2] are expected to work together to address eight priorities over five years. Primary Health Networks have been given the leadership role initially, with the intention that the two will develop a strong co-leadership and governance approach over time. The Plan represents the nationally-agreed policy for the five years to 2023 as a result of the National Mental Health Commission's review of the Australian mental health system and the Australian Government response to the review.

Fifth National Mental Health and Suicide Prevention Plan	
Priority areas	1. Integrated planning and service delivery
	2. Suicide prevention
	3. Coordinating for severe & complex mental illness
	4. Improving Aboriginal mental health
	5. Physical health & mortality
	6. Stigma & discrimination
	7. Safety & quality
	8. Enablers of performance & improvement

The **National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023**[3] forms an essential component of the national response to Aboriginal and Torres Strait Islander health. It complements the Fifth National Mental Health and Suicide Prevention Plan to support the work of PHNs in partnership with Aboriginal communities and Community Controlled Health Services.

The Framework has seven overlapping domains as sources of wellbeing and connection, including body, mind and emotions, family and kin, community, culture, country, spirituality and ancestors. Its

[1] http://www.coaghealthcouncil.gov.au/Portals/0/Fifth National Mental Health and Suicide Prevention Plan.pdf

[2] In our region, Western NSW Local Health District and Far West Local Health District, are the local arms of NSW Health.

[3] https://pmc.gov.au/resource-centre/indigenous-affairs/national-strategic-framework-mental-health-social-emotional-wellbeing-2017-23

five action areas are intended to reflect the stepped care model of primary mental health care service delivery.

	National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017-2023
Action areas	1. Strengthen the foundations 2. Promote wellness 3. Build capacity & resilience in people and groups at risk 4. Provide care for people who are mildly or moderately ill 5. Care for people living with severe mental illness

In addition to these two main national mental health policy statements, there are **numerous PHN guidance documents**[4] published by the Commonwealth Government Department of Health, including on suicide prevention, stepped care, Aboriginal mental health, child and youth mental health, low-intensity services, and severe mental illness. Also, Equally Well (www.equallywell.org.au) seeks to improve the overall health of people living with mental illness. Guiding principles for providing mental health, social and emotional wellbeing support for Aboriginal and Torres Strait Islander people is clearly summarised in the Gayaa Dhuwi (Proud Spirit) Declaration[5]. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project[6] report has valuable guidance.

Additionally, in December 2018, the **Australian Senate published its report into the accessibility and quality of mental health services in rural and remote Australia**[7]. Among its 18 recommendations are key proposals to strengthen services, including the local design of services, longer and more flexible contracts for providers, peer worker support, education of communities and advertising of digital services. In addition, it proposes: the development of a national rural and remote mental health strategy; a review of the role of PHNs in commissioning mental health services under a stepped care model; and that PHN-commissioned services embody the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017-2023.

A note about primary health care

> *Primary health care is often the first level of contact people have with the health system in relation to their health. It is those parts of the health system that focus on protecting and promoting the health of people in communities, and is often engaged in working with issues regarding health in a preventative manner. It is also the place where health problems are commonly identified, managed or referred in the context of early intervention*[8].

Thus primary health care is about more than general practitioners, whilst recognising that they play a key role.

