COORDINARE

phn SOUTH EASTERN NSW
An Australian Government Initiative

NSW GOVERNMENT Health
Southern NSW
Local Health District

NSW GOVERNMENT Health
Illawarra Shoalhaven
Local Health District

South Eastern New South Wales

Regional Mental Health and Suicide Prevention Plan

2018-2023

Consumer foreword

It is with great hope and expectation we commend to you the Regional Mental Health and Suicide Prevention Plan. It is plan that will make a significant and positive difference to the mental health and wellbeing of the people of South Eastern NSW, and one that will influence the development of such plans across Australia.

At a time when funding for mental health services has undergone a significant transformation with the emergence of PHNs and the establishment of the NDIS, it is important that consumers are at the centre of service planning. It is no longer acceptable that consumer are simply kept informed or just consulted about the things they know are needed in their communities. Today we understand that consumers need to lead system planning and design, rather than passively accepting structures and pathways that do not embody the principles of recovery and trauma informed care.

The development of the Regional Mental Health and Suicide Prevention Plan for South Eastern NSW has been undertaken with people with lived experience of mental illness being an integral part of the Project team from the very beginning. This is a reflection of the leadership and culture of each organisation that people working in designated lived experience positions are also working in positions of influence.

The leadership of people with lived experience has resulted in planning that seeks to support and develop the lived experience peer workforce as one of the critical workforces needed to promote the mental health and wellbeing of people in this region. Peer workers have natural and living connections to their communities and these connections are at the heart of the consultations that informed the development of this plan.

The work done in developing the Plan and the work that is to follow in its implementation and evaluation provides a model for mental health planning and reform. Leaders with lived experience, informed by consumers, carers and families, and working in equal relationships with traditional mental health leadership, can make a difference.

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Chief Executive foreword

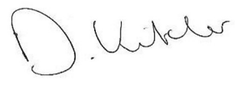
Since the establishment of Primary Health Networks (PHNs) in July 2015, our three organisations have developed a strong bond, working closely together to improve health outcomes for people living in South Eastern NSW. Nowhere is this more evident than in the development of the first Regional Mental Health and Suicide Prevention Plan for South Eastern NSW.

While developing a Regional Mental Health and Suicide Prevention Plan is a requirement of the Fifth National Mental Health Plan, our commitment to work together and improve mental health services for our communities began earlier than that. In fact it was in June 2016 when the Executive teams of Illawarra Shoalhaven LHD, Southern NSW LHD and COORDINARE – South Eastern NSW PHN first met together and agreed that mental health should be one of two joint priorities across the region.

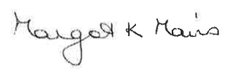
Many people and organisations have had input to this Plan, from the local consultations that were held in developing a local stepped care approach to mental health services, other forums and discussions, through to the public online consultation process. In particular, people with lived experience have had strong involvement throughout development of the Plan, with three representatives sitting on the Working Group that met regularly to bring the Plan to life.

Our Regional Mental Health and Suicide Prevention Plan is very much a foundational plan. It sets the scene for both real action to improve services and access now, as well allowing ongoing collaboration and development as the mental health needs for our communities change into the future.

We commend this Plan to you and look forward to working together and with our local communities and partner organisations to make the vision a reality.



Dianne Kitcher
Chief Executive Officer
COORDINARE – South
Eastern NSW PHN



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Executive Summary

The South Eastern NSW Regional Mental Health and Suicide Prevention Plan is intended to provide a blueprint for collaborative action for mental health service development over the next five years and to promote the partnerships and integrated approaches needed to reduce the impact of mental illness and suicide in the region.

It is informed by the first priority in the Fifth National Mental Health and Suicide Prevention Plan to support integrated regional planning, and also by important state and regional mental health plans and frameworks. It has been prepared jointly by a working group comprising senior mental health, planning officials and people with lived experience of mental illness from COORDINARE, the Illawarra Shoalhaven Local Health District (ISLHD), and Southern NSW Local Health District ISLHD (SNSWLHD).

The Plan focuses on ways in which COORDINARE, the ISLHD and SNSWLHD can work together with consumers, carers and other stakeholders to reduce fragmentation, address shared priorities and establish joined up systems and pathways. The plan has a practical focus and identifies specific collaborative action required to enhance responsiveness to local consumer needs. It seeks to promote integration of services. Through these integrated partnerships it offers strategies for continuing and local service planning, development and review.

The population of South Eastern NSW experiences high levels of psychological distress, and has recorded a relatively high number of suicides compared to other NSW regions. Over 102,000 people in the region may experience a mental illness in any one year. Population health data[1] available to COORDINARE provides the following summary picture of the region's needs:

- There is a relatively high prevalence of mental illness and psychological distress. Overall the region has 11.9 per 100 adults reporting high and very high levels of psychological distress.
- A greater burden of mental illness is borne by Aboriginal people and people living in the more rural parts of the region.
- The region experiences relatively high rates of suicide – among the highest regions in NSW. Particularly high rates and spikes have been experienced in some areas including Shoalhaven, South Coast, Goulburn-Yass and Snowy Mountains.
- The region experiences high rates of self harm especially among youth and Aboriginal people. Self harm is particularly high in Bega Valley, Eurobodalla, Goulburn Mulwaree areas.
- There is an inequitable distribution of services across the region – service availability does not match population needs particularly in rural areas.
- There is a high incidence of mental health problems among people using drug and alcohol services.
- There is a high level of physical illness among people with mental illness; and;
- Overall there are lower workforce to need ratios compared to state and national average figures.

The draft plan has been informed by the results of recent consultation undertaken by all three organisations on other mental health initiatives, and notes the problems and gaps from the perspective and experience of consumers and carers. Concerns have been expressed about fragmentation, about lack of communication between services and the lack of timely and appropriate pathways to care across the spectrum of need and across the lifespan. It notes that the physical health needs of people with mental illness are not well met. As well, it identifies the difficulty people experience accessing the right service. In some areas of the region, and for some groups, there are significant service gaps which are associated with workforce and other resource shortages and with broader developments including service changes associated with the transition to the National Disability Insurance Scheme.

The regional plan seeks to build on momentum and early partnerships which are underway to address many of these problems. The plan considers promising developments and enabling factors in the region which may lay the ground work for further service development and integration. This includes the growing peer support workforce in both primary and specialist care services, collaborative efforts underway in relation to suicide prevention, and innovative approaches to supporting our young people and addressing the needs for coordinated physical and mental health and psychosocial support services for people with complex, severe illness.

The plan identifies ten priority areas against which key actions are identified which involve working together across program, and government boundaries and with consumers and other stakeholders to provide better integrated care for people with mental illness.

These priorities are:

1. Ensuring consumers are at the centre of planning, delivery and review of services.
2. Integrated planning and governance at a regional and local level to deliver stronger healthcare neighbourhoods and service improvement.
3. Providing services across the spectrum of mental illness and across the lifespan to match the broad range of needs in the region.
4. A collaborative and systematic approach to suicide prevention, including clear arrangements for follow up.
5. Better coordinated care for people with complex and severe mental illness including management of physical health needs.
6. Reducing the impact of mental illness and suicide on Aboriginal an Torres Strait Islander people.
7. Early intervention through low intensity, through targeted child and youth mental health services and through digital supports.
8. Collaborative action to improve access to services for people in rural areas and other communities experiencing locational barriers to access.
9. Building the capacity and confidence of the mental health workforce through embedding a culture of collaboration and integration.
10. Provide a coordinated and collaborative regional mental health response to disasters and public health emergencies.

To implement collaborative change and integration of the nature proposed through the priorities and actions will take time. The plan offers a phased approach to service development and integration, which will establish the groundwork and partnerships required and draw on joint service mapping, needs assessment and service monitoring and redesign.

Consultation on the draft plan will be used to help to refine priorities and actions and to inform the approach to implementation, which will include a focus on developing the vital partnerships with the community needed to achieve a more integrated and responsive mental health system to meet the needs of our region.

[1] Based on: COORDINARE Baseline Needs Assessment – 2016 Update, COORDINARE – South Eastern NSW PHN; Ghosh A, 2017. Suicide Update Snapshot - Nov 2017, COORDINARE – South Eastern NSW PHN (Unpublished); COORDINARE internal reports and analysis produced by COORDINARE's Population Health and Information Service.

