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in partnership with the Western NSW and Far West Local Health Districts

Western NSW Regional Mental Health and Suicide Prevention Plan

A joint Foundational Plan between Western NSW PHN, Western NSW Local Health District, and Far West Local Health District

2019-2022

Acknowledgement of Country
We acknowledge that we work on the traditional lands of many Aboriginal clans and nations. We commit to working in collaboration with our region's Aboriginal communities and peoples to improve their health, emotional and social wellbeing in the spirit of partnership.

Published by the Western NSW PHN
February 2020

Acknowledgements
This Foundational Plan has been a collaborative project, thanks to the following for their insights and consultation in putting this plan together. We would also like to thank and acknowledge the people who shared personal messages about their experiences of the importance of mental health and wellbeing services in their communities.

- Western New South Wales Local Health District (WNSWLHD)
- Far West Local Health District (FWLHD)
- Community and Clinical Councils and Aboriginal Health Council
- Aboriginal Community Controlled Health Organisations (ACCHOs)
- Primary Health Care Providers
- Health Service Providers within the WNSW PHN region
- Education Training and Research Organisations
- Local Government and Non-Government Organisations (NGOs)

Special thank you to the University of Newcastle's Centre for Rural and Remote Mental Health for their guidance and support.

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Chief Executives' Foreword

Western NSW Regional Mental Health and Suicide Prevention Plan

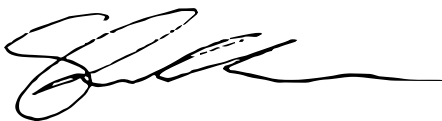
Since the Primary Health Network's (PHN) establishment in July 2015, there has been strong collaboration in Western NSW with the two Local Health Districts (LHD). This was broadened in 2017 to form the Western NSW Health Collaboration, an initiative of the Chief Executive Officers of the Western NSW Local Health District, Far West Local Health District, Western NSW PHN and NSW Rural Doctors Network, to promote collaborative activities, enable cooperative health service and workforce planning that address the challenges in providing effective primary health care.

The Collaboration has specifically targeted the development of integrated primary and acute health care service pathways and sought to enhance access to primary health services. Success has already been created through the Western NSW 2030 Primary Care Workforce Project, Western NSW First 2,000 Days Health Planning Project and Western NSW Digital Health Region Strategy.

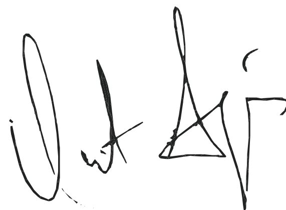
A key collaborative project between the Western NSW LHD, Far West LHD and Western NSW PHN has been the development of Western NSW's first Regional Mental Health and Suicide Prevention Plan. While this is a requirement of the Fifth National Mental Health Plan, it builds on our ongoing commitment to work together to improve mental health services for our communities. This foundational plan proposes action to improve current services and address the importance of future needs of our communities with ongoing collaboration.

We appreciate the involvement of the many people and organisations who have contributed to its preparation particularly people with lived experience. We look forward to our ongoing work with our local communities and partner organisations to put this plan into action.

Yours sincerely,



Scott McLachlan
Chief Executive
Western NSW
Local Health District



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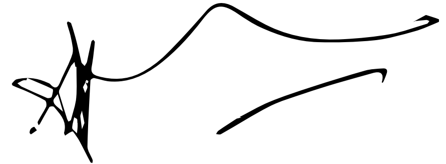
Chief Executive
Far West
Local Health District



Andrew Harvey
Chief Executive Officer
Western NSW
Primary Health Network

in partnership with the Western NSW
and Far West Local Health Districts

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Key Terminology

Term	Definition
Carer	Someone who provides unpaid care and support to family members and friends who have a mental illness.
Chronic disease	Long lasting conditions with persistent effects.
Clinical governance	The term used to describe a systematic approach to maintaining and improving the quality of patient care within a clinical care setting, health program or health system.
Co-design	Co-design brings together various stakeholders as to better inform and support service design by gathering a range of views, ideas and experience. Co-design focuses on gathering input and contributions from those stakeholders who have direct contact with the issue at hand (especially consumers, carers and those with a lived experience), rather than just the views of certain stakeholders (e.g. funders).[1]
Commissioning	A strategic, evidence-based approach to planning and purchasing services.
Consumer	Any person who identifies as having a current or past lived experience of psychological or emotional issues, distress or problems, irrespective of whether they have a diagnosed mental illness and/or have received treatment.
Cultural safety and cultural competence	Cultural safety involves the effective care of a person or family from another culture by a health professional who has undertaken a process of reflection on their own cultural identity and recognises the impact their culture has on their practice. Cultural competence is defined as a set of behaviours, attitudes, and policies that enable health professionals to work effectively in cross-cultural situations.[2] A safe and culturally responsive workplace environment is one that acknowledges, respects and accommodates difference.[3]
Continuity of care	Continuity of care refers to how an individual's health care is connected over time and often between different service providers.
Digital health services	Digital health services involve the application of digital technologies to improve the efficiency of health care delivery. Digital health encompasses eHealth, telehealth and more. Digital health also includes electronically connecting up the points of care so that health information can be shared securely.
Evidence-based	Defines an approach that emphasises the application of findings from the best available current research.
Foundational Plan	A plan which focuses on working together to identify service gaps, shared priorities and make better use available resources to meet regional needs in the short term.
Governance	Refers to the set of relationships and responsibilities established by a health service between its executive, workforce and stakeholders (including consumers).
Hospitalisation	Refers to an admission to hospital for treatment.
Integration	A form of health care reform that seeks to improve how services work together, communicate and provide care to the consumer.
Models of care	Broadly defines methods of health care delivery. A model is supported by concepts, theories, principles and processes to develop, plan, implement and evaluate care delivery.
Mortality	Refers to the death rate or number of deaths for a certain disease or group of people.
Multi-disciplinary team	A group of health care workers who are members of different disciplines and with different skills, knowledge and experience.

1 - https://www1.health.gov.au/internet/main/publishing.nsf/Content/E7C2647FBB966A98CA2582E4007FE11F/$File/Provider%20Info%20Sheet%20-%20Co-design%20v1.1.pdf
2 - https://www.racp.edu.au/docs/default-source/advocacy-library/an-introduction-to-cultural-competency.pdf
3 - National Aboriginal And Torres Strait Islander Health Workers Association – Cultural Safety Framework

National Mental Health Services Planning Framework	A tool for estimating the need and demand for mental health care and the mix of services required for a certain population.
Peer Worker	Someone employed on the basis of their personal lived experience of mental illness and recovery (consumer peer worker), or their experience of supporting family or friends with mental illness (carer peer worker).
Person with lived experience of mental health	A person who has experienced suicidal thoughts/behaviours or a person who has supported someone else with suicidal or thoughts or is bereaved by the loss of a family member or friend to suicide. A person with lived experience may or may not also identify as a 'consumer.'
Primary health care	The first level of contact that individuals have with the health system i.e. typically a general practitioner.
Prevalence	The proportion of a population who have a specific characteristic in a given time period.
Psychosocial	Relates to a combination of psychological and social factors.
Referral pathways	The process by which a consumer or referrer understands their treatment options and provides information on service availability.
Service provider	A health service provider conducts health-related activities such as diagnosing, managing or treating illness.
Social and emotional wellbeing	The term social and emotional wellbeing is used by many Aboriginal and Torres Strait Islander people to describe the social, emotional, spiritual, and cultural wellbeing of a person. The term recognises that connection to land, culture, spirituality, family, and community are important to people and can impact on their wellbeing. It also recognises that a person's social and emotional wellbeing is influenced by policies and past events.[4]
Stepped care	A system of delivering and monitoring treatments, so that the most effective yet least resource intensive, treatment is delivered to patients first; 'stepping up' or 'down' to more/ less acute services as clinically required.
Systems approach to suicide prevention	A multi-component approach to suicide prevention that employs a range of different interventions simultaneously such as education, means restriction, stigma reduction, responsible media reporting and mental health treatment.
Trauma	A psychological or emotional response to an event or an experience that is deeply distressing or disturbing.
Trauma informed care	A framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service need. At the very minimum, trauma-informed services aim to do no further harm through re-traumatising individuals by acknowledging that usual operations may be an inadvertent trigger for exacerbating trauma symptoms.[5]

Acronyms

ACCHO	Aboriginal Community Controlled Health Organisation
GP	General Practitioner
HIU	Health Intelligence Unit
ED	Emergency Department
FWLHD	Far West Local Health District
LEN	Lived Experience Network
LGA	Local Government Area
LHD	Local Health District
MOU	Memorandum of Understanding
NGO	Non-Governmental Organisation
NMHSPF	National Mental Health Services Planning Framework
WNSWLHD	Western New South Wales Local Health District
WNSWPHN	Western New South Wales Primary Health Network

4 - https://healthinfonet.ecu.edu.au/learn/health-topics/social-and-emotional-wellbeing/
5 - https://aifs.gov.au/cfca/publications/trauma-informed-care-child-family-welfare-services/what-trauma-informed-care

Aim

The Western NSW Regional Mental Health and Suicide Prevention Plan is intended to show how the Western New South Wales Primary Health Network (WNSW PHN), Western New South Wales Local Health District (WNSWLHD) and Far West Local Health District (FWLHD) are working together, along with regional stakeholders, to improve outcomes for and with communities in the region. It outlines a set of shared priorities and actions to address regional mental health and suicide prevention needs in the short term.