[4] http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools

[5] https://natsilmh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf

[6] https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf

[7] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Report

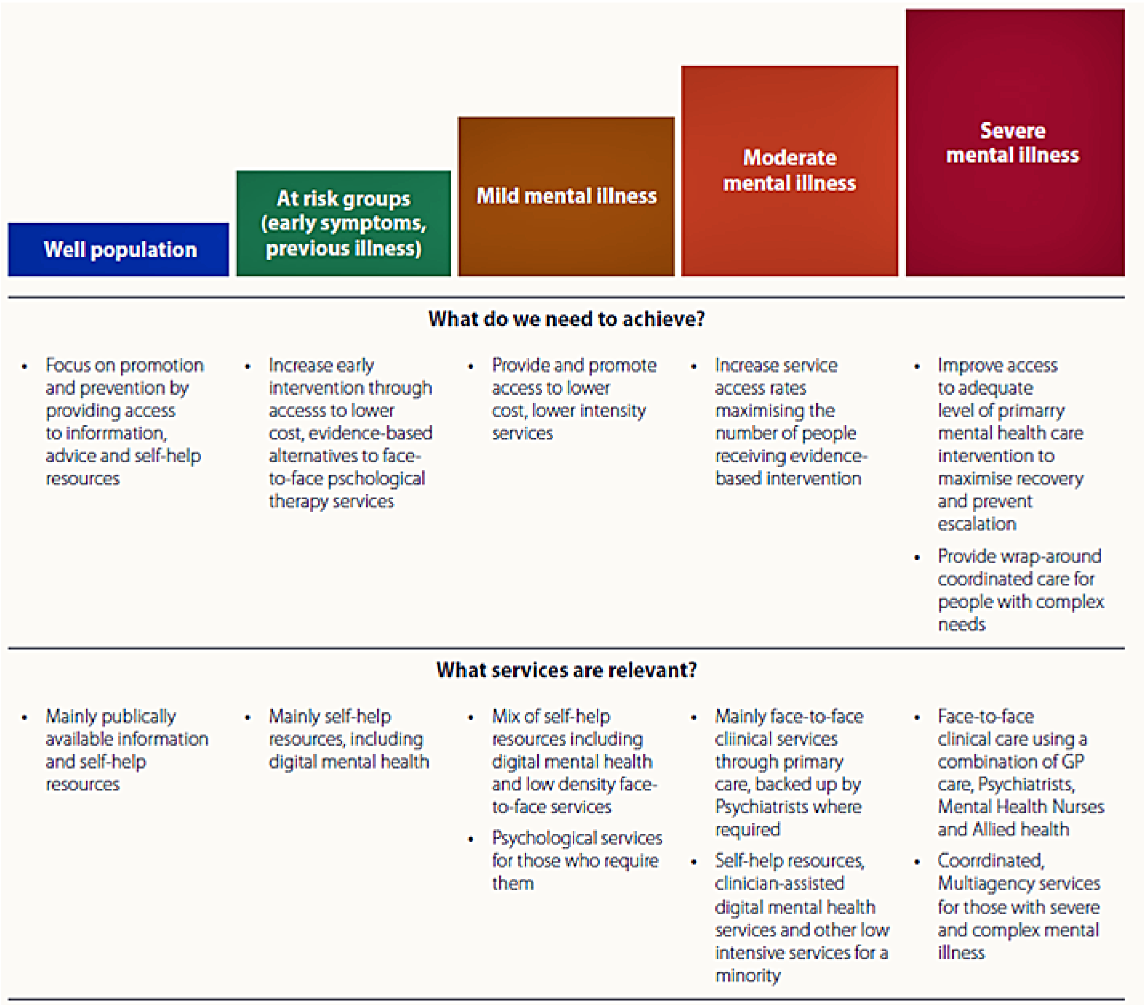
[8] https://blogs.crikey.com.au/croakey/2010/06/17/primary-care-vs-primary-health-care-who-cares-part-2/

A note about stepped care

> *"Stepped Care is a system of delivering and monitoring treatments so that the most effective yet least resource intensive treatment is delivered to clients first, only 'stepping up' to intensive or specialist services as clinically required. Stepped care is seen as essential to improving service integration and navigation through the system and to optimising the use of available resources." 9*

The Australian Government response to the National Mental Health Commission's report *Contributing Lives, Thriving Communities* includes an approach to stepped care across the spectrum of need and the primary and secondary service sectors. The graphic below provides an accessible interpretation of the concept that guides all PHNs in their mental health planning.