The Plan at a Glance

Values

- Hope
- Quality
- Equity
- Respect
- Citizenship
- Community
- Recovery

Principles

- Care and planning should be recovery oriented, trauma informed, and consumer centred.
- Reduce fragmentation and improve transitions
- Promote partnerships, alliances and networks
- Stepped care – matching services to need
- Early intervention – access to timely care
- Consumers are entitled to safe, high quality services
- Mental health workforce should be valued and supported.

Vision

One mental health system - planned, delivered and monitored together - providing better health and social outcomes for people with mental illness.

Problems (from)	Priorities (to)
Services and pathways not focused on the needs of consumers	Ensuring consumers are at the centre of planning, delivery and review of services
Fragmentation and poor transitions	Integrated **planning and governance at a regional and local level**
Services are not available to match the varying needs of people with mental illness.	Providing services **across the lifespan** and across the spectrum of wellness.
High rate of self harm and suicide, and lack of routine follow-up after suicide attempt.	Collaborative and **system-based suicide prevention**, including clear arrangements for follow up.
Poor outcomes and high rates of hospitalisation and readmission for mental illness among people with severe mental illness.	**Better coordinated care for people with complex and severe mental illness** including management of physical health needs
High representation of Aboriginal people among hospital admissions for mental illness and self harm	Reducing the impact of mental illness and suicide on **Aboriginal and Torres Strait Islander people.**
Lack of timely treatment and support early in the trajectory of disease to reduce impact of disease	**Early intervention** through low intensity and child and youth mental health services and digital services
Gaps in services for people in rural areas of the region.	Collaborative action to improve access to services for people **in rural areas** and other communities at risk
The workforce providing mental health services lacks professional support, skills and networks.	Build the capacity and confidence of the **mental health workforce** to provide integrated, quality services.

Enablers

- Engagement of consumer and carer voice in planning, delivery and review
- A well supported and connected workforce
- Peer support workers
- Health Pathways
- A strong healthcare neighbourhood
- Regional and local governance
- Communication
- Digital service provision
- Data
- Planning tools
- Regular review

Working Together

- Collaboration
- Joint planning
- Shared mapping
- Joint needs assessment
- Coordinated commissioning
- Workforce networks
- Shared or collocated service delivery
- Shared data systems
- Shared measurement and accountability.
- Links to other sectors including NDIS

Objectives

- Better access – services matched to need and more equitably distributed through better resource use
- Integrated care – consumers receive holistic, joined up services and transitions are smoother
- Better outcomes for consumers –care should be available to address mental health issues early and reduce the overall impact of illness
- Workforce confidence, networks and satisfaction improved – through team work, better communication and support

1. Background and Context

1.1 Introduction and purpose

The South Eastern NSW Regional Mental Health and Suicide Prevention Plan is intended to provide a blueprint for collaborative action for mental health service development over the next five years to reduce the impact of mental illness and suicide within our region.

There have been many mental health plans and strategies at a national, state and an organizational level. This plan is different in that it is the first time a plan has been prepared for joint regional action and collaborative service development between a primary care organization (COORDINARE) and local public health services in the region (Illawarra Shoalhaven Local Health District, ISLHD, and Southern NSW Local Health District, SNSWLHD). It focuses on ways in which COORDINARE, the ISLHD, SNSWLHD, consumers and other key stakeholders can work together to reduce fragmentation, address shared priorities and put in place joined up systems and pathways for people with mental illness or at risk of suicide. The plan is intended to have a practical, concrete focus, with specific actions to inform real change over time in the way services are delivered and clear roles and responsibilities for these actions.

The plan focuses on services and options for people in the community and seeks to cover the spectrum of mental health and suicide prevention needs within the region, from prevention through to the interface with acute care within an integrated system approach. It also recognises the importance of considering different ways in which integrated services and care can be achieved. This ranges from better communication between providers through to shared delivery of services.

The plan is underpinned by the important role people in the community and their families and friends can play in promoting connections and improving quality of care. It also recognises the particular challenges in delivering mental health services to a region with diverse geographic and population characteristics and needs such as South Eastern New South Wales. Finally, the plan acknowledges and seeks to build upon promising developments in mental health service delivery in the region.

1.2 How was this plan developed?

The plan was prepared with the advice of a joint working group which included the senior mental health lead, the senior population health planning officer and a person with lived experience of mental illness from COORDINARE, ISLHD and SNSWLHD. The group was chaired by COORDINARE and supported by a technical writer. It drew on the views of consumers, providers and the broader community provided through previous consultations on mental health issues. And it was shaped through an iterative process of consultation with clinical and community advisory groups, culminating in a broader consultation process.

The plan has been informed by data and evidence available to the region on the demographics of the area in terms of mental health need, current service and workforce availability, service gaps and issues particular to the region.

1.3 The broader context

Commitment has been given at the national, state and local level to the development of regional mental health and suicide prevention plans, developed through partnerships between LHDs and PHNs, to promote better integrated service delivery and planning.

The importance of a regional plan to support service integration and promote clarity of responsibilities was highlighted in the Commonwealth Government's Response to the Review of Mental Health Programs and Services[2] and is reflected as a priority for PHNs. At a national level, the Fifth National Mental Health Plan[3] approved in August 2017 identifies integrated regional planning, led by PHNs and LHDs as a key priority and a vital step towards addressing fragmentation in service delivery. The Fifth Plan emphasizes the importance of identifying gaps, duplication and inefficiencies and making better use of existing resources to improve sustainability. This plan has sought to implement a number of policy priorities and actions which are promoted through the Fifth Plan.

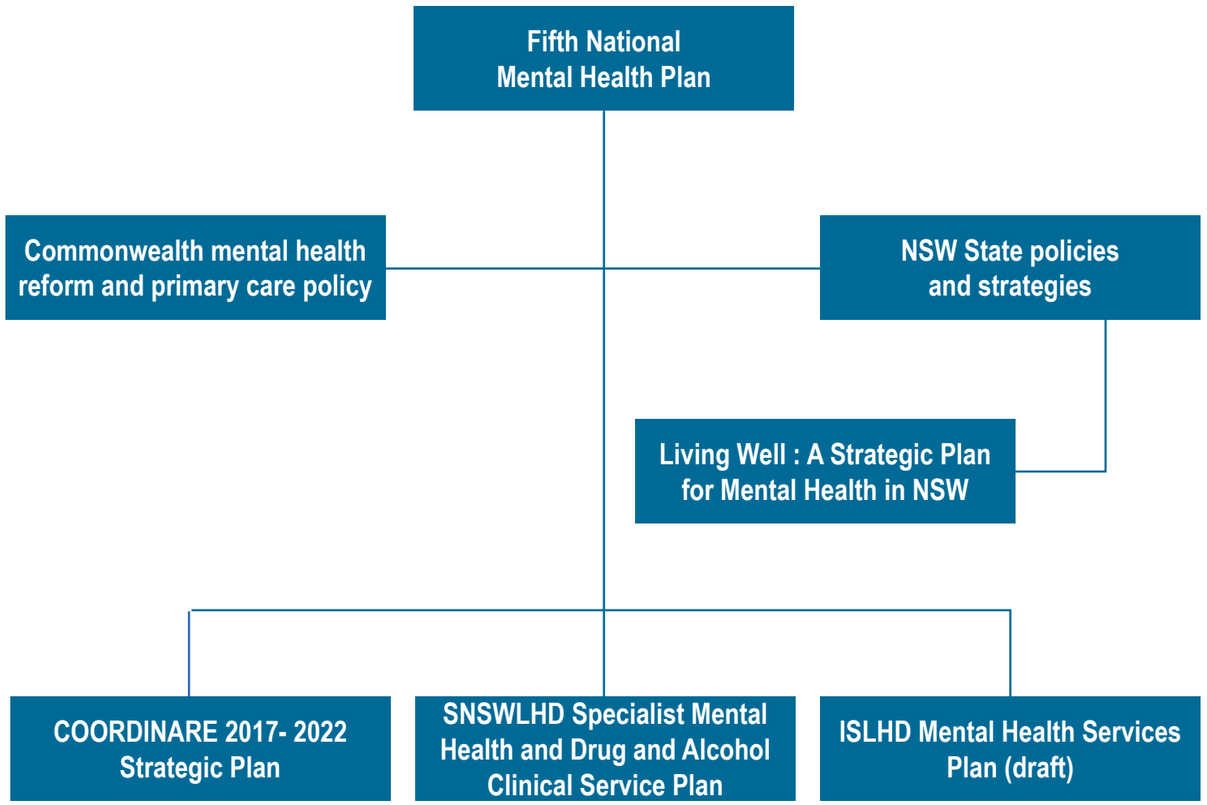
At a state level, there has been a strong commitment to partnerships and integration in mental health. Living Well: A Strategic Plan for Mental Health in NSW[4] promotes integration between LHD funded mental health services and primary care and a stepped care approach across a continuum of services. At a regional level, all three organisations represented on this working group have reflected a commitment to working collaboratively to jointly plan for better integrated mental health service delivery.