Its focus is on cumulative changes to service design, commissioning and delivery that can be made over the next two years, to better use existing resources, enhance and develop new ways for the WNSW PHN, WNSWLHD, FWLHD and regional stakeholders to work together to improve outcomes for and with communities in the region.

The Foundational Plan sets a framework for activities to improve integration, inform service and system development in the region. This plan is underpinned by eight priority areas that will be expanded on to complete more comprehensive service development and detailed planning due in mid 2022.

Scope

This plan focuses on two areas of work: mental health and suicide prevention[6]. It is an agreement, about priority areas, how changes will be implemented and who will be responsible. Importantly, it is not about addressing all the issues identified during the consultative process (more of these will be subject to inclusion in the comprehensive plan). This plan focuses on joint priorities and actions that can be achieved in the short term. Importantly, the process of jointly implementing this plan will lay the foundation for co-design of the comprehensive plan by 2022.

> “
> ***People are not books they are stories still being written and by working together and sharing experiences, people will show you what you can’t learn from a book***
>
> \- from a consumer

6 - At the time of preparing this report, there was no funding agreement for Primary Health Networks for alcohol and other drug services beyond June 2020. Hence, alcohol and other drug services and interventions are not included in this report.

Our Principles

A series of principles have been developed from consultations conducted in Western NSW to underpin development of the plan and to shape its implementation.

- **Participation** – Including the voices of consumers, people with lived experience, families and carers in service planning and delivery.
- **Equity** – Ensuring equity of access to health care for rural and remote residents including a commitment to addressing avoidable or remediable differences in health outcomes for Aboriginal and Torres Strait Islander peoples and those with severe and complex mental illness.
- **Respect** – Improving the service user's primary and specialist health care experience through the provision of culturally and clinically appropriate mental health care according to need.
- **Holistic** – Investing in the promotion of social and emotional wellbeing, mental health and recovery, and the prevention and early intervention of mental illness. A holistic approach is integrated, person-centred and takes into consideration mental, physical health and health care across the lifespan.
- **Evidence-based** – Promoting evidence-based planning, delivery and evaluation of services fit-for-purpose in Western NSW.
- **Sustainability** – Developing and implementing financially and clinically sustainable and stable solutions based on available resources and capacity.

Engagement and Consultation

How this plan was developed

This Foundational Plan builds upon previous consultation and was developed by Western New South Wales Primary Health Network (WNSW PHN), Western New South Wales Local Health District (WNSWLHD), and the Far West Local Health District (FWLHD), with the support of the University of Newcastle – Centre for Rural and Remote Mental Health.

We thank and acknowledge the generous contributions throughout the consultation phases and production of this plan:

- Community members, consumers, carers and people with lived experience
- Western NSW PHN: Western and Far West Community and Clinical Councils
- Western NSW PHN: Aboriginal Health Council
- Aboriginal Community Controlled Health Organisations (ACCHOs)
- Primary Health Care Providers, including GPs
- Health Service Providers within the WNSW PHN region
- Education Training and Research Organisations
- Local Government and Non-Government Organisations (NGOs)

The Foundational Plan involved an extensive engagement and consultation process. Phase 1 centred on examining existing information and talking to stakeholders. This generated substantial information about the incidence of mental health concerns and suicide in the region, the varying levels of need and the spread of current services. This was crucial to identifying the gaps and overlaps in services, information that is crucial to decisions about where to allocate money and changes so that better outcomes and cost-effectiveness can be achieved. WNSW PHN has undertaken health needs assessments in the region which has provided valuable insights from a range of community members and many of these insights have identified the needs in mental health, suicide and addiction issues.

Phase 1 led to the production of a discussion paper[7] and a series of principles and processes to enable better collaboration, that would guide future discussion and focus areas for the next stage of collaborative work with both LHDs and other key stakeholders. However, it was evident that further consultation was required, particularly with consumers, carers, people with lived experience and general practitioners. This consultation completed Phase 2 of the consultation and engagement process.

The consultation and engagement process is outlined below:

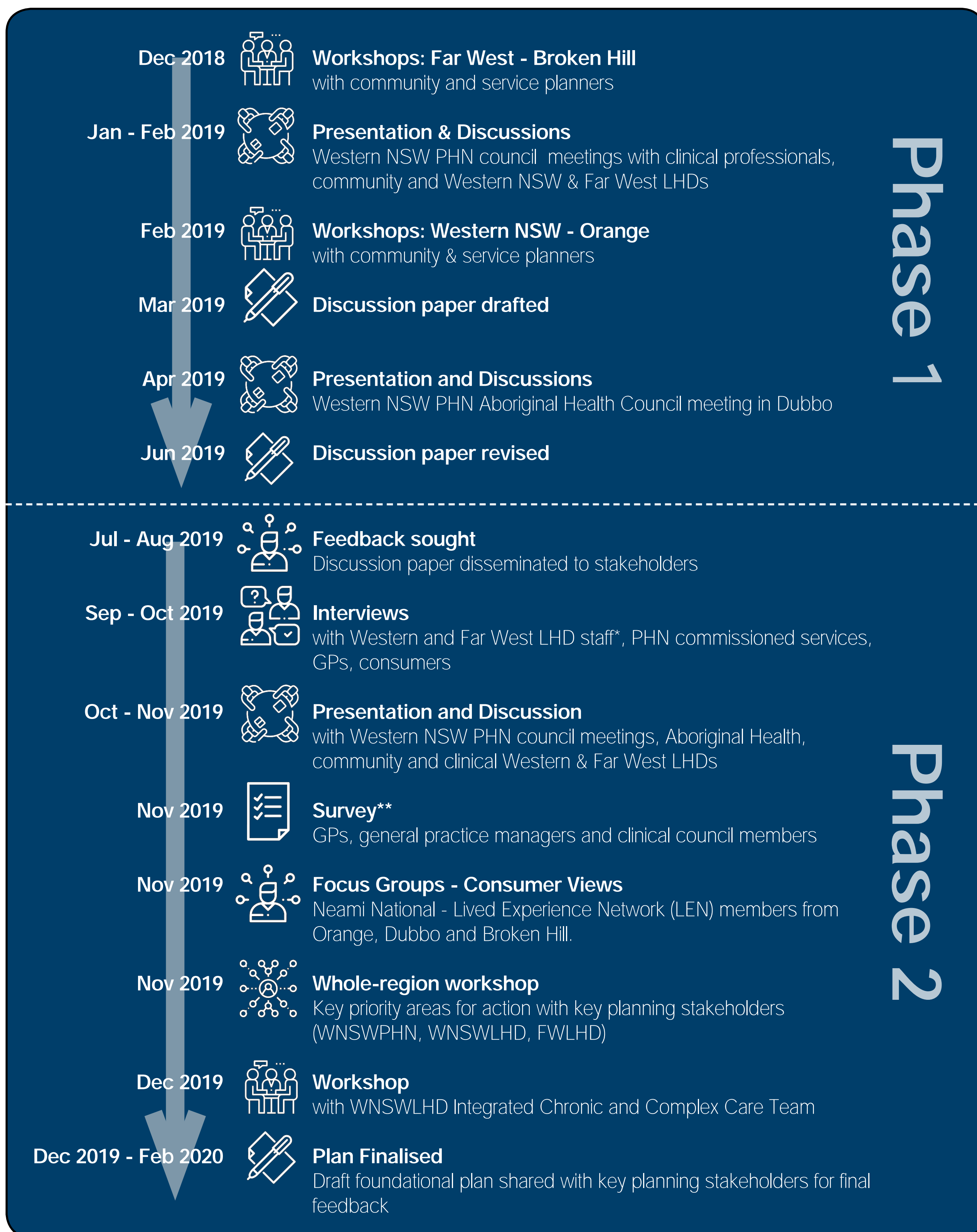


Figure 1: Consultation and Engagement process taken in the WNSWPHN Region to produce this Foundational Plan
* Staff included: Community mental health, peer workforce, child and adolescent mental health, integrated care, drug and alcohol, Rural Adversity Mental Health Program;
** Survey based on a focused summary of the issues identified during Phase 1 and 2 consultations

7 - Dalton H, Leary J, Roberts R and Perkins D (2019) Discussion paper: Towards a Regional Mental Health and Suicide Prevention Plan in Western NSW, July 2019. Centre for Rural and Remote Mental Health, University of Newcastle, Australia.

Stakeholder Engagement
Summary of consultation themes

Results from all of the consultations have been collated under the key priority areas identified in the Fifth National Mental Health and Suicide Prevention Plan and PHN guidance documents.

1. **Integrated regional planning and service delivery** – In several communities, there is an adequate supply of good services, but continuity of care is compromised by a lack of coordination and sharing of information. Place-based planning in small and remote communities was highlighted as a need. Inadequate information available to providers and consumers was considered a barrier to efficiency and to people receiving timely care. Acute teams were stretched triaging non-acute patients referred from primary care. More also needs to be done to recognise and improve current barriers to cooperation between services to acknowledge alternative referral pathways into the mental health system, such as from police, pharmacies, stock and station agents and the disability sector.

2. **Suicide prevention** – There is confusion regarding suicide prevention due to the many organisations and interventions that have received funding, resulting in duplication of effort across areas. An overarching framework and improved planning is needed to ensure a coordinated systems approach to suicide prevention. Stigma still persists in the community and in care settings. There is a need for better care for those in suicidal crisis, both in Emergency Department (ED) settings and in aftercare follow-up.