The literature on stepped care identifies two key principles: the principle of '***least burden'*** where less intensive and restrictive treatment options that provide significant health gain are recommended to consumers first; and the principle of ***'self-correction'*** where treatment strategies are responsive to patient progress, and corrections to the level of care are made based on regular assessment.



Source: The Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services (2015)

It is important to note that ***high-intensity treatments are not necessarily more effective than low-intensity treatments***. It is more helpful to conceptualise stepped care within the context of an ethical

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[9] The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023, p.18.

imperative of ***choosing the most beneficial and least intrusive intervention*** taking into account principles of 'matched care'.

A number of key principles are associated with positive outcomes in stepped care. These include the provision of information, patient involvement, clarity about pathways through care and the processes by which this is assessed. An effective stepped care model of service delivery is one that:

- is responsive to the needs of people, their families, carers and professionals
- adapts the model to fit around the person and not the person around the model
- minimises the need for transition between different services or providers
- provides easy movement between levels and to other pathways (e.g. physical health)
- has prompt assessments that are not repeated unnecessarily to access interventions
- has designated staff to coordinate engagement with the pathway
- uses holistic criteria to determine movement between steps
- is outcomes focused, and has mechanisms for responding to changes in needs
- shares information with the person, GPs and other health professionals
- provides training and support on the operation of the pathway.

How are we going about it?

Our initial activities have centred on examining existing information and talking to stakeholders. We have substantial information sources to draw upon about the incidence of mental health problems and suicide in our region, the varying levels of need, and the spread of current services. This provides a way to identify the gaps and overlaps in services, information that is crucial to decisions about where to apply money and changes so that better outcomes and cost-effectiveness can be achieved. The WNSWPHN has undertaken health needs assessments in the region which have provided valuable insights from a range of community members, and many of these insights have identified the needs in mental health, suicide, and addiction problems.

We have held workshops in Broken Hill and Orange which achieved good attendance from members of the community and service providers, and our local health district partners have joined us in special planning sessions. Presentations to the WNSWPHN advisory councils (Western & Far West Clinical & Community Councils and the Aboriginal Health Council) have been conducted, followed by discussions and out-of-session opportunities to contribute. We have also spoken with the Sydney University Department of Rural Health in Broken Hill about how their initiatives and research activities can enrich the future for regional mental health care, particularly in the area of workforce development. An analysis being undertaken by the Centre for Rural and Remote Mental Health of the Senate report on the accessibility and quality of mental health services in rural and remote Australia which will provide insights in how to shape our responses and our future.

For the past two years WNSWPHN has been gathering input about suicide prevention from service providers and community members through the service providers that it funds to undertake suicide prevention work across its region. These include general community and Aboriginal Community Controlled organisations funded as part of the National Suicide Prevention Trial being undertaken in the Local Government areas of: Brewarrina, Bourke, Cobar, Lachlan, Walgett and Weddin. It also includes organisations that WNSWPHN has funded to establish and support groups of people with Lived Experience and Aboriginal Community led Suicide Prevention Networks in towns ranging from Bathurst to Broken Hill, Coonamble, Wilcannia and Dareton. In April 2019, WNSWPHN hosted a Regional Suicide Prevention Forum bringing together service providers and community members which included identification of priorities for the plan. It intends to host another forum in April 2020 to update and refine these priorities.

What have we learnt so far?

We have drawn together the feedback to produce a series of principles and processes that will enable better collaboration and consumer-facing services. These services come under a **stepped care model**, in which people can access appropriate needs-based care.

Principles

The table on the next page outlines the principles as captured from the feedback thus far.