Important regional plans and strategies which set forth the context for this plan include:

- COORDINARE's 2017 – 2022 Strategic Plan[5] includes a priority statement on a stepped care approach to mental health and identifies development of an agreement of a joint, whole-of-region mental health and suicide prevention plan with LHDs as a key priority.
- SNSWLHD's Specialist Mental Health and Drug and Alcohol Clinical Service Plan, Towards 2026[6], which supports pursuing opportunities for better integration between mental health services and primary care providers.

The ISLHD is currently finalizing a Mental Health Services Plan to cover the period 2017 – 2027 which is understood to support better integration of mental health services and stronger ties to the work being undertaken through COORDINARE.

Figure 1 – National, state and regional mental health plans



Extract from Fifth National Mental Health Plan[7]

"Action 2 Governments will work with PHNs and LHNs to implement integrated planning and service delivery at the regional level.

This will include:

2.1. utilising existing agreements between the Commonwealth and individual state and territory governments for regional governance and planning arrangements

2.2. engaging with the local community, including consumers and carers, community-managed organisations, ACCHSs, NDIS providers, the NDIA, private providers and social service agencies

2.3. undertaking joint regional mental health needs assessment to identify gaps, duplication and inefficiencies to make better use of existing resources and improve sustainability

2.4. examining innovative funding models, such as joint commissioning of services and fund pooling for packages of care and support, to create the right incentives to focus on prevention, early intervention and recovery

2.5. developing joint regional mental health and suicide prevention plans and commissioning services according to those plans

2.6. identifying and harnessing opportunities for digital mental health to improve integration

2.7. developing region-wide multi-agency agreements, shared care pathways, triage protocols and information-sharing protocols to improve integration and assist consumers and carers to navigate the system

2.8. developing shared clinical governance mechanisms to allow for agreed care pathways, referral mechanisms, quality processes and review of adverse events."[1]

1.4 Providing care in a stepped care environment

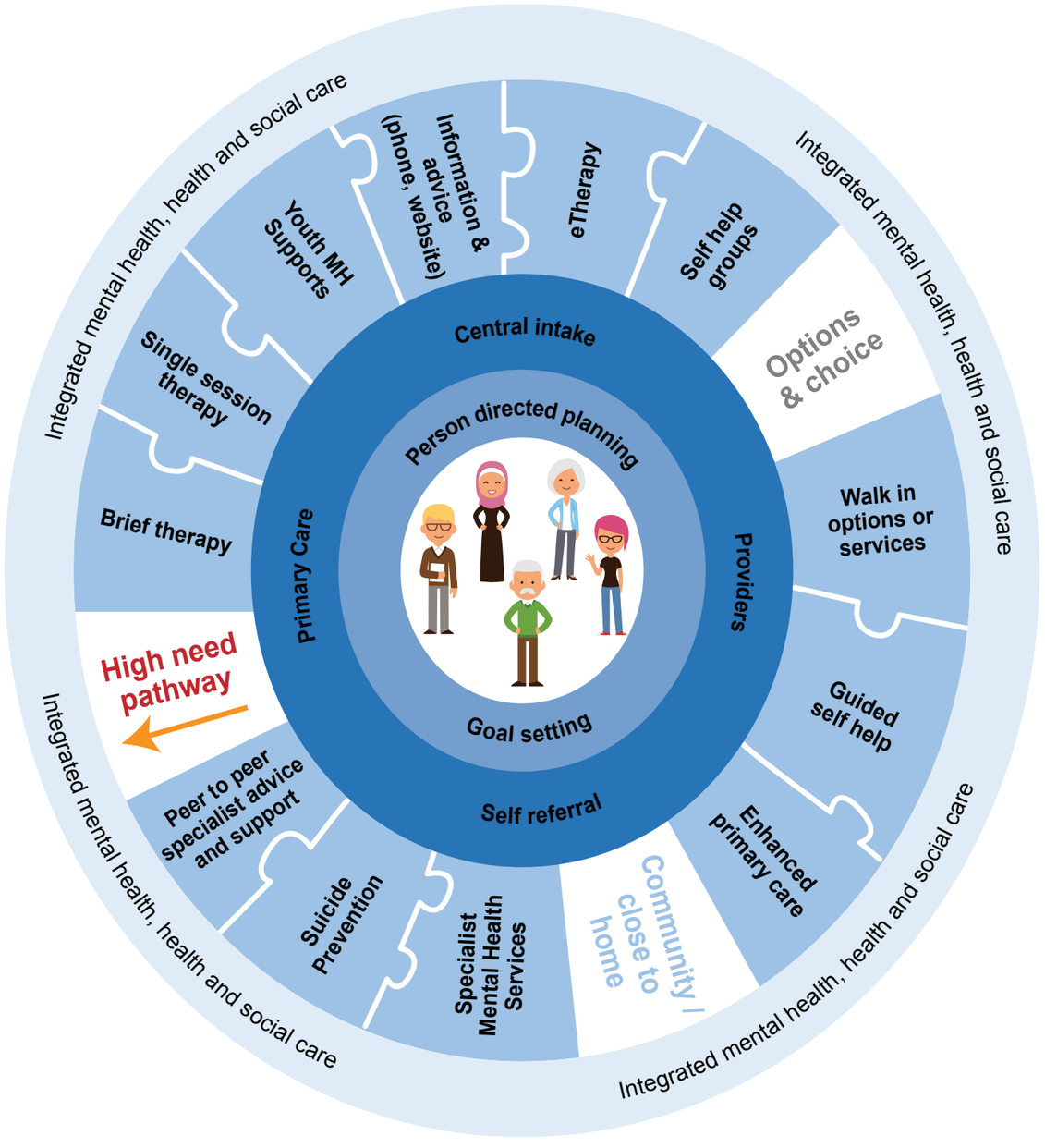
"We must support people across the continuum of care, keeping people well and supporting their recovery when they become unwell."

- (COORDINARE: Stepped Care Workshop)

A key premise for this plan is that a regional mental health system should offer stepped care to people with or at risk of mental illness. A stepped care approach is a staged system of options that match to an individual's needs, ranging from the least to the most intensive. The multiple levels of a stepped care approach do not operate in silos or as directional steps, but instead offer a spectrum of service options. In essence, a stepped care approach allows an individual to access the right service to meet their needs at the right time, to maintain their wellness, or to support their recovery back to wellness, as required. The below diagram illustrates COORDINARE's perspective on a stepped care approach to mental health and suicide prevention within the region.

[2] *Australian Government, Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services, Commonwealth of Australia, 2015*
[3] *Fifth National Mental Health and Suicide Prevention Plan,*
[4] *Living Well: A Strategic Plan for Mental Health in NSW, NSW Mental Health Commission (2014).*
[5] *COORDINARE, 2017 – 2020 Strategic Plan,*
[6] *Southern NSW LHD Mental Health Drug and Alcohol Clinical Service Plan – Towards 2026.*
[7] *Fifth National Mental Health and Suicide Prevention Plan*

Figure 2 – A Stepped Care Approach to Mental Health and Suicide Prevention



Key:

☐ The centre (people) The core (planning) The hub (Access) The spokes (options) The rim (wider support)

1.5 Values, principles and a vision for the future.

Values

The plan is underpinned by the values set forth in Living Well[8]. These are as follows:

- Hope
- Quality
- Equity
- Respect
- Citizenship
- Community
- Recovery

Principles

The key principles adopted by this plan are a blend of those which appear in many documents associated with the National Mental Health Strategy, Living Well and regional plans and policies. They are as follows:

- Mental health services and planning should be recovery oriented, trauma informed and consumer-centred.
- People in the community should have an active voice in planning, delivering and reviewing mental health service options.
- Partnerships, alliances and networks supporting effective mental health care should be promoted and resourced.
- A stepped care approach to service delivery should be pursued, matching services to intensity of need across the spectrum of age and illness.
- An early intervention approach should be pursued through which timely services are provided.
- People are entitled to safe, high quality mental health care services and to wrap around care which recognises their broader needs.
- The mental health workforce should be valued and supported.
- Services should be designed and delivered to address the diverse needs of people in the region, and to address barriers to service options experienced by particular groups in the community.