3. **Coordinating treatment and support for people with severe and complex mental illness** There was an expressed need for after-hours services to reduce emergency department presentations and increase service availability for those experiencing distress. Strategies that build the capacity of general practitioners to support those with drug and alcohol problems as well as severe and complex mental illness such as home detoxification and depot antipsychotic medication are needed.

4. **Improving Aboriginal social and emotional wellbeing and preventing suicide** – Working with ACCHOs and communities to provide culturally appropriate care for better health outcomes, including striving to build on existing successful approaches. Effort is required to ensure that mental health services demonstrate that they are culturally safe and responsive, and have cultural safety strategies to support access and care for Aboriginal and Torres Strait Islander peoples. Holistic prevention and early intervention programs in trauma, grief and loss, perinatal care and culture-based programs need to be built into the stepped care model and staff resourced to implement them, including enabling ACCHOs to deliver services across the stepped care continuum.

5. **Improving physical health and mortality** – Roles and responsibilities need to be clearly outlined in local service agreements to ensure the delivery of physical health care to people with mental illness is prioritised. Enrolment with a primary care provider for those with severe and persistent mental illness should be encouraged as it is likely to improve care coordination and provide physical health treatment. Where this is required, bulk billing agreements with a core set of GPs would ideally be in place to ensure equitable access for all social groups.

6. **Reducing stigma and discrimination** – There should be mandatory training requirements for all primary care and allied health professionals in cultural competence and trauma informed care.

7. **Making safety and quality central to service delivery** – Service access issues including wait times, geographical complexity and lack of GP services and low to moderate intensity psychosocial services need to be addressed. Training of primary care professionals in evidence-based mental health care guidelines should be prioritised.

8. **Enablers of performance and improvement** – It was recognised that opportunities existed to better coordinate enablers to support workforce such as joint service planning, training opportunities, shared data and communication. Informants said that more could be done to strengthen and commission existing local services – especially non-clinical services – rather than commissioning external organisations. Better engagement with consumers, carers and Aboriginal and Torres Strait Islander communities in the co-design of services was acknowledged as a priority.

Service Gaps

Service gaps identified by GPs, LHD staff, PHN Council members and consumers include:

A. Integrated regional planning and service delivery
   i. Improve collaboration between services regarding referral pathways navigation, communication and continuity of care for patients in crisis or recently discharged from in-patients services
   ii. Information to support referrals and clinical decision-making, including more information on what services are available, service eligibility criteria, wait lists and alternative services, if books are closed
   iii. Community directory of mental health services to improve service navigation and referral

B. Addressing gaps in general practice:
   i. GPs are in short supply, particularly in small towns (ongoing and expanding problem)
   ii. Improve the capacity of GPs to manage patients at risk of suicide
   iii. Support multi-disciplinary teams including psychologists, mental health nurses and Aboriginal Health Workers to work in general practice to improve patient access and outcomes
   iv. Building capacity in general practice to manage preventative and maintenance care
   v. Strategies to assist the role of GPs in-home detoxification and prescribing practices to support those with drug and alcohol problems including opiate treatment

C. Addressing gaps and access in mental health services:
   i. low to moderate mental health services (including counselling and coaching);
   ii. aftercare services;
   iii. bereavement services;
   iv. mental health after-hours services;
   v. community clinics for telehealth psychology and psychiatry;
   vi. child adolescent psychiatry services
   vii. programs with a perinatal focus
   viii. drug & alcohol detoxification and rehabilitation services delivered in community for Aboriginal people, particularly those exiting prison

> "
> ***Being able to easily navigate mental health services is crucial for anyone in a caring role. There is often an urgency component to the need for services at a stressful time and service navigation being obtuse is not helpful at all.***
>
> \- from a consumer

D. Collaborative approach to suicide prevention
   i. Ensure clear protocols to support person-centred follow-up care for individuals after a suicide attempt.

E. Improve care coordination across services for people with complex mental illness, including management of their physical health needs

F. Improving Aboriginal social and emotional wellbeing and suicide prevention
   i. Non-clinical prevention and early intervention programs that focus on trauma, family violence, grief and loss
   ii. In recognition of the ongoing impact of colonisation and intergenerational trauma, services need training to be competent to address these added complexities.
   iii. Basic literacy programs and culture-based programs for Aboriginal and Torres Strait Islander people

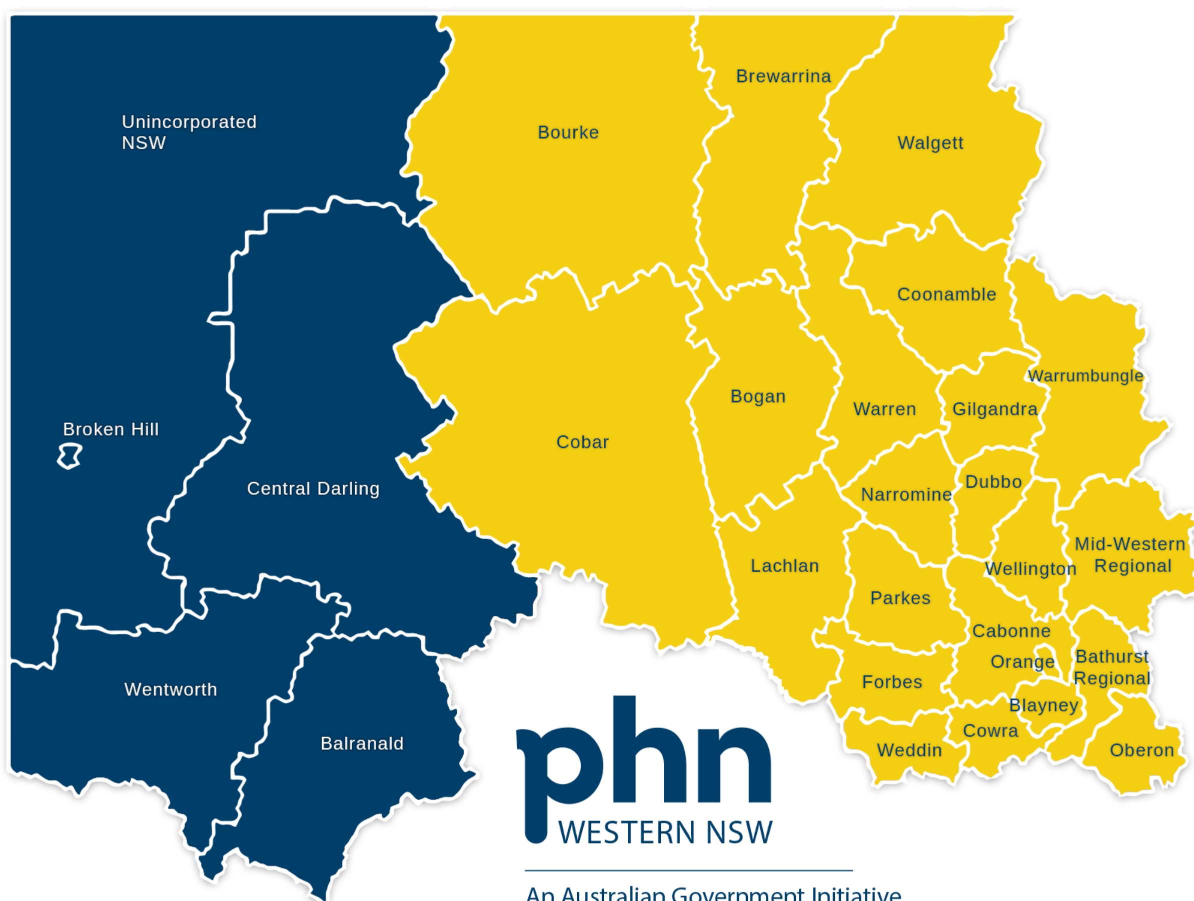
G. Mental health workforce support through system level and collaborative enablers
   i. Improve communication within and between services and the community
   ii. Enable shared care planning through improved data systems and collaborative practice
   iii. Improve coordination of training opportunities between LHDs and PHN
   iv. Services need to work better with other sectors including police, pharmacies, stock and station agents, the disability sector, etc. This is particularly important in remote areas where there are significant workforce shortages.
   v. Strengthen supervision structures through telehealth model

Our Region

WNSW PHN shares boundaries with both the WNSWLHD and FWLHD as well as 27 Local Government Areas (LGAs). The population of the WNSW PHN region is geographically dispersed, living within over 60 towns and communities across more than half of the state's land area.

In 2019, the total population was estimated to be over 313,600 with almost a third (32%) aged younger than 25 years and 19% aged 65 years and older[8]. More than 10% of the population living within the footprint of the WNSW PHN region identified as Aboriginal in the last census; the third-highest proportion of any PHN nationally[9].

The region is characterised by significant disparity. In 2016, of the 27 LGAs, 67% were classified as socially and economically disadvantaged and 39% as remote or very remote. Notably, 50% of the region's population lived within one of four regional LGAs (Bathurst, Broken Hill, Dubbo Regional and Orange).



8 - Based on the Australian Bureau of Statistics estimated resident populations (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. HealthStats NSW. Available at: http://www.healthstats.nsw.gov.au Accessed: 4/12/2019
9 - Source: Population Health Information Development Unit (PHIDU), 2018 'Social Health Atlas of Australia, Data by Primary Health Network' Available at: http://www.phidu.torrens.edu.au/social-health-atlases/data Accessed: 15.10.2018

The Regional Mental Health System

The Need for Mental Health Services in the Region (Key Demographic and Service Data)

Mental health services, including suicide prevention, were identified as the most important need for action in the *WNSW PHN 2019-2022 Health Needs Assessment*[10]. From the *2018 Western NSW Community Health Survey*, mental health was in the top five health priorities, and both mental health and drug and alcohol were perceive to be the top two health concerns facing the community.