Principles	
Consumer and carer participation	Consumers and carers need a voice to inform how mental health care services are planned, delivered and improved to support recovery and to support the community to be well. Moreover, a wide variety of consumer voices are needed to do this.
Care close to home	Care should be provided as close to home as practicable. This may involve innovations such as telehealth, specialist support of local services, creative solutions to facilitate access (addressing transport and digital barriers).
Positive first contact	Primary health care is often the first level of contact people have with the health system, thus it should be a positive experience that is sensitive and supportive of the individual, coupled with a comprehensive assessment of needs.
Equity – equal but different	Rural and remote residents should get equitable access to services that meet their needs, even if the services look different to how they are delivered in large cities.
Equally well – equity for those with severe and persistent mental illness	Equity in the provision of physical health care for those with severe and persistent mental illness. Moreover, it can also be taken to recognise that for those with chronic health conditions, their mental health needs should be recognised and addressed.
Better services for Aboriginal people that support social and emotional wellbeing	Working with Aboriginal Community Controlled Health Services and communities to provide culturally appropriate care for better health outcomes, including striving to build on existing successful approaches. This also means that standard services should strive for cultural safety and responsiveness. It is important to recognise and acknowledge intergenerational trauma, therefore care provision must be trauma-informed. As relationships, continuity and the building of trust is really important to Aboriginal people, prior poor experiences can undermine trust in services. Striving for stable, culturally safe and responsive services represents the best path for improved access and acceptability of care for Aboriginal people.

Principles	
Appropriate care across the lifespan	Mental healthcare services suitable for children, youth, adults and older people. This includes better links with schools, aged care services etc.
Evidence-based	This includes effective use of data to inform needs assessments, planning and evaluation of service delivery. Moreover it requires that services offer care that evidence-based, and that it builds evidence as it goes, especially for innovative programs, to build an understanding of what is fit-for-purpose in Western NSW.
Recovery focused	Recovery oriented mental health care acknowledges that each person is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them.
Invest in keeping people well	Investing in primary prevention and early intervention is essential to better meeting the mental health needs of the whole population.
Sustainability	Provision of services are constrained by the resources we have and the workforce capacity we have, therefore we need to prioritise what to address first, where to invest for gains now and into the future. When considering how best to support Aboriginal people in primary care, it is key to work with Aboriginal Community Controlled Health Services who already have an enduring, sustainable and trusted place in the care system and a holistic approach to mental health, social and emotional wellbeing.

Processes

Enhanced communication

Service planners, service providers, service users and communities all need effective communication to plan and deliver care that better meets the needs of the consumer. Feedback should be easily facilitated to aid in the improvement activities of services and ultimately in the way services are planned and commissioned, for instance providing new services where gaps exist. Enhanced communication capabilities are also needed across services to better integrate the experience of consumers, their carers and their GPs. Consumer feedback and participation needs to be planned for all levels of service provision, planning and review.

Enhanced referral and service access

Providing community and providers with a clear map of services available, with referral pathways and sufficient information for consumers and clinicians to make an informed choice (eligibility conditions, potential out-of-pocket costs, wait-lists, mode of service provision, clinician gender). This also means that service providers know these and can guide consumers and refer on to appropriate services, such that consumers experience ‘no wrong door’ to entry in to mental health care. This will also require a balanced view on how assessments happen, balancing understanding what care someone needs, without unduly traumatising them, or requiring people to repeat their stories. There needs to be consideration as to how to ensure that referrals are successful and bring continuity between services, ensuring that communication mechanisms and protocols enable sensitive follow-up with people and clinicians.

Promote collaboration, coordination and integration

This means thinking through how to commission services that supports collaboration, thus allowing time to build trust, providing resources, training and KPIs to promote this. In thinking through integration and the experience of care by consumers, there is a need to redefine collaboration and coordination of services that does not require the consumer have a thorough knowledge of the system. A consumer's experience of care should be of a whole system, wherein the behind the scenes fragmentation (jurisdictional, organisational, clinical, financial) does not affect their journey in care, that they experience person-centred care across the span of their care.