Vision

The vision underpinning this plan is for a single, integrated regional mental health system which:

- is responsive to the diversity of consumer need in the region, reducing inequities and addressing barriers in the system,
- aligns resources and workforce with evidence-based approaches to improving mental health, physical health and social outcomes for people with mental illness and reducing the impact of suicide,
- collaboratively plans, delivers and reviews the performance of mental health services in the region.

Objectives

Within this vision, the objectives of the plan should be to achieve:

- Better access – services matched to need and more equitably distributed through better resource use
- Integrated care – consumers should receive holistic, joined up services and experience smooth transitions
- Better outcomes for consumers – care should be available to address mental health issues early and reduce the overall impact of illness
- Improved workforce confidence, networks and satisfaction – through respectful team work, better communication and timely support.

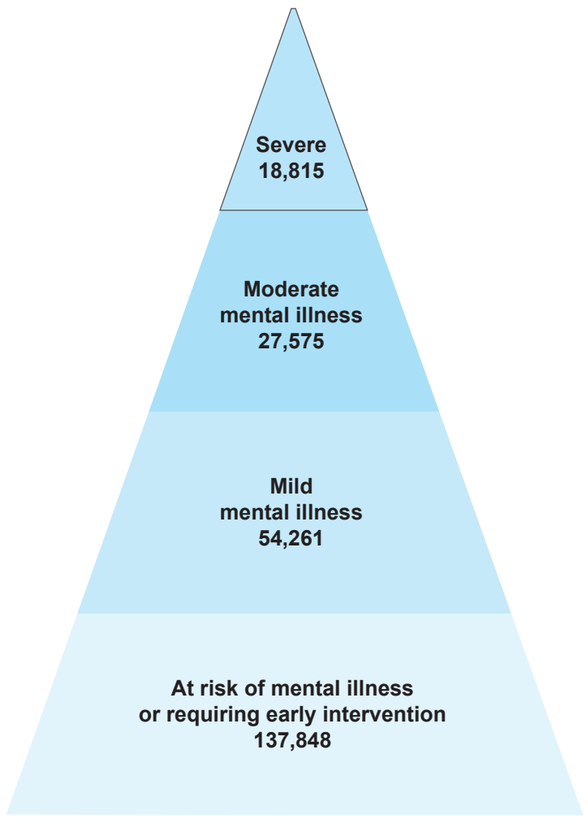
[8] *Living Well: A Strategic Plan for Mental Health in NSW, NSW Mental Health Commission (2014).*

2. The current regional mental health service system

2.1. Need for mental health services in the region – key demographics and features of the region

This section of the plan explores what we know about the current system and how it is meeting the region's needs for mental health services, both from the views expressed to us by consumers, carers and other stakeholders in consultation and from the data available to us. It starts with an analysis of what we know about our regional population and their needs.

Figure 3 – Estimated prevalence of mental illness within the region. [9]



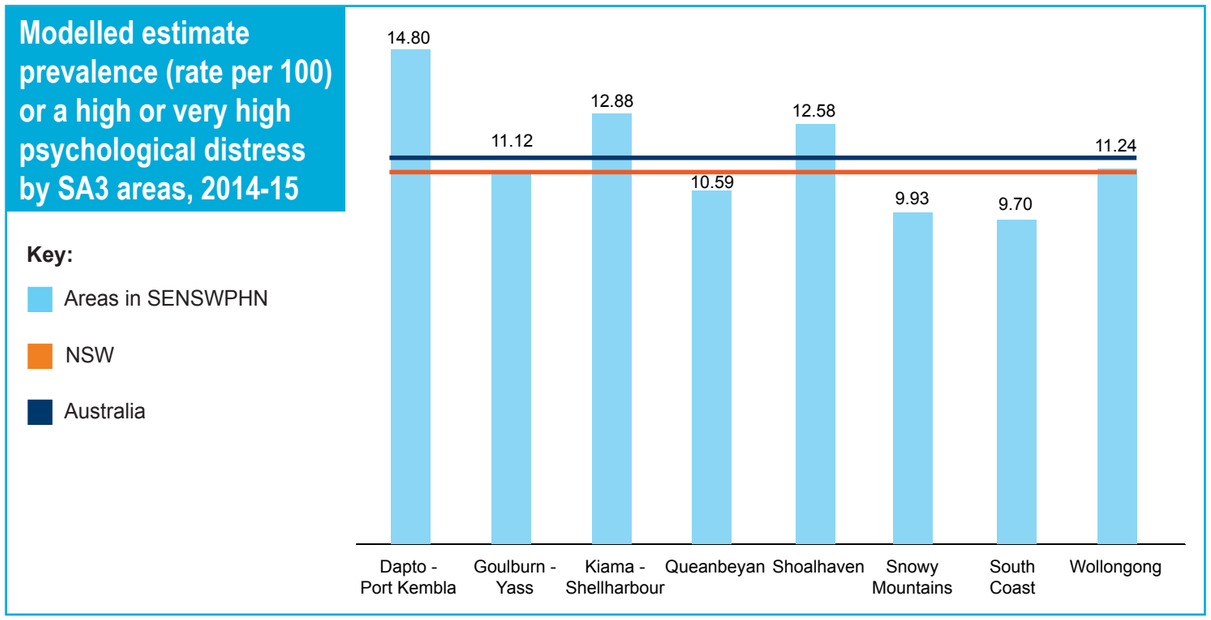
In a population of 611,000 in the region, it could be estimated that approximately 102,037 people would be likely to have mental illness in a 12 month period. The above Figure illustrates the estimated number of people who could be expected to be impacted by different levels of severity of mental illness, based on broader population prevalence. It also illustrates that a further 140,530 could require some level of early intervention or be at risk of mental illness over the same period (23.4% of the population). Not all of these individuals will necessarily seek or require services as this document explains in a later section.

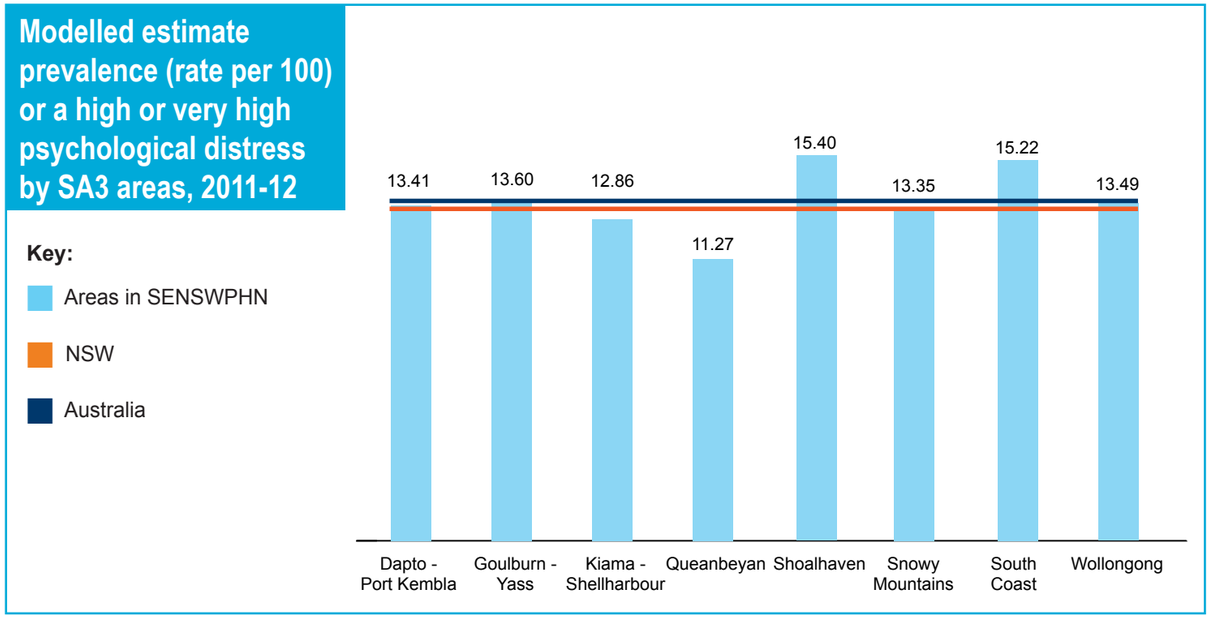
Population health data[10] available to COORDINARE provides the following summary picture of the region's needs:

- There is a relatively high prevalence of mental illness and psychological distress. Overall the region has 11.9 per 100 adults reporting high and very high levels of psychological distress. There is significant area level variability.
- A greater burden of mental illness is borne by Aboriginal people and people living in the more rural parts of the region.
- The region experiences relatively high rates of suicide – among the highest in LHD regions in NSW. Particularly high rates and spikes have been experienced in some areas including Shoalhaven, South Coast, Goulburn-Yass and Snowy Mountains.
- The region experiences high rates of self harm especially among youth and Aboriginal people. Self harm related burden is particularly high in Bega Valley, Eurobodalla, Goulburn Mulwaree areas.
- There is an inequitable distribution of services across the region – service availability does not match population needs particularly in rural areas.
- There is a high incidence of mental health problems among people using drug and alcohol services
- There is a high level of physical illness among people with mental illness; and;
- Overall there are lower workforce to need ratios compared to state and national average figures.

Figure 3 gives a summary picture of the levels of psychological distress and an indication of mental illness in different parts of the region, compared to the state and national average. Figure 4 gives an indication of deaths by suicide in the two LHD areas in the region and how these compared to other regions in the state in 2015.

Figure 4 – Prevalence of psychological distress



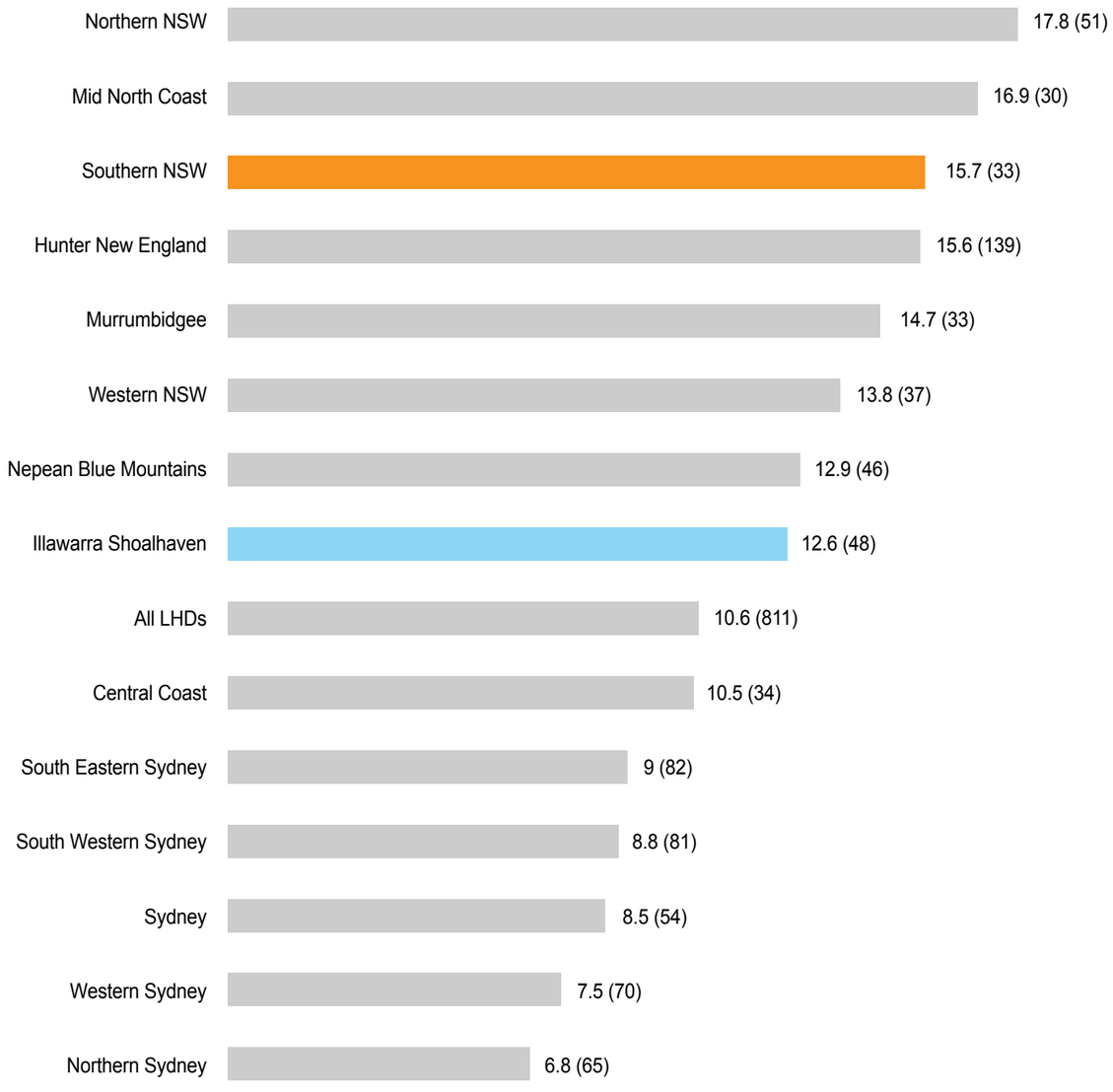


[9] Based on population prevalence estimates produced by the National Service Planning Framework for South Eastern NSW PHN catchment using 2018 projections.

[10] Based on: COORDINARE Baseline Needs Assessment – 2016 Update, COORDINARE – South Eastern NSW PHN; Ghosh A, 2017. Suicide Update Snapshot - Nov 2017, COORDINARE – South Eastern NSW PHN (Unpublished); COORDINARE internal reports and analysis produced by COORDINARE's Population Health and Information Service.

Figure 5 – Age Standardised Suicide Death Rates

Region wide comparison of age standardised suicide death rate per 100,000 (and crude number of deaths) by LHDs in NSW, 2015



2.2 Roles and responsibilities for mental health service delivery in the region

Responsibility for funding mental health services in the region is shared between State and Commonwealth services. The NSW Government through the LHD is responsible for specialist public mental health services and acute care to a relatively small number of people with severe mental illness and complex needs. Commonwealth funded primary care services support service provision to the majority of people with less complex forms of mental illness in the community and less intense needs. GPs are involved in the provision of care to people across the spectrum of severity, particularly given their role in providing physical as well as mental health services.

Services provided by ISLHD and SNSWLHD in the region include:

- Emergency and crisis services (including Triage and Emergency Care)
- Specialised mental health care services provided in acute or sub-acute settings in Wollongong, Shellharbour, Nowra, Bega, and Goulburn
- Community mental health care services including adult services, Child and Adolescent Mental Health Services, Older Persons services, Assertive Outreach and crisis/ emergency services
- Residential rehabilitation services
- Rural adversity programs targeting people in isolated rural areas.
- Suicide prevention aftercare services.
- Supported accommodation services
- Programs for particular specialised needs eg perinatal depression, eating disorders or trauma.

The LHDs also commission some NGO services including psychosocial support and suicide prevention after care services from NGOs in the region. This includes psychosocial support provided in association with the Housing and Accommodation Support Initiative (HASI) Program.

The NSW Government also funds services in the region for people with mental health problems through some specialist community support programs, drug and alcohol services, education, community services and other mainstream programs. The service offer in the region through LHDs has included specific initiatives for people with particularly challenging types of mental disorders such as eating disorders and borderline personality disorders. The below case study is one such service.

A case study in support for people with borderline personality disorders or at risk of self harm.

Gold Card Clinic in the Illawarra.

Gold Card Clinics are part of a stepped care model of integrated, collaborative, borderline personality disorders service. The model integrates a brief intervention program with longer-term evidence based group skills approaches. It focuses not only on the person with a borderline personality disorder but also supports carers, health services and clinicians.