The following provides a regional overview of the prevalence and incidence of mental illness and suicide, risk factors, service utilisation and gaps that were used to inform the development of this plan.

Prevalence

The prevalence of the population living with a mental health condition in Western NSW is estimated below, based on the National Mental Health Services Planning Framework[11]. This correlates well with local 2018 Practice Incentive Program (PIP) data from participating general practices across the region where 17% of the active population had been diagnosed with at least one mental health condition. Of those active patients diagnosed with a mental health condition:

- 71% were diagnosed with depression
- 42% were diagnosed with anxiety
- 5% were diagnosed with bipolar disorder
- 4% were diagnosed with schizophrenia

	Early intervention	Mild	Moderate	Severe	
				Episodic	Persistent
Estimated population prevalence (Approx. Western NSW)		17% diagnosed with a mental health condition			
	23.1% (72,442)	9% (28,224)	4.6% (14,426)	2% (6,272)	1.1% (3,449)
Service need	24% need some services	50% need some services	80% need some services	100% need some services	100% need some services
Approx. WNSW PHN Treatment population	**17,385**	**14,112**	**11,540**	**6,272**	**3,449**

Table 1: Estimated service need and provision type for WNSW PHN (based on NMHSPF)

Prevalence of Psychological Distress

In 2017, 15% of WNSW PHN adults surveyed in the *NSW Adult Population Health Survey* reported high or very high psychological distress in the past month, equal to that for NSW (15%), but more than a third higher than for 2013 (11%)[11].

10 - https://www.wnswphn.org.au/about-us/our-region/needs-assessment
11 - National Mental Health Service Planning Framework tool https://nmhspf.org.au/

Emergency Department Presentations

For the three years from July 2015 to June 2018, the most common mental health diagnoses for Emergency Department (ED) presentations in WNSW PHN were:

- Anxiety (17%)
- Mental health problem (unspecified) (14%)
- Suicidal thoughts (9%)
- Depressive disorder (7%)
- Mental disorder (unspecified) (4%)[12].

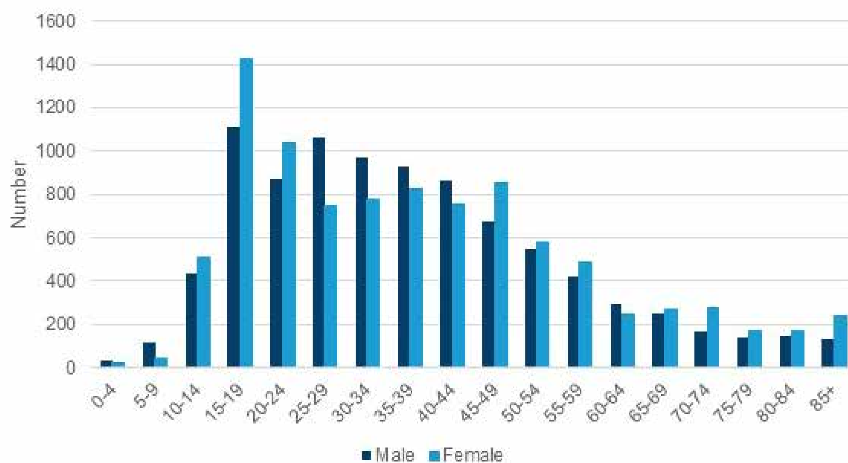


Figure 2: Mental health emergency department presentations by age and sex (2015-16 to 2017-18)
Source: NSW Emergency Department Records for Epidemiology for Western NSW (SAPHaRI 2019). Analysed by the Western NSW Health Intelligence Unit.

Hospitalisations

For the three years from July 2015 to June 2018, there were 13,005 mental health hospitalisations across the region. For the reporting period, the annual average age-standardised rate of mental health hospitalisations was slightly higher in females than for males (1349.6 compared to 1337.5per 100,000). For the reporting period, rates were highest in those aged from 35 to 44 years for both males and females (Figure 2). Of note, is the rate in males aged between 65 to 69 years which is double that for females (2211.2 compared to 1115.3). The most common mental health diagnoses for hospitalisations in WNSW PHN were:

- Mood (affective) disorders (28%)
- Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders (27%)
- Mental and behavioural disorders due to psychoactive substance use (17%)
- Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders (13%)
- Mental disorders due to known physiological conditions (8%)[13].

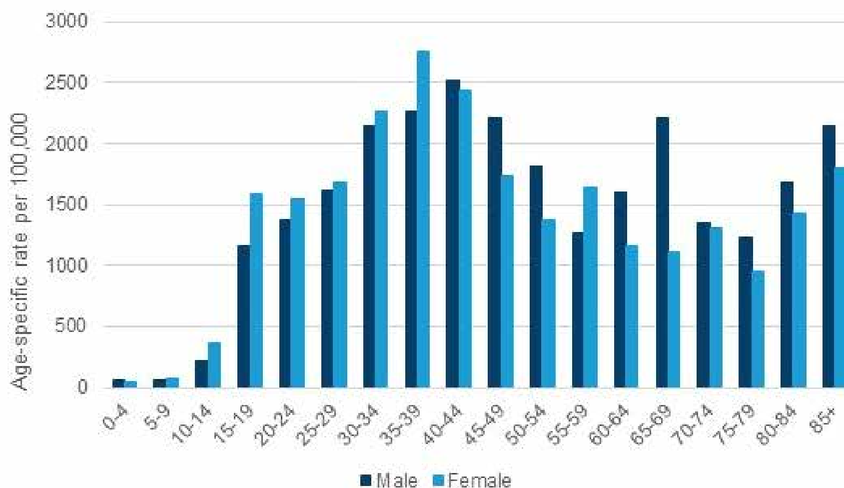


Figure 3: Mental health hospitalisations by age and sex (2015-16 to 2017-18, Western NSW)
Source: NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI 2019). Analysed by the Western NSW Health Intelligence Unit.

12 - NSW Emergency Department Records for Epidemiology (SAPHaRI) 2019. Analysed by the Western NSW Health Intelligence Unit.
13 - NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI) 2019. Analysed by the Western NSW Health Intelligence Unit.

In 2016-17 the rate of mental health hospitalisations for Aboriginal people in WNSW PHN was 87% higher than for non-Aboriginal people, 2333.4 compared to 1247.8 per 100,000, respectively[14]. While the rate of mental health hospitalisations was almost double for Aboriginal people, they make up <12% of the total population for the region.

In 2017-18, the rates of mental health hospitalisations were similar for males and females, 1385.9 compared to 1347.1 per 100,000, respectively.[15]

Intentional Self-Harm Hospitalisations

In 2017-18, the rate of intentional self-harm hospitalisations in WNSW PHN for all ages was 1.3 times higher than that for NSW (126.6 compared to 95.5 per 100,000, respectively) but 1.7 times that for 15-24 year old persons (393.8 compared to 233.5 per 100,000, respectively). In FWLHD, rates for all ages and those aged 15-24 years were double those of the NSW average (Figure 1).

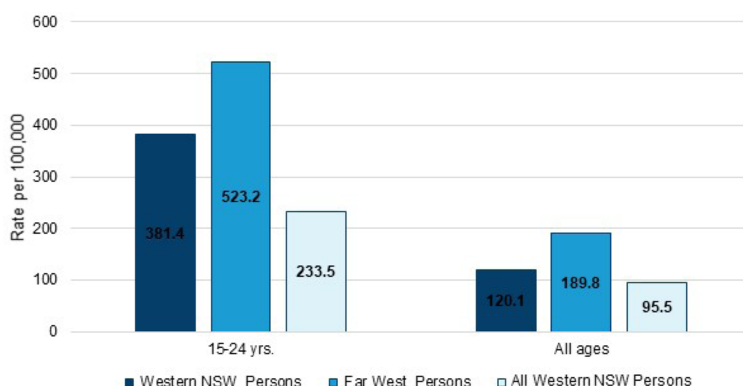


Figure 4: Rates of intentional self-harm hospitalisations by LHD, for persons aged 15-24 years and all ages, NSW 2017-18
Source: Centre for Epidemiology and Evidence, NSW Ministry of Health. Available at: http://www.healthstats.nsw.gov.au Accessed: 4/12/2019

Incidence of Suicide

In 2017, there were 41 suicides in WNSW PHN, representing a suicide rate 24% higher than that in NSW (13.4 compared to 10.8 per 100,000, respectively)[14].

Mental Health Service Provision in Western NSW

The responsibility for funding mental health services in the region is shared between State and Commonwealth government departments. The NSW Government through the WNSWLHD and FWLHD is responsible for specialist public mental health services and acute care to those with severe mental illness and complex needs (a small number of people). The Commonwealth-funded primary care services support the provision of services to the majority of people who experience less complex forms of mental illness in the community, with less intense needs. GPs have a key role in providing care to all people who experience mental illness, regardless of severity. They identify, diagnose and refer people to other care and they look after physical health, which can be particularly affected by those with serious and complex mental illness.