Data-informed planning, commissioning and review

Use of multiple data sources to understand the needs of the community (community views, consumer feedback, population health outcome data, demographic and social data, service use data (PHN, LHD, AMS/ACCHS), mental health atlas, etc). Use of innovative tools to support planning for services based on need and available resources, such as the National Mental Health Service Planning Framework[10]. This also means capacity building to effectively gather, analyse and use this data (e.g. the investment in the Health Intelligence Unit). Establishing and/or promoting the protocols for the sharing of information and data. This will also enable accountable reporting, professionalism and transparency in evaluation. As the electronic Medical Health Record matures, this should be taken into greater account to deliver an integrated care experience to consumers.

Over the past year, WNSWPHN has been collaborating with the Sax Institute and University of Western Sydney who have developed a computer-based decision support tool to guide suicide prevention commissioning decisions.[11] The tool utilises all relevant research evidence and other data to make forecasts about what type of interventions are likely to produce the greatest reductions in suicide attempts and deaths. WNSWPHN is exploring the extension of this tool to include mental health interventions. The tool has much potential to be used as a foundation for planning and coordinated action across the region and service sector.

Collective governance

This plan will establish the collective governance framework of mental health, drug and alcohol and suicide prevention in Western NSW, this will be overarching and not override existing clinical and service governance frameworks. This means we will set out the responsibilities, protocols and processes for working together to deliver mental health care in Western NSW. It will establish collective accountabilities for health outcomes.

Feedback – other themes

Our region, like many rural and remote regions in Australia, has high rates of mental health problems and suicide, low numbers of GPs and other health professionals, and low rates of private health insurance cover. ***Access to services*** is poor for several other reasons as well, as we have heard from stakeholders, such as lack of coordination in remote areas and inadequate information available to providers and consumers about what is available. By normal measures, Aboriginal communities are often disadvantaged, but this can be exacerbated when service types and structures are imposed by health authorities without proper consideration of local needs. Nonetheless, there are effective Aboriginal health services who work in well with other providers in

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[10] https://nmhspf.org.au/

[11] Page, A., Atkinson, J., Campos, W., Heffernan, M., Ferdousi, S., Power, A., McDonnell, G., Maranan, N. and Hickie, I. (2018) "A decision support tool to inform local suicide prevention activity in Greater Western Sydney (Australia)." ANZJP

the interests of their communities, but there is a need to invest more in Aboriginal people as mental health workers and to boost training for mainstream workers to understand Aboriginal issues more deeply. For planning, there needs to be better understanding of how Aboriginal communities perceive mental health and suicide to inform the way we can commission more effective services.

We have learnt that there are service models that are working well in some places, and others that are compromised by ***lack of information and coordination*** between service organisations. There are towns, like Dareton, that are not technically remote, but are the most underserviced by health professions. In other towns such as Bourke, there are a lot of services which are disjointed and have a lot of eligibility criteria for inclusion, thus rather than experiencing 'no wrong door' people can experience too many doors, which is exhausting to navigate. In some smaller localities, ***community connectedness and resilience*** provides a real strength on which to develop locally-tailored solutions. There was a strong voice we heard about the need to train key community members and the value of a peer workforce in general, but in particular, in small communities where there are few health professionals. For small communities, there was a strong call for grass-roots movements and community safety strategies, especially for suicide prevention and support. This was voiced in terms of shifting the power to the community and recognising local community members as the experts.

There was common concern that the plan must address the ***needs of younger and older people*** as focussed areas, especially as early intervention and suicide prevention opportunities. Stronger ***links with school and juvenile justice*** systems are required to increase the capacity of these sectors and improve coordination, but this will need to be supported by a focus on sustainable relationships. Indeed the involvement and connection with local councils was also raised.

Coordination - and better ***governance*** more generally - has been a common theme in our discussions, supporting the policy directions that have appeared in national and state plans. In some places, there is an adequate supply of good services, but efficiency is compromised by lack of coordination and sharing of information. In other places where several visiting health professionals are the main providers, lack of coordination can result in duplication and gaps. Holistic care is needed, particularly for people with ***co-occurring chronic conditions and physical illnesses***, alcohol and drug problems, and domestic violence, emphasising another dimension of coordination and integration that is often missing in the mental health system. On several occasions, we heard accounts of ***service users having to repeat their stories*** too many times because of the lack of communication between service providers, and this at a time when the person is at their most vulnerable and easily dissuaded from engaging and continuing with treatment. The Chronic care coordination network was raised as an exemplar of how effective coordination could be achieved. Consideration should be given as to how this could be mandated into commissioned service contracts, with resourcing to support data collection, sharing and consumer care.