The establishment of these programs supports better consumer outcomes. They are designed to divert people from emergency and inpatient units to the rapid follow up brief clinics, which act as a gateway to longer term treatment options when indicated. The programs also help to develop a more confident and skilled staff workforce working with people with borderline personality disorders.

Gold Card Clinics are part of the Project Air Strategy for the treatment of Personality Disorders developed by Brin Grenyer in the Department of Psychology, University of Wollongong. The approach was implemented in Child and Adolescent Mental Health Services in ISLHD in 2011 and has since expanded to include an adult Gold Card clinic facilitated by the Illawarra Community Mental Health Service.

The Gold Card clinic continues to be offered to people presenting with emerging borderline personality disorders or significant risk of self-harm. The intervention consists of up to four individual sessions which aim to collaboratively develop a safety plan with the young person and their family and consider ways to manage urges to self-harm. A Gold card is offered to people who present with concerns around self-harm who may be reluctant to engage in longer term psychotherapies.

The Commonwealth Government funds primary mental health services in the region through the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS), through program funding to COORDINARE and through programs delivered by NGOs, digital mental health, and school based mental health programs. The MBS also subsidises private health services provided in private hospitals and private psychiatry services. The most commonly used mental health services in the region are MBS funded GP services, followed by MBS funded psychological services under the Better Access program. MBS service provision is not equitably spread across the region. MBS subsidised services provided in the community by psychiatrists and clinical psychologists in particular are concentrated in the northern areas of the region.

As of 2016-17 figures it is estimated that over 69,000 residents of the South Eastern NSW catchment received some form of MBS subsidised/funded mental health services to a total sum value of $29,655,651 in terms of benefits paid by MBS[11]. Given estimated prevalence figures, this would suggest that a significant number of the 102,000 people with mental illness accessed some form of MBS service for their illness. The region has a relatively high rate of use of PBS subsidised medications. 12.5% of the population accessed mental health-related medications in 2011, compared to 10.9% nationally.

Programs offered through COORDINARE's role in commissioning mental health services target gaps within the stepped care framework and services for communities at risk including:

- Low intensity services for people at risk of or with mild forms of mental illness
- Psychological therapies for hard to reach groups
- Aboriginal and Torres Strait Islander Mental Health Services
- Peer support services and mental health nursing for people with severe and complex illness
- After care services for people who have attempted suicide,
- Youth mental health services, and
- Separate funding for drug and alcohol services.

COORDINARE also plays an important role in coordination of primary health care services, and capacity building within the primary care sector. COORDINARE uses this role, together with the capacity to commission services to facilitate change, and support system integration and improvement.

The Australian Government funds other mainstream programs which support people with mental illness in the region including income support programs, social services, and employment programs. Both levels of government have contributed to funding the National Disability Insurance Scheme which provides services for people with psychiatric disability. A number of NGOs provide psychosocial support programs which target people with psychiatric disability which will transition to the NDIS over the life of this plan.

The highest level of Commonwealth mental health funding in the region is provided to income support programs for people with mental illness, such as the Disability Support Pension. Another significant area of government spending in the region is PBS subsidised medications, particularly anti-depressants. The region has a higher than average uptake of these medications, particularly in some of the more rural and isolated areas, where alternatives to medication such as psychological therapy may not be as readily available.

2.3 What would optimal service delivery in the region look like?

The following table illustrates the type of service which optimal service delivery would offer across the spectrum of need, based on evidence based 'packages' of care recommended through the National Service Planning Framework (NSPF)[12]. This table indicates the number of people in different groups based on the severity of their need, and indicates the proportion and estimated number in the region who might seek or benefit from services, based on evidence-based treatment. This proportion ranges from 100% for those with severe mental illness down to only 24% in the early intervention group. The table also outlines the types of care which are recommended for different groups of people, again based on evidence underpinning the NSPF. Not all services would be required (or available) in a package of care for an individual.

There are many reasons why this mix and level of service delivery is difficult to deliver in a region like South Eastern NSW, but it provides an optimal picture of care.

Figure 6. What is the estimated need for different service types in the region?

Intervention type	**Early intervention** 24% need services	**Mild** 50% need services	**Moderate** 80% need services	**Severe** 100% need services
Estimated prevalence and need	137,848 of whom 32,604 need services	54,261 of whom 27,131 need services	27,575 of whom 22,060 need services	18,815 of whom all need services
Integrated physical health care			●	●
Specialist Public MHS Community and bed based				
Individual community support and rehabilitation				●
Primary care support for severe - Mental Health Nurse, peer support				●
Specialist Private MH Private psychiatrists, private hospitals			●	●
Primary Mental Health Care – GPs, psychological services	●	●	●	●
Low intensity e.g. digital services	●	●	●	

[11] *Ghosh A, 2018. Secondary analysis of Department of Human Services – Medicare Benefits Schedule service data 2016-17, COORDINARE – South Eastern NSW PHN*

[12] *Adapted from 'Using the NMHSPF to estimate service requirements for stepped care' Presented at Sharing learnings from early implementation of stepped care: A PHN collaborative workshop, 2016, Sandra Diminic, School of Public Health, University of Queensland*

2.4 Services in the region for specific groups of people with mental illness.

In terms of looking at the services which are available, another way to look at regional service provision is from the perspective of those mental health services which are available for particular cross sections of the community at a relatively high level of analysis.

Group	Services available in the region
People at risk of mental illness in the broader population or with very early symptoms	Digital self help, peer support and clinician supported mental health available by phone/web/apps e.g. Head to Health
Children and young people	Headspace services, School based health promotion and school counseling services, new wellness hubs, Royal Far West Child Telehealth, CAMHS services, Assertive outreach targeting youth with severe symptoms
For people with mild to moderate illness	MBS funded GP and psychological services. Digital (phone and web-based) mental health services, psychological therapies (Grand Pacific Health).
For people with severe, less complex mental illness	MBS funded GP services including physical health, and psychological services. Primary care support (mental health nurse and peer support services), psychiatry services, rehabilitation, individual support services. private hospital care, PBS medication.
For people with severe, more complex mental illness	MBS funded GP services including physical health, individual support and rehabilitation, specialist community mental health care services and public bed based services in key regional centres, NDIS services, private hospital care, other NGO psychosocial services, PBS medication
For people in rural areas of the region and other 'hard to reach' groups.	Targeted psychological services programs to supplement MBS services for hard to reach groups, rural adversity programs, digital mental health services, outreach services, Triage and Emergency Care Services, GP services.
For Aboriginal and Torres Strait Islander people and other special groups	Culturally appropriate services provided through Aboriginal Controlled Health services, Specialised services targeting CALD, eating disorders, perinatal services.
For older people with mental health problems	Older persons mental health services. GP and psychological services.
For people at risk of suicide	After care services, MBS psychological services, other mental health services, digital services (including phone based services such as Lifeline), school based services postvention support.

"I am getting into a more holistic way of thinking about things. As an Aboriginal woman, cultural healing can be a very good thing."

- (Being: Consumer story)

2.5 Geographic spread of mental health services within the region

As previously explained, there are significant challenges involved in delivering services across the diverse geographic areas of the region, including less populated areas. A very high level and descriptive summary of the type of services offered in different population centres, and the sort of workforce available to deliver them is as follows:

Larger urban centres in the region

- Reasonable to good supply of GP practices
- Acute inpatient and rehabilitation services generally available
- Community mental health teams available to provide adult, CAMHS rehabilitation and older persons services
- Some specialised mental health services available through psychiatry, and clinical psychology services
- Psychological services available through MBS
- Headspace services available
- NGO services provide psychosocial support and community support.

Smaller regional towns

- Ambulance journey required to access specialised acute mental health services
- GP services available, but lower numbers
- Community mental health teams available locally or on an outreach basis
- Access to Headspace being developed
- Travel required to access to psychiatry or clinical psychology
- Some limited psychological services available through private MBS and COORDINARE funded services
- Suicide prevention Aftercare, peer support and mental health nurse services linked to GP services are provided for people at risk of suicide or with complex needs in some locations through COORDINARE
- Smaller NGOs provide non-clinical community support.

More rural and isolated areas of the region

- Limited local GP services
- Travel to larger regional centres required to access acute or specialised services including psychiatry, headspace or psychological therapies.
- Digital services available including low intensity services for children.