> “
> *when you work collaboratively with other services I find the consumer tends to achieve better results*
>
> \- from a peer worker

14 - Centre for Epidemiology and Evidence, NSW Ministry of Health. Available at: http://www.healthstats.nsw.gov.au Accessed: 4/12/2019
15 - NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI) 2019. Analysed by the Western NSW Health Intelligence Unit.

Services Provided by the WNSWLHD and FWLHD Across the Region Include:

- Emergency and crisis care services (Triage and Emergency Care, including telehealth capacity via the Mental Health Emergency Care (MHEC) – which provides 24/7 telephone support, psychiatric assessment service and provides clinics as needed)
- Specialised mental health, drug and alcohol services, in acute and sub-acute settings.
- Community mental health, drug and alcohol services delivered via a hub-and-spoke model, with hubs (and smaller centres) in Bathurst (Mudgee, Cowra), Orange (Parkes, Forbes, Condoblin), Dubbo (Wellington, Bourke, Lightning Ridge) and Broken Hill (Wilcannia, Menindee) and Dareton provide to Balranald. The RFDS provide drug and alcohol services Tibooburra, White Cliffs, Ivanhoe and Menindee. This include services for adults, older persons, children and adolescents, acute and continuing care, flexible and assertive community treatment, drug and alcohol and crisis/emergency services.
- Residential rehabilitation services
- The Rural Adversity Mental Health Program and drought-support counsellors - supporting the mental health and wellbeing of farmers, their families and drought-affected communities
- Programs to support specialised needs such as perinatal depression, eating disorders, school-based support, specialty drug and alcohol programs
- The LHDs also commission NGOs to provide services to support the accommodation and psychosocial needs of those who live with severe mental illness (e.g. via the Housing and Accommodation Support Initiative (HASI) Program

The WNSW PHN commissions the following services:

- Supporting GPs in mental health care, through specialist psychiatric advice via the GP psychiatry support line
- Psychological goal-focused coaching for people with mild conditions (NewAccess)
- Psychological services for people with mild to moderate mental illness, particularly underserved and hard to reach groups (Strong Minds)
- Mental health nursing services for people with severe or complex mental illness (Mental Health Nurse Incentive Program)
- Youth-focused services for mental health, drug and alcohol, grief and trauma (Headspace, the mobile community outreach program Rural Youth Mental Health Service and Youth Trauma, Loss and Grief Initiative)
- Suicide prevention planning and delivery of local support services, workforce training and community awareness raising

The WNSW PHN and LHDs also provide other services to support the rural workforce and services to deliver evidence-informed health care – this includes communication, education, training and professional development services. Digital services also serve the region and needs of the population but are funded by other sources including the Commonwealth Government.

> ***"it's reassuring to hear about all the things you do and how you work in with other services***
>
> - from a consumer

Population Access Across Stepped Care (Planning Services to Meet the Need)

The National Mental Health Services Planning Framework (NMHSPF) is a tool for identifying the prevalence of problems, severity, the different types of interventions required and workforce implications. The Framework uses mental health epidemiological data to provide a population picture of the number and proportion of people who have mild, moderate and severe problems, the proportions of these, those that are seeking treatment and the type of treatment they are likely to need. We acknowledge that these have yet to be incorporated in the forthcoming NMHSPF adaptations for rural and remote locations, as well as Aboriginal and Torres Strait Islander populations, which should improve its usefulness for planning in the WNSW PHN region. Table 1 indicates the estimated population need for WNSW PHN and corresponding service need, based on the current tool.

These figures are indicators for the WNSW PHN, WNSWLHD and FWLHD, to use in determining an approach to the allocation of resources, meet demand and service type. Where these figures are at a variance with current activity and investment, they can be used to inform future services. To support the identification of priority actions for smaller communities, demographic and existing service information is used to inform decisions.

		Early intervention	Mild	Moderate	Severe	
					Episodic	Persistent
Service need	Estimated population prevalence (Approx. Western NSW)	23.1% (72,442)	9% (28,224)	4.6% (14,426)	2% (6,272)	1.1% (3,449)
	Service need	24% need some services	50% need some services	80% need some services	100% need some services	100% need some services
	Approx. WNSW PHN Treatment population	**17,385**	**14,112**	**11,540**	**6,272**	**3,449**
Service provision	Integrated physical health care		◆	◆	◆	◆
	Specialist Public MHS Community and bed based					◆
	Individual community support and rehabilitation				◆	◆
	Primary care support for severe – e.g. Mental Health Nurses, peer support				◆	
	Specialist Private MH – psychiatrists, private hospitals			◆	◆	
	Primary Mental Health Care – GPs, psychological services	◆	◆	◆	◆	
	Low intensity e.g. digital services	◆	◆	◆		

Table 1: Estimated service need and provision type for WNSW PHN (based on NMHSPF)

Geographic Spread of Mental Health Services

Western NSW occupies half of NSW geographically, as such it presents significant challenges for service delivery. We outline below, a brief summary of the type of services offered in different population centres.

Larger Regional Centres with Urban Areas

- GP services in good supply
- Low intensity psychological and coaching support (e.g. NewAccess)
- Psychological services available through MBS (e.g. Strong Minds with a subsidy via a GP Mental Health Treatment Plan)
- Headspace services available for youth
- Aboriginal Health community controlled health organisation provides low to moderate mental health support social and emotional wellbeing and group programs
- Mental health nurses in general practice (e.g. MHNIP program)
- Community mental health teams, who are available to provide adult, Child and Adolescent Mental Health Services (CAMHS), rehabilitation and older persons services
- Some specialised mental health services available: psychiatry, and clinical psychology
- Acute inpatient and rehabilitation services generally available
- 24/7 Mental Health Emergency Care (MHEC) telehealth psychiatric assessment and support
- Digital and telephone support services available including low-intensity services for children.
- Psychosocial support and community support through NGO services

Smaller rural towns

- GP services are available, but in lower numbers
- Low intensity psychological and coaching support (e.g. NewAccess via phone)
- Services available for youth in Western NSW such as the Rural Youth Mental Health Service (RYMHS)
- Aboriginal Health community controlled health organisation provides low to moderate mental health support social and emotional wellbeing and group programs community mental health teams are available locally or on an outreach basis
- Community mental health teams are available locally or on an outreach basis
- Some limited psychological services available through private MBS and PHN-funded services or via telehealth
- Access to psychiatry or clinical psychology via telehealth, RFDS or travel to a regional centre
- Access specialised acute mental health services via ambulance and Royal Flying Doctors Service (RFDS) (i.e. travel to regional centre)
- Mental health nurse services linked to GP services are provided for people
- 24/7 Mental Health Emergency Care (MHEC) telehealth psychiatric assessment and support
- Digital services available including low-intensity services for children
- Smaller NGOs provide non-clinical community support

More rural and isolated areas of the region

- Local GP services are limited
- Low intensity psychological and coaching support (e.g. NewAccess via phone)
- Psychological therapies, which may also be accessed via telehealth or phone
- Access specialised acute or specialised mental health services (e.g. headspace, psychiatry) via travel to a regional centre, some telehealth available and RFDS outreach support
- 24/7 Mental Health Emergency Care (MHEC) telehealth psychiatric assessment and support
- Digital services available including low-intensity services for children

The Broader Context for Joint Regional Planning

The concept of a regional plan arises from the Fifth National Mental Health and Suicide Prevention Plan agreed by the Council of Australian Government's Health Council in 2017[16]. Importantly, PHNs and LHDs are expected to work together to address eight priorities over five years. PHNs have been given the leadership role initially, with the intention that they will develop a strong co-leadership and governance approach with their LHDs 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 regional planning and service delivery
2. Suicide prevention
3. Coordinating treatment and support for people with severe and complex mental illness
4. Improving Aboriginal mental health and suicide prevention
5. Improving physical health and mortality of people living with a mental illness
6. Reducing stigma and discrimination
7. Making safety and quality central to service delivery
8. Enablers of performance and improvement

Source: PHN guidance documents published by the Commonwealth Government Department of Health outline additional requirements for the joint regional plan.[16]

Stepped Care

Stepped care is central to the Australian Government's mental health reform agenda, and there is an expectation that PHN regional mental health planning and commissioning of services will be founded upon a stepped care approach. Stepped care is a staged system for the delivery of adaptive treatment in which treatment options are organised in a hierarchy of intensity that correlates with the acuity and complexity of conditions[17]. 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 gains 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.

PHNs are be expected to ensure primary mental health service options are available within a stepped care approach to include low-intensity mental health service options for people with or at risk of mild mental illness. PHNs also have a role in actively promoting the availability of mental health services that are low or no cost to consumers, including the digital mental health services that the digital mental health gateway will refer users to.

In developing the stepped care framework, emphasis will be given to the usefulness of the framework to achieve commissioning decisions in the six priority funding areas identified by the Commonwealth:

- Improve targeting of low intensity psychological services
- Cross sectoral early intervention for children and young people
- Address service gaps in provision of psychological services to rural, remote and hard to reach populations
- Management of severe and complex needs in a primary care setting through coordinated mental health packages and mental health nurses
- Suicide prevention
- Aboriginal and Torres Strait Islander service integration

16 - http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf
17 - O'Donohue, W.T. and C. Draper, The case for evidence-based stepped care as part of a reformed delivery system. In Stepped care and e-health: Practical applications to behavioural disorders, eds. W.T. O'Donohue and C. Draper. Springer: New York, 2011; p. 1-16; 2011.