The issue of how and where a person can ***enter the care system*** – the so-called gateway - came up frequently. Traditionally, GPs are the gateway in a primary care system, but with the new interventions and service types emerging in mental health, the question was asked: should there be different or multiple gateways? And how is this conceived in ***stepped care systems*** that must reflect local circumstances in small communities. Frequently, we heard the rejection of the notion that one size can fit all circumstances in such a disparate region.

For a region the size of western NSW, responses to individuals in need cannot be coordinated from the main population centres, and ***service design must be informed by local experience***. Governance arrangements for local areas need to be explored, invested in, and authorised. These, however, would need to be linked to regional governance structures that extend across organisational boundaries in a high-functioning system of integration and communication. Skills need to be developed in organisations to support collaboration across boundaries, and thought should be given to ***measuring contract performance on collaboration*** that improves the filling of gaps and eliminating duplication. At the level of commissioning, this might be achieved by binding organisations into ***collective executive responsibilities***. People are keen to understand better how to sustain partnerships in support of a truly comprehensive plan.

The issue of ***short-term funding cycles*** drew much attention in our discussions with stakeholders. Effective collaboration across sectors, organisational boundaries and professional cultures takes time, and workforce strategies cannot be entertained without some degree of stability in staffing. More generally, ***current funding models*** and tender processes drive services into silos, exacerbate competitiveness and duplication, and dissipate funds into small packets.

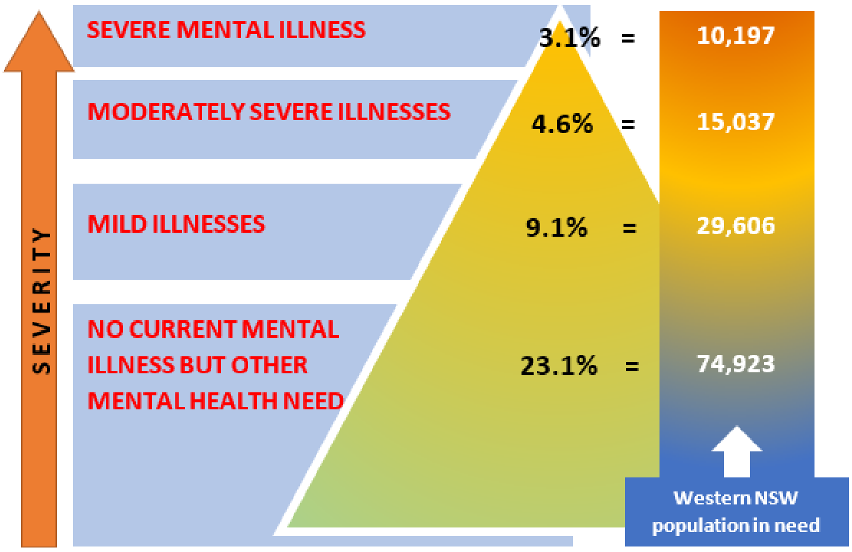
In discussions, some ideas were advanced for local service design opportunities, providing support for the WNSWPHN's intention to ***explore place-based planning models*** for its various communities. In the process of holding workshops, presenting information and listening to feedback, it has become clear that there needs to be ***better engagement with consumers and carers, Aboriginal communities, and GPs*** before we can come close to developing a *comprehensive* plan. The *foundational* plan will give us this opportunity.

This is just a summary of some of the important things we have learnt and heard. A lot more detail underpinning these general statements has been recorded during our information gathering which will prove very valuable in developing our future directions.