"I see a psychiatrist over Skype….The one I am seeing now is good…she could be in Sydney. There is no psychiatrist in the area except Canberra"

- (Being: Consumer story)

GP services also have an unequal distribution but have broad coverage across the region, as follows.

Area Name	GP FTE[13] (2016 estimates)	GP FTE per 100,000 persons[14] (2016 estimates)
Dapto - Port Kembla	73.0	93.7
Kiama - Shellharbour	91.1	98.5
Queanbeyan	64.1	107.8
Snowy Mountains	28.0	141.8
South Coast	94.5	131.0
Shoalhaven	129.7	127.7
Wollongong	166.7	125.1
Goulburn - Yass	81.2	111.2

"She was as experienced as any country GP can be in mental health. She had more knowledge than any city GP would because they've got to deal with so many different people. You see your GP first so they've got pretty base knowledge. She seemed pretty much to know her stuff and the right things to say, then point me in the right direction of things."

- (Being: Consumer story)

2.6 What have consumers and carers told us about service gaps and overlaps in the region?

All three organisations have undertaken recent consultation with consumers, carers and other important stakeholders on mental health planning and/or commissioning issues (References: ISLHD MHS Plan Final Draft p.42, COORDINARE Consumer and Carer Forum - Queanbeyan , ConNetica Report, Queanbeyan, October 2017, Comprehensive Needs Assessments, COORDINARE 2013-14). COORDINARE has sought the views of consumers and carers about the mental health system through consultations associated with needs assessments, through workshops assisting the development of a stepped care framework and through consumer panel arrangements.

"Mental health patients often sit outside looking in, so referral systems may only reach 50% of those in need"

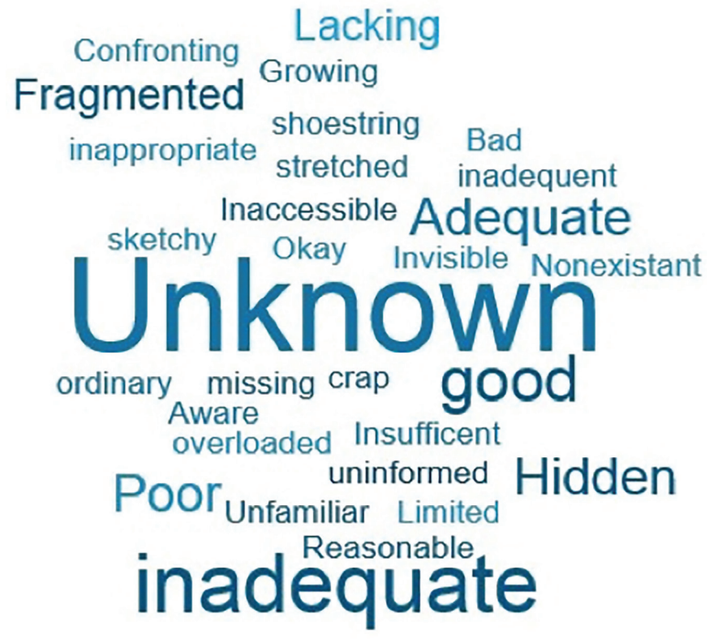
- (ISLHD workshop)

Overall a very strong theme of fragmentation has consistently emerged from these consultations. Another view repeatedly put forward in consultation was that there is a lack of information about what services are available. As one consumer said, if consumers are to access or be involved in services, "first they have to know about them". The stories heard by the three organisations in consultations suggested that sometimes people stumble on the right service – they aren't routinely connected to the service that meets their need.

Key service gaps identified in the context of developing previous plans or policies have included:

- A lack of information for the community about what mental health services are available in particular areas and how to access them;
- Poor coordination and links between services – particularly between state funded public services and primary care and between mental health and broader social support, family support or educational services;
- Limited access to many types of services across the continuum of care – preventive services, child and adolescent services, psychiatry, and services targeting people with moderate to severe mental illness;
- Problems in particular at the point of transfer of care between services and sectors, including at point of discharge from hospital;
- Inequitable spread of services, particularly given limited workforce in some parts of the region which means needs cannot be met;
- Lack of coordinated suicide prevention services and support for people at suicidal crisis in some parts of the region;
- Limited access to culturally appropriate mental health services for Aboriginal and Torres Strait Islander people and poor links between these services and specialist support;
- Lack of focus on the physical health of people with mental illness; and
- Access to psychosocial support services for people with severe mental illness who are not eligible for the NDIS; and
- Overall a lack of holistic care which recognises non- health needs.

A word cloud of responses from a survey of COORDINARE's Consumer Panel revealed the following picture of the regional mental health system. Progress is underway to address many of the above concerns, as discussed in section 2.8 and 2.9.



[13] *Ghosh A, 2018. Secondary analysis of National Health Workforce Dataset, COORDINARE – South Eastern NSW PHN*

[14] *Calculated estimates using referent population figures drawn from Australian Bureau of Statistics (ABS) 3218.0 - Regional Population Growth, Australia, 2016*

2.7 What are the service gaps and overlaps?

The evidence from demographic and workforce data and from the high level service mapping associated with the development of this plan supports many of the concerns raised by consumers. In particular it highlights an overall shortage of particular groups of mental health professionals within the region – particularly the short supply of psychiatrists and clinical psychologists and mental health nurses. It indicates challenges with supporting access to services in rural areas of the region, where access is not matched to need, and where siloed structures inhibit cooperation between the workforce that is available.

The service mapping also confirms there is some duplication in services and programs between different levels of government. School based mental health programs are a good example in the region, given different initiatives are funded by state education, LHDs, Commonwealth Health, and through Lifespan programs, and these funding streams sometimes compete or may leave gaps.

2.8 How are services currently working together?

A key theme in all consultations undertaken by the LHDs and by COORDINARE has been concern about the fragmentation of service delivery in the area. Services and workforce under pressure, limited communication between services, poorly defined transition arrangements and sometimes patchy local service availability all contribute to a system which is very hard for consumers and service providers to navigate. It can also seriously compromise outcomes for consumers.

Possibly the most concerning problem in this respect is that consumers report that service arrangements and communication protocols are not routinely in place in all parts of the region to ensure that consumers experience a smooth transition to care in the community through primary or specialist community mental health care upon discharge from hospital or inpatient care. This increases chances of readmission, and raises risk of suicide.

The service mapping confirms that there are certain areas of service delivery where there are shared and overlapping service responsibilities. Youth mental health is a significant area of shared responsibility, where connections between services are so important. However it is the care of people with severe mental illness where both primary care and specialist services must play an important and complementary role to meet both physical and mental health needs.

The separation of funding and service delivery through different funding streams has meant that there has to date been little incentive, flexibility or opportunity to offer integrated services. This is particularly the case in areas of limited workforce. Service providers, commissioning organisations and consumers and carers all agree a shift is needed from the current siloed approach to planning and delivering services in the region if best use of resources is to be achieved.

Consultations with consumers have indicated people want to be connected early in their treatment to the service that best meets their particular needs and not be sent from place to place until this happen. They expect their GPs to be supported by and in touch with specialist services at times their needs elevate. They expect step down services after acute episodes to be supported by clear communication. They want their service providers to know about other non-health services which might meet their needs. Finally they want their mental health to be treated like physical health – with a focus on providing support before health deteriorates and a crisis occurs.

All three organisations have taken actions to address some of these system problems and to promote joined up approaches to service delivery. The following section outlines some of these promising developments.

"Hand on heart I don't think we are doing the best we can with the combined resources we have"

- (consumer - COORDINARE stepped care workshop)

A case study in partnerships to prevent suicide

System-based Suicide Prevention in the Bega Valley and Eurobodalla.

Early in 2018 representatives from key sectors came together to discuss how they could collectively improve the integration, coordination and effectiveness of suicide prevention activities across the Bega Valley and Eurobodalla. Informed by the Proposed Suicide Prevention Framework for NSW and with the experience of participating in the Illawarra Shoalhaven Suicide Prevention Collaborative, a similar collaborative system based approach was seen to be valuable.

As with any collective impact effort, ownership and cooperation across agencies, sectors and organisational boundaries was required. A Cross Sector Leadership Group was formed to enable the system change and embed the partnership required for the approach to become integrated and succeed. SNSW LHD and COORDINARE are joined by other critical sectors such as education, local government, Aboriginal Controlled Community Health Organisation and General Practice in leading this approach in partnership with people who have a lived experience of suicide or suicide bereavement and members of the local Aboriginal community.