Primary Health Care

Primary health care is the entry level to the health system and as such, is usually a person's first encounter with the health system. It includes a broad range of activities and services, from health promotion and prevention, to treatment and management of acute and chronic conditions[18]. It encompasses a large range of providers and services across the public, private and non-government sectors. While most Australians will receive primary health care through their GPs, providers also include nurses (including general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, Aboriginal health workers and peer support workers. A strong, accessible primary health care system reduces pressure on hospitals by supporting people to manage their health issues in the community.

PHNs commissioned services support primary care in Australia, whilst Local Health Districts/Networks provide secondary and tertiary care services. With this distinction, in responsibility of service provision, it is essential to work and plan together to better integrate services, avoid service gaps and limit duplication.

Consumer Participation and Centeredness

Consumers, their families and carers should be at the centre of, and take an active role in shaping, the way in which services are planned, delivered and evaluated. Organisational cultures, resources, employment opportunities and governance arrangements should reflect this intent.

> ***"Mental health services that do not consult carers and consumers with regard to the planning of service delivery and miss a unique opportunity to be more effective in making a huge difference to the lives of carers and consumers***
>
> \- from a carer

Policy Context

In addition to the Fifth National Mental Health and Suicide Prevention Plan, there are numerous policies which support and underpin the development of a regional stepped care model of mental health care provision. They include guidance for planning, mental health, and considerations for Aboriginal social and emotional wellbeing and suicide prevention.

Living Well: A Strategic Plan for Mental Health in NSW 2014–2024[19] places community and innovative and inclusive co-design approaches at the centre of reform. The Lived Experience Framework for NSW provides a guide for embedding lived experience in mental health and social service system processes. The National Mental Health Commission's consensus statement *Equally Well*[20] provides a vision for improving the quality of life of people living with a mental illness.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*[21] complements the Fifth National Mental Health and Suicide Prevention Plan to support the work of PHNs in partnership with Aboriginal communities and Aboriginal Community Controlled Health Organisations (ACCHOs). Its five action areas are intended to reflect the stepped care model of primary mental health care service delivery.

Guiding principles for providing social and emotional wellbeing support for Aboriginal and Torres Strait Islander people are clearly summarised in the *Gayaa Dhuwi (Proud Spirit) Declaration*[22]*.* The *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project*[23] report has valuable guidance, as have two guides specifically developed for PHNs by the Black Dog Institute and the Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention.

The *Strategic Framework for Suicide Prevention in NSW 2018-2023*[24], together with the Commonwealth's Towards Zero Suicide initiatives and the NSW Government's Premier's Priorities provide key directives for suicide prevention[25].

18 - https://www.aihw.gov.au/reports-data/health-welfare-services/primary-health-care/overview
19 - https://nswmentalhealthcommission.com.au/sites/default/files/141002%20Living%20Well%20-%20A%20Strategic%20Plan%20(1).pdf
20 - https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf
21 - https://healthinfonet.ecu.edu.au/healthinfonet/getContent.
22 - https://natsilmh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf
23 - https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf
24 - https://nswmentalhealthcommission.com.au/resources/strategic-framework-for-suicide-prevention-in-nsw-2018-2023
25 - We acknowledge the statements in the Strategic Framework for Suicide Prevention in NSW (2018-20123) that there are many factors that influence suicidal thoughts and attempts. Mental illness is not always a factor. There are a range of factors including individual, situational, and social/cultural factors that can contribute to suicidal thoughts and attempts. Factors including trauma, substance use, job loss and relationship breakdowns are just some examples.

Priority Areas for Collaborative Action

1. **Integrated Regional Planning and Service Delivery**
   - 1.1. Governance through formalising collaborative planning, implementation and review processes
   - 1.2. Building transparent pathways to care

2. **A Collaborative Approach to Suicide Prevention**
   - 2.1. Collectively develop a Regional Suicide Prevention Framework in line with research evidence, modelling tools/projections, evaluation results from the National Suicide Prevention Trial
   - 2.2. Improve knowledge and attitudes of community and care professionals to support suicide prevention

3. **Better Coordinated Care for People with Complex and Severe Mental Illness**
   - 3.1. Establish a Chronic and Complex Mental Illness (CCMI) working group

4. **Improving Aboriginal Social & Emotional Wellbeing and Suicide Prevention**
   - 4.1. Improve organisational and clinical capacity to deliver trauma-informed care
   - 4.2. Improve access to holistic, culturally safe and responsive services for Aboriginal people that provide continuity of care across the continuum of need

5. **Improving the Physical Health of People with a Mental Illness**
   - 5.1. Improve physical health support for people living with a mental illness

6. **Reducing Stigma and Discrimination**
   - 6.1. Reduce stigma and discrimination through inclusive processes and training

7. **Making Safety and Quality Central to Service Delivery**
   - 7.1. Improve quality and safety frameworks to better support the delivery of high quality and safe care
   - 7.2. Improve capacity for data collection, monitoring and analysis across the services

8. **Build the Capacity of the Mental Health Workforce to Deliver High Quality Mental Health Care Through Integration, Collaboration and Other System Level Enablers Highlighted in This Plan**
   - 8.1. Leverage our joint strengths to better support and develop the mental health workforce
   - 8.2. Coordinate training efforts to reduce duplication and add value to the training delivered
   - 8.3. Build on data and information-sharing capability to support planning, service delivery and monitoring
   - 8.4. Maximise use of existing services, leverage off digital options and promote effective service choice through a communications strategy

> *“If you’re an almond tree, it would really make things blossom. It would. By having those two organisations together, it is going to blossom and produce fruit*
>
> - from a connection’s program participant

Priority Area One
Integrated Regional Planning and Service Delivery

1

1.1 Governance through formalising collaborative planning, implementation and review processes

Objective: Support integrated planning and service delivery at the regional level, including oversight of development, implementation, monitoring, evaluation and reporting activities pertaining to the Foundational Plan.

1.1 A Formalise the Western NSW Regional Plan Steering Committee to drive regional planning, including roles and responsibilities, agreements as needed.

1.1 B Establish a forum for regular collaboration to discuss joint planning, commissioning of services, service delivery issues and responsibilities at the regional level

1.1 C Establish or leverage off existing working groups to put the Foundational Plan into action, these shall cover across the priority areas. They will include representation from key organisations, communities and consumers, their families and carers to assist with the implementation of the plan, including planning, delivery and review of services; providing ongoing guidance as required.

1.1 D Ensure that consumer and community representation is incorporated across the implementation of this plan, inline with the PHN Consumer and Community Engagement Framework.

1.1 E Map our existing KPIs against these priority action areas, record and report these. Develop new KPIs where key gaps exist.

1.1 F Where gaps exist and opportunities arise, we will lobby, advocate and apply for funding or resources to support the implementation of plan activities.

1.1 G Communications plan for reporting progress on this plan to government, the community and other stakeholders.

1.2 Building transparent pathways to care

Objective: People in Western NSW receive timely assessment, referral guidance and pathways to access the information and services they need, when they need them. This priority area reinforces a commitment to the provision of PHN commissioned and LHD clinical and psychosocial services across the stepped care continuum and reinforces a system of a no-wrong-door approach.

1.2 A Map existing mental health, drug, alcohol and suicide prevention resources across the region and explore options for a service directory. This includes reviewing existing directory options and considering the needs of service providers, GPs and the community.

Promote the availability of digital self-help and clinician supported services to communities and to the GPs who provide services to them, including the Head to Health digital gateway .

Provide clear information about services available for people across the stepped care spectrum including information on service referral, service eligibility and service status, to ensure that GPs and other stakeholders have information about services available throughout the region.

1.2 B Build and gain collective agreement around referral pathways and protocols for primary mental health care. Promote these healthcare pathways to provide clarity around service description and availability for those referring to services and for those accessing services.

1.2 C Explore opportunities for collaboration between headspace and Child and Adolescent Mental Health Services (CAMHS) to improve shared care and referral pathways for young people.

1.2 D Building upon the existing success and use of the Mental Health Emergency Care (MHEC) helpline and information service, a project to explore its use as a central point of intake for assessment and referral for non-acute services will be undertaken.

Priority Area Two

Suicide Prevention

2

2.1 Collectively develop a regional suicide prevention framework in line with research evidence, modelling tools/projections, evaluation results from the National Suicide Prevention Trial

Objective: Planning and implementation of an integrated and coordinated suicide prevention plan to prevent suicide and to support person-centred follow-up care after a suicide attempt.

2.1 A Explore opportunities for joint working to implement a systems approach to suicide in line with the Towards Zero Suicide initiatives and the NSW Government's Premier's Priorities.

2.1 B Develop and trial new models of crisis services that provide an alternative to emergency departments for people at immediate risk of suicide.

2.1 C Prioritise an after-hours service model that utilises telehealth to improve the quality of care to those in crisis. The Mental Health Emergency Care (MHEC) helpline and information service is an existing 24/7 platform that could be supported to provide this service.

2.2 Improve knowledge and attitudes of community and care professionals to support suicide prevention

Objective: Coordinate training activities that promote help-seeking and reduce stigma in both health care settings and in the community, to reduce duplication of effort and enhance the collective capacity to reach across the region.

2.2 A Provide training opportunities for GPs in managing suicide risk.

2.2 B Review, collectively plan and coordinate training activities in all health care settings and in the community. This will bring together the training capability of the PHN with clinical and community training of the LHDs and other key providers.