What does the current service system look like?

Mental health and suicide prevention services are funded by the Commonwealth and state governments, through Medicare, primary health networks and local health districts. Specialist public mental health services are provided by LHDs serving a small proportion of the overall need - those with acute and complex conditions - through acute in-patient and out-patient services. Governments also fund community-managed organisations to provide community support programs for people with severe and complex problems in collaboration with LHDs.

The more common and less complex mental health conditions are provided for through primary health care - including GPs, private psychology, and other allied health and nursing practices - funded either through Medicare or primary health network programs. The diagram below demonstrates the population prevalence of mental illness by level of severity.



Based on Australian Government Department of Health PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance- Stepped Care p.4 at http://www.health.gov.au/internet/main/publishing.nsf/content/phn-mental_tools

Although it is still being refined for Aboriginal and rural populations, the National Mental Health Services Planning Framework indicates that health services should aim to treat 100% of people with severe illness, 80% of moderate, 50% of mild, and 24% of early intervention and prevention needs. With these estimates, we can begin to understand how and where resources might be placed, bearing in mind that more complex need is more expensive to address. This type of modelling also contributes to the design of stepped care systems that ensure people can identify and gain direct access to care that is matched to their needs, and move smoothly between levels of care if and when they need to.

General practitioners are often first to see people with mental illnesses, accounting for 12.4% of GP encounters. GPs provide 30% of all mental health-specific Medicare-subsidised services, mainly for depression and anxiety[12]. GPs treat many of these people directly and refer others to psychiatrists, psychologists and other health professionals, as well as to state health services. Some general practices in western NSW employ mental health nurses to assist with people with moderate and severe illnesses, while others have shared care arrangements or joint clinics with the LHDs.

New service types are emerging for people with low levels of mental health need and mild illness which have been implemented in places in western NSW, including non-clinical coaching and online information and interventions. These lower intensity services have the potential to address most of the common mental health problems, but increasing the uptake of these has been challenging. These services can be accessed directly by the people needing them; but if they are referred through a GP, this is done without the usual formality of clinical referrals, making them easier to access than many of the more clinical services needed for people moderate and severe illnesses.

For people with common mental illnesses, or even for those with less complex moderate-to-severe illnesses, psychological therapies are available through private allied health professionals, either Medicare-funded for the general population or funded through the WNSWPHN for hard-to-reach groups. Community support services are also funded in the non-government sector and staffed by mental health nurses for people with more severe, but not acute problems.

In the group of people with severe illness, there are some who can be cared for through community-managed organisations, both in residential and community settings. Residential recovery centres are based in Dubbo and Broken Hill, both provided by the non-government sector. Community-based support programs such as *Partners in Recovery* (PIR) and the *Housing and Accommodation Support Initiative* (HASI) are provided from larger towns and several of the smaller towns. A new type of service called *Likemind* has been established in Orange which provides a range of health professional and other support services from many organisations under one roof.

At the apex of the triangle in the diagram above, 1.7% of Australians with severe mental illness receive specialised community mental health care through state and territory government services, and 0.68% received overnight hospital services[13]. Aboriginal people are hospitalised for mental illness at twice the rate of non-Aboriginal people. In urban areas, these types of services are geographically accessible, but in western NSW they are concentrated in larger population centres, with overnight acute and rehabilitation hospital care available in Orange, Dubbo, Bathurst and Broken Hill only. In smaller towns where small community mental health teams are funded, there are often difficulties in recruiting health professionals and positions remain vacant for long periods, reducing accessibility even further than that already imposed by distance. Sub-specialist services are

[12] Australian Institute of Health and Welfare, Mental Health Services in Brief, 2017

[13] Australian Institute of Health and Welfare, Mental Health Services in Brief, 2017

provided for younger people through teams centred in Orange and Broken Hill, and for older people in Orange only.