Priority Area Three

Coordinating Treatment and Support for People with Severe and Complex Mental Illness

3

Objective: Leverage off existing chronic and complex care pathway to better serve those with severe and complex mental illness

3.1 A Establish a Chronic and Complex Mental Illness (CCMI) working group

3.1 B Explore how to apply lessons learned from the successful Integrated Chronic and Complex Care (ICCC) program which supports other chronic conditions in primary care to support those with severe and complex mental illness. This includes consideration of the potential role for mental health nurses in primary care could play such as those funded by WNSW PHN through Mental Health Nursing Incentive Program (MHNIP).

Priority Area Four

Improving Aboriginal Social and Emotional Wellbeing and Preventing Suicide

4

4.1 Improve organisational and clinical capacity to deliver trauma-informed care

Objective: Improved knowledge and capacity to deliver trauma-informed care in Western NSW

4.1 A Develop core components of a targeted training program (train-the-trainer) for the primary health and specialist workforce utilising the following: trauma-informed care, social and emotional wellbeing and de-escalation techniques.

4.1 B Review resources and seek funding opportunities to purchase external trauma-informed care training for key staff, whilst local training program is in development.

4.2 Improve access to holistic, culturally safe and responsive services for Aboriginal people that provide continuity of care including care intergration across the continuum of need.

Objective: Aboriginal and Torres Strait Islander Peoples experience improved social and emotional well-being and have improved access to culturally-safe and responsive services

4.2 A Ensure services offer a measurable approach to improve access to culturally-safe and responsive services for Aboriginal and Torres Strait Islander peoples).

4.2 B Review commissioning options to financially support clinical placements with Aboriginal Community Controlled Health Organisations (ACCHOs). This can build on existing arrangements brokered by the LHDs in this region.

4.2 C Partner and maintain investment with Aboriginal Community Controlled Health Services to build their capacity to provide mental health and social and emotional wellbeing services. Seek opportunities to develop alternative culturally appropriate models of care across the stepped care continuum.

4.2 D Explore small towns with high Aboriginal populations to trial place-based approaches based on agreed local priorities within a framework of shared responsibility, decision making and accountability.

4.2 E Ensure services demonstrate the provision of annual cultural competency training for staff, and implement cultural safety strategies to support access and care for Aboriginal and Torres Strait Islander peoples. This could be supported using the WNSW PHN Cultural Safety Framework[26].

26 - https://www.wnswphn.org.au/about-us/cultural-safety-framework

Priority Area Five

Improving Physical Health of people living with a mental illness and reducing early mortality

5

5.1 Improve physical health support for people living with a mental illness

Objective: More effective care for physical health problems in people reporting long-term mental health conditions.

5.1 A Identify and introduce strategies that encourage local services to expand their service models to focus on social interaction and physical activity.

5.1 B Review the Integrated Chronic and Complex Care program (ICCC) to better support those with mental health problems within care settings and upon discharge into the community.

5.1 C Seek opportunities to grow the number of mental health nurses working in general practice through the Mental Health Nursing Incentive Program (MHNIP), including potential connectivity with the ICCC.

5.1 D Promote and expand the metabolic monitoring clinic in pharmacies to other regional centres across Western NSW.

5.1 E Explore the joint commissioning of an exercise physiologist to be deployed in a range of health settings.

Priority Area Six

Reducing Stigma and Discrimination

6

6.1 Reduce stigma and discrimination through inclusive processes and training.

Objective: Take action to reduce the stigma and discrimination experienced by people with mental illness. This action will be achieved while working across other priority areas:

6.1 A Inclusive processes for consumers and community members in the implementation of the plan (aligns with 1.1 D).

6.1 B Joint planning coordination and delivery of a range of training programs. Seeking opportunities to encourage cross-sectoral awareness and collaboration.

6.1 C Training in cultural safety and responsiveness and trauma-informed care (4.1, 4.2).

6.1 D Training in mental health literacy and suicide prevention to reduce stigma both in health care and community settings (8.1).

Priority Area Seven
Making Safety and Quality Central to Service Delivery

7

7.1 Improve quality and safety frameworks to better support the delivery of high quality and safe care

Objective: Develop safety and quality frameworks to guide the delivery of health and support services ensuring evidence-based design and delivery of services; ongoing systems for monitoring, evaluation and performance review at local and regional levels.

7.1 A Review and revise the *WNSW PHN Clinical Governance Framework*, giving consideration to the interface with LHDs and other providers, and to the mechanisms for supporting access and stepped care. This will include the development of mechanisms that allow for shared care planning, movement between primary care and LHD services, and clear crisis escalation pathways and protocols.

7.1 B Review and implement where necessary new and emerging national safety and quality priorities inline with national priorities and standards.

7.2 Improve capacity for data collection, monitoring and analysis across the services

7.2 A Ensure the voice of consumers, carers and community are heard via systematic data collection approaches. This means including consumer experience and feedback into the assessment of quality and safety (e.g. the Yes! Survey can be used across services and feedback can be mandated as part of the reporting process).

7.2 B Improve data and reporting to monitor quality and performance and make this information publicly available, where data governance and privacy permits. This may include supporting services to increase capacity to comply with data reporting requirements.

Priority 8

Build the Capacity of the Workforce to Deliver High Quality Mental Health Care Through Integration, Collaboration and System Enablers to Achieve the Priorities

8

8.1 Leverage our joint strengths to better support and develop the mental health workforce

Objective: Growth and development of the mental health workforce in building sustainable and effective care across the region.

8.1 A Develop a joint strategy to better support and connect peer workers across the region and facilitate access to training, supervision, mentoring and support.

8.1 B Support, resource and utilise the peer workforce to build recovery-oriented approaches to care. This will enable the workforce to mature and have a bigger impact on outcomes.

8.1 C Explore alternatives to primary care service model planning and delivery in areas where there are identified issues with the GP workforce such as nurse-led clinics with mental health expert support via telehealth and digital means.

8.1 D Explore options to develop a shared supervision framework particularly in instances of workforce shortages.

8.2 Coordinate training efforts to reduce duplication and add value to the training delivered

Objective: To maximise the impact of training through coordinated planning, thereby reaching more health professionals and community members in formats that reinforce collective goals. This will minimise any duplication of training and maximise resources.

8.2 A Coordinate joint training forums between the PHN and LHDs based on specific training needs identified across the region. There are established education coordinators in the PHN and the LHD who are best placed to identify training needs and opportunities and bring together key stakeholders to upskill, collaborate and network. Training actions are also articulated in other priority areas (2.2, 4.1, 4.2, 6.1 and 8.1).

8.3 Build on data and information-sharing capability to support planning, service delivery and monitoring

Objective: Data and information inform joint planning, service delivery and monitoring.

8.3 A Identify and improve information and data-sharing agreements and systems needed to support integrated coordinated care between primary care and LHD services, as well as between primary care, LHD services, and other services such as ACCHOs, headspace and other NGOs.

8.3 B Support and utilise the resources of the Western NSW Health Intelligence Unit to monitor and improve service performance and quality.

8.3 C Undertake shared needs assessments to support planning.

8.4 Maximise use of existing services, leverage off digital options and promote effective service choice through a communications strategy

Objective: People are well informed of treatment options and GPs and other providers can refer effectively to appropriate treatment options

8.4 A Promote within the region the availability of online, phone and digital self-help, peer support and clinician directed mental health services for people with mild to moderate mental health conditions.

8.4 B Promote the use of virtual clinics to provide coordinated, locally available, 24-hour specialist support in collaboration with the rural workforce.

8.4 C Promote website and on-line service directories, including referral pathways as they mature, with targeted campaigns for general practitioners, other service providers and the community.

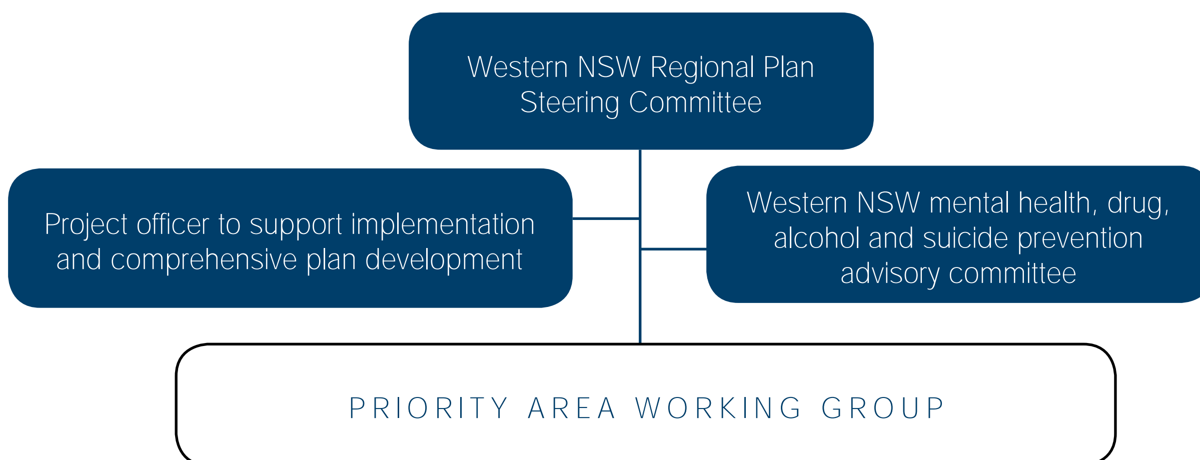
Implementing Change

The actions outlined in the previous section will take time to implement. The Foundational Plan acknowledges this, and that considerable groundwork is needed to establish and support joint working at a regional and local level. Some of this work has already begun through the formation of the Western NSW Health Collaboration, and through the building of strategic partnerships during consultation and development of the plan.

Effective governance will be vital. This will need to include the right level of representation from WNSW PHN, WNSWLHD and FWLHD to commence the plan's activities, and to consider the logistics, resources, and timeframe for completion. It will also require representation from both Aboriginal and non-Aboriginal consumers, their families, carers and other service providers (including Aboriginal health service providers).

As outlined in the model below, the steering group will be formalised first, with a terms-of-reference based on this plan. An advisory committee of stakeholders for mental health and suicide prevention in the region will be constituted, again with its own terms of reference.

For the priority area working groups, some of these exist already, some need enhancement to better suit the needs of the objectives and others will be constituted from scratch. Some actions can begin prior to the formalising of these working groups but will sit under them once constituted. Actions pertaining to communications, data and information systems represent enablers across the system and won't sit in any one working group, but will serve all. Whilst training is also an enabler, there are clear training teams in the PHN and LHDs that can collectively come together to support multiple priority area goals and thus will form a working group very quickly.



The first year of the plan – formalising the steering committee is a priority and key governance arrangements, including the clinical governance, will be determined by this group. Terms of reference for the advisory committee will be devised and expressions of interest set out by mid-year will meet prior to the end of the year.

The priority area working groups are intended to operationalise the plan, and thus their structure and constitution may be flexible – for example, the workforce group may be better served in two parts, one addressing the support of the peer workforce and a separate group constituted later to address chronic GP shortages in some areas. They should always be inclusive of PHN, LHD, expert and consumer representation.

As the steering group, advisory committee and working groups are not yet constituted, the primary actions of this plan are to establish these. The steering group will be responsible for moving this work forward and developing the comprehensive plan, thus future actions are only briefly signalled. This group will be responsible for nurturing the collaborative relationships and bringing this plan to life.

The governance arrangements will need to be finalised and fully agreed to by mid-year 1 (June 2020), to build the authorising environment and resource support to enact the plan.

There will be a review of progress every six months.

Comprehensive planning will begin by mid-year two (June 2021) and be finalised by mid-year 3 (June 2022). As part of comprehensive planning, the incorporation of drug and alcohol must also begin by mid-year two (June 2021), if not sooner.

- Those working outside the mental health sector are not **familiar with eligibility criteria for different services**.

- Multi-purpose mental health models must be **inclusive of drug and alcohol**.

- There is a need for the **integration of psychosocial programs/services into stepped care model** (for example, perinatal; justice; family violence; employment).

- Improved access to **telehealth specialist services** to communities is required.

- Place-based planning and **alternatives to stepped care models** should be considered for **small and remote communities** where there are no existing GP services to support people through this model.

- **Clarity is needed around referral pathway navigation, communication and continuity of care** for patients, particularly for specialist, aged care and mental health services.

- Collaboration between PHN commissioned and LHD services and GPs/ACCHOS is needed to improve continuity of care for patients across settings – including **postvention and relapse prevention upon discharge**.

- **GPs** should be incentivised to become involved **in case-conferencing**.

- Support **multi-disciplinary teams** including psychologists and mental health nurses to work in general practice improve patient access and outcomes.

- Build **integration and partnerships into tendering** (e.g. organisations must show how they are working with others. For example, no tender to organisations without evidence of joint working or peer support component.

- Suicide prevention funding is complicated and there are many organisations including the PHN that have funding to provide services/education/promotion. There should be a limited number of **providers that work together to endorse a suicide prevention plan** (including actions) together. Currently, the community are confused regarding suicide prevention as there are many professionals and services.

- Ensure that clear **protocols exist to support person-centred follow-up care** to individuals after a suicide attempt and that there is no ambiguity in the responsibility for provision of this care.

- There is considerable need for **after-hours access** to a combined peer-led and clinical lead space in the community to reduce ED presentations and increase service availability and supports for people who are experiencing distress.

- More services should be taken **out of clinical environment and into the community**.

- Strategies need to be implemented to **support the role of general practitioners in:**
  i. home detoxification; and
  ii. prescribing practices to support those with drug and alcohol problems including opiate treatment; and
  iii. depot antipsychotic medications.

- The PHN could do more in the **commissioning drug and alcohol services**.

- Access for GPs to **specialist mental health clinical advice** should be prioritised.

- Programs for Aboriginal and Torres Strait Islander peoples need to be integrated into the stepped care model including **holistic prevention and early intervention programs**; trauma; grief and loss; basic literacy programs; and culture-based programs.

- All mental health services commissioned by WNSW PHN should demonstrate that they are **culturally safe and have cultural safety strategies** to support access and care for Aboriginal and Torres Strait Islander peoples.

- There is a need for **localised drug and alcohol detox and rehabilitation** services delivered in-community for Aboriginal people, particularly those exiting prison.

- An **after-hours Aboriginal Health Worker** to assist community mental health team with acute patients would help mitigate current concerns over the cultural safety of services.
- There needs to be **clear roles and responsibilities for the delivery of physical health services to people with mental illness** as part of local service agreements.
- **Enrolment of clients with GPs** should be encouraged for those with complex physical health and mental health needs.
- Mandatory **cultural competency and trauma-informed care training** of GPs and allied mental health service staff is required.
- There is greater scope for **supporting carers and family members.** The client/family should be involved in the transfer of care meeting.
- Attention should be paid to service access issues including long waiting times and **increasing the supply of low to moderate intensity services, programs with a perinatal focus and child adolescent psychiatry services**.
- Resources for the **training of GPs in evidence-based mental health** care guidelines (including mental health treatment plans) should be available.
- Services must demonstrate the availability of **professional development and supervision for staff**, especially for psychologists, Aboriginal social and emotional wellbeing workers, and peer support workers.
- There is a need for greater LHD staff **training in mental health, drug and alcohol and suicide prevention.**
- Governance needs to **include peer workers and consumers and carers** (as separate groups).
- There are multiple **telehealth and web-based services** available, but no-one to **streamline these services and assist consumer access** and navigation.
- **Identify and work with existing local trainers,** upskill as necessary, and utilise (e.g. Aboriginal Mental Health First Aid).
- Consumers and GPs need **education about the stepped care model**; what services provide and who they are for.
- **Recruitment and retention** strategies for allied health staff in services should be implemented in line with a hub and spoke model.
- **Local workforce training and career pathways** should be made available.
- **Shared outcomes need to be developed** for measuring accountability, partnership, and co-production.
- The PHN should **review tendering processes** to ensure they are simple and transparent.
- The PHN should **utilise available resources.** Consultative place-based and problem-based tendering rather than funding external agencies.
- Better consultative process and processes of representation are needed to **engage with consumers, carers, and Aboriginal and Torres Strait Islander communities** in the commissioning and co-design of services.
- A systematic **regional approach to mental health promotion and mental health literacy** for vulnerable groups is required.

Consumers' Views
Appendix B

The views of consumers and people with lived experience of suicide were gathered through focus groups with the Lived Experience Networks (LEN) and other consumers supported by NEAMI National in Orange, Dubbo and Broken Hill. Feedback centred on a number of key issues, and we wish to highlight them specifically.

- **A need for high quality crisis services.** The current mental health system does not respond well to individuals in suicidal crisis. There are often extended waiting times in Emergency Departments for admission and sometimes admission is denied for various reasons. Consumers with certain psychiatric diagnoses are stigmatised and their suicidal crisis is labelled "attention seeking" and so appropriate help is not provided. Consumers have also spoken about the stigma of mental illness and how that can affect help seeking from a mental health service for suicidality, especially in people with no psychiatric illness. Alternatives to hospital admission and traditional mental health services need to be researched and established. Of particular interest are services led by individuals with lived experience. For individuals in remote parts of the PHN catchment, lack of access is due distance which makes the need for alternative services to be developed by, and for, local communities even more essential. Many of our most remote communities have informal and unfunded arrangements in place already that could be strengthened and supported.

- **A need for aftercare services.** Many LEN members were concerned that the people with lived experience consulted had not received any support following a suicidal crisis/suicide attempt. They identified the value of a sub-acute mental health service such as the Far West Mental Health Recovery Centre at Broken Hill where many consumers stay following a suicide attempt. Both the LEN members and other consumers have found psychosocial support and integrated clinical care extremely beneficial to their recovery. Current LEN members also have reported benefits from the group work interventions during aftercare support. They reported that groups helped them develop a plan of wellbeing and help-seeking strategies to prevent subsequent attempts. Also lacking is access to non-pharmaceutical approaches that support people to recover from the trauma that has led them to their current situations.

- **A need for bereavement support.** This is scattered and ad hoc across Western NSW. There are no protocols for emergency and health services to support families following the loss of a loved one.

- **A need for non-discriminating, culturally competent, person-centred care.** Consumers report a lack of knowledge from health professionals regarding the causes or contributing factors of suicidal behaviour. Knowledge about and practice of trauma-informed care is not widespread. Many consumers feel stigmatised and their distress diminished when they are not assessed by the clinician as requiring help, i.e. "not being unwell enough," "attention-seeking." Having a known support person when presenting to services for support has been reported as helpful. A common theme amongst the LEN when interacting with the current mental health system is the lack of person-centred care offered to them.

> *"A long road traveled in the support of a family member. Carers can travel this road with the one they care for, but they cannot travel it for them. A reality that must be faced and dealt with early on in the journey, in order to retain the ability to provide continued support at whatever level is needed at the time.*
>
> \- from a carer

in partnership with the
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Local Health Districts.

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