Telehealth is used for mental health services at both ends of the need spectrum, including for coordinating access to emergency responses across many facilities[14] and for video consultations between practitioners and service users in areas where service limitations demand novel solutions. The use of these approaches has potential to ease some of the access problems in western NSW, but the limits of their potential have not yet been tested.

The National Disability Insurance Scheme (NDIS) has recently entered the mental health service system funding person-centred packages of care, mainly through the non-government and private sectors for people with psycho-social disability.

The WNSWPHN is participating in the National Suicide Prevention Trial in six local government areas. These focus on improving follow-up care, improving the competencies of frontline workers, equipping primary care, using evidence-based treatment, promoting resilience in schools, reducing access to means, and community engagement and training.

How has all this shaped our thinking for the plan so far?

One of the central issues we need to address in the *foundational* plan is putting the consumers at the centre of services, planning and co-design. This will require improvements in how to engage with them and include them in the core processes in developing the *comprehensive* plan. Just as important is the need to improve how we bring Aboriginal communities and GPs into consultations and co-design. These point to the need for the early development of sustainable partnerships and governance approaches at the regional and local levels that will serve us as a collective for the long term.

It might be possible in the short-to-medium term – that is, over 2019 to 2022 – to develop with our partners some joint innovative approaches in a few chosen localities based on the collective impact of our resources. These could set the scene for new ways of doing business in the future across organisational entities, and inform the commissioning of services to engender those collective executive responsibilities we mentioned earlier in the paper.

Special attention needs to be given to better ways of improving mental health and reducing suicide in Aboriginal communities. We will need to work closely with Aboriginal community-controlled organisations and learn from the wisdom in two recent national policy and guidance documents[15] that provide evidence-based principles and strategies for addressing this special area of concern. There are likely to be some early, readily achieved, workforce competency improvement activities that can form a practical part of the overall and longer term strategies for Aboriginal communities.

In the short-to-medium term, we should be able to improve the way that existing services work together to improve access and continuity of care for consumers by modelling stepped care approaches and building clinical pathways more explicitly into commissioning. Linked to this is the need to make some early gains in the distribution and uptake of low intensity interventions. The

[14] The Mental Health Emergency Care Rural Access Program (MHEC-RAP)

[15] https://pmc.gov.au/resource-centre/indigenous-affairs/national-strategic-framework-mental-health-social-emotional-wellbeing-2017-23,

http://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf *foundational* plan could also introduce strategies that develop a better understanding of how to use telehealth in stepped care models for smaller towns and communities.

How will the plan be implemented?

The *foundational* plan being drafted now will have two main avenues of effort. Firstly, changes to service delivery that are required sooner, and can be made readily within current circumstances, will be plotted out over the three years of the plan. There will be a focus on cumulative change within primary mental health care and the improving the links with secondary mental health services provided by LHDs.

Secondly, the activities and arrangements that will be necessary for developing the *comprehensive* plan by 2022 will be scheduled from 2019 to 2022. Particular attention will be paid to on-going governance and the investment needed to sustain collaboration and develop a joint vision for beyond 2022. These will be underpinned by the co-design principles inherent in PHN commissioning approaches and involve further, more detailed, consultation with stakeholders and communities. Shared principles and steps will be identified to take us towards 2022, and any opportunities for local change or progressive implementation of new approaches will be pursued.

It won't be possible to address all identified need in the first instance, so first order priorities will be identified for direct action, and second and third order priorities will be mapped out for when resources become available. It will be important to identify service overlaps and opportunities for redirecting resources to cover gaps where possible. To support the important principle of stepped care, there will need to be an early focus on integration, coordination, and smooth transitions between services and intervention levels.

The Western NSW PHN has engaged the Centre for Rural and Remote Mental Health to facilitate the development of this foundation plan. If you would like to give feedback or request to be updated on progress, please email: CRRMHresearch@newcastle.edu.au

We invite you to share this discussion paper with others and encourage them to respond, especially consumers and carers.