The breadth of suicide prevention strategies combined with the far reaching impact suicide has in communities result in a large number of stakeholders. Implementation working groups are established to provide the structure and connect stakeholders with the key activities most relevant to their expertise.

SNSW LHD community mental health team are working with COORDINARE, GP's and a number of NGO's in developing a shared approach to implementing the strategies relating to health service delivery, including; improving follow up care for individuals following a suicidal crisis, building capacity of GP's and Primary Care and training for clinicians and frontline staff.

Local schools principals and key teachers from the Public, Catholic and Independent education systems are working together to promote help-seeking and mental health literacy in schools and develop the systems required to effectively link students with the right services and supports when they are needed.

Community groups are joining with service providers and organisations such as the Rural Adversity Mental Health Project and Family and Community Services to discuss how, together they can strengthen community awareness campaigns, reduce stigma in local communities and identify and train community members to recognise and appropriately refer people who may be experiencing mental illness, psychological distress or a suicidal crisis.

Where needed, the working groups join to share skills sets and to resolve challenges that are common to across strategies and working groups. The activity of each working group contributes to a common evaluation framework and add cumulatively to a primary objective of reducing suicide deaths and attempts in the Bega Valley and Eurobodalla.

2.9 Promising developments - enablers and opportunities

There have been promising developments in mental health service delivery in the region which have been acknowledged in consultations and in the key plans and policies of regional organisations. Some of these are summarised below:

- COORDINARE is leading the commissioning and coordination of stepped care mental health services in the region, with pooled primary mental health program funding.
- ISLHD and SNSWLHD are progressing through their mental health plans new recovery focused and trauma informed models of specialist care which seek to offer a quality service more responsive to consumer needs.
- The Lifespan suicide prevention collaborative in the Illawarra Shoalhaven has brought together a collaboration of partners within and beyond the health system to cooperate in reducing the impact of suicide in the region.
- The expansion of the peer support workforce through LHD funded specialist community mental health and more recently through COORDINARE funding has been well received by consumers and other providers and has helped to embed a consumer focus in services and create a vibrant peer worker network.
- An increasing focus on consumer engagement and respectful staff interactions with consumers is being reflected in feedback on services through Accreditation processes and consumer feedback.

- Progress has been made in significantly reducing the use of seclusion and restraint in mental health services in the region.
- The new Head to Health digital mental health gateway recently launched by the Commonwealth Government offers ease of access to on-line, phone based and app based mental health services to all areas of the region
- HealthPathways offers opportunity for ensuring providers are informed of services within their area.
- The expansion of youth mental health services, including the new headspace service at Bega, has improved early intervention for young people with or at risk of mental illness.
- Improvements in data systems, data available at the regional level and planning tools will also offer opportunities for better planned and linked services in future.
- The appointment of positions such as GP Liaison officers within LHD funded services provides an important opportunity for better communication with primary care services.

In summary, there are a number of system based problems which have been identified in previous consultations and plans, and which are supported by the evidence. These problems are very relevant to this plan because they relate to the way services and health professionals work with each other on the ground.

However the opportunities afforded by a renewed commitment to work together, and new service structures in the region as outlined above, offer a chance to implement collaborative action to make the most of resources available in the region. The challenge will be to ensure new innovative approaches to workforce and service delivery help to inform, support, link and where appropriate re-shape existing services, not duplicate them. The following section outlines these actions.

A case study in workforce innovation
Consumer Peer Workers - Supporting Cultural Change in the Workforce

Peer work is key to embedding person-first, recovery-oriented and trauma-informed approaches in mental health services. Consumer Peer Workers are people who have a lived experience of mental illness and recovery, and Carer Peer Workers are people who have supported someone who has a lived experience of mental Illness and recovery. While lived experience is a pre-requisite for peer work, the accepted qualification is a Certificate IV in Mental Health Peer Work.

Peer workers can fulfill many roles and functions in mental health services, in family and community services, in housing, employment and education. Peer Support Workers help to restore hope and personal agency as they walk together with people on a shared journey of recovery. Other roles such as individual and systemic advocacy, health promotion, education and training, research and innovation, supervision, and coordination and management are often part of the peer worker toolkit.

Most frequently, peer workers work as an integral part of a multi-disciplinary team supporting either a specialist mental health service or a GP in the overall care of an individual with severe mental illness. They can deliver better outcomes through their ability to engage consumers and increase participation in treatment. Linked through peer networks, peer workers are vital to the joining up of the services and programs that exist throughout our region. They can make transitions amongst services easier to navigate and less stressful for people, their families, friends and supports.

In our region, on any given day, peer workers are reducing the incidence of seclusion and restraint in acute mental health units, assisting people with their transition from hospital to home, helping with discharge planning, empowering people to advocate for themselves, assisting people to understand their rights and responsibilities, enabling people to access services, joining in on equine therapy, running groups on recovery, mindfulness and yoga, assisting people with housing, accommodation and support, teaching nursing students about recovery, facilitating physical health coaching, working on recovery with the person and a mental health nurse, psychologist or occupational therapist, helping people write wellness plans, and sharing their stories of recovery.

COORDINARE, SNSWLHD and ISLHD have identified the peer workforce as central to the development of our mental health workforces into the future. Peer workers can be the key to cultural change to help our organisations and services become more recovery oriented, trauma-informed and person-led.

3. Priorities for collaborative action

3.1 How should we target the right priorities and actions for the region?

A broad range of actions have been identified in many plans, reports and reviews of mental health services at a national, state and regional level. This plan does not seek to list all of these actions, nor to be a sum of commitments which have been made at a regional level. The more priorities and actions there are, the more diluted efforts may need to be to implement them.

Instead therefore this plan has selected priorities and actions which:

- Focus on ways of working together to improve and develop services;
- Address the key problems relating to fragmentation of services and systems raised by stakeholders and supported by evidence which were outlined in the above section;
- Have been identified consistently in the Fifth National Mental Health Plan, in Living Well and also in recent mental health plans and strategies from COORDINARE, ISLHD and SNSW LHD;
- Harness momentum already underway in parts of the region;
- Address the particular needs of the region; and
- Are supported by evidence.

At a high level, these priorities and actions seek to achieve the following shift in how the regional mental health service works together to meet consumer needs.

From where we are now	To where we want to be
Services and pathways not always focused on consumer needs	Consumers will be at the centre of planning, delivery and review of services and the system will respond flexibly to the diverse needs of consumers. "Nothing about us without us!"
Fragmentation and poor transitions	Integrated planning and governance at a regional and local level will deliver strong healthcare neighbourhoods and support ongoing system redesign and improvement. Integration, partnerships and continuous improvement at a local level.
Treatment options focus on established illness rather than prevention or early intervention and do not meet the spectrum of needs.	A strong primary mental health care system will provide timely interventions and help to reduce the impact of mental illness and suicide. Services will be available across the lifespan, including older people.
High rate of self harm and suicide and lack of routine follow-up after a suicide attempt	A collaborative, systems based approach to suicide prevention, including ensuring follow-up care in the community is provided following discharge after a suicide attempt. Integrated, whole of community approach to suicide prevention.
Poor mental health and physical health outcomes, lack of holistic care and high rates of hospitalisation among people with severe mental illness	People with complex and severe mental illness will receive appropriate and well coordinated care which addresses their mental health, physical health and psychosocial needs.
High representation of Aboriginal people among hospital admissions for mental illness and self harm	The impact of mental illness and suicide on Aboriginal and Torres Strait Islander people in the region will be reduced through joined-up, culturally appropriate services.
Lack of timely treatment and support early in the trajectory of disease	The impact of mental illness on children and young people will be reduced through availability of early intervention services and a joined up approach to supporting youth mental health. Low cost and easy to access digital mental health services and other low cost alternatives to therapy will be available as part of the stepped care approach.
Gaps in services for people in rural areas of the region	Better use of available workforce and other resources in rural areas and uses of innovative approaches including technology will enable a better service offer to people outside urban areas of the region.
The workforce providing mental health services lacks professional support, skills and networks.	The regional mental health workforce will have the capacity, confidence and local connections to provide integrated, quality services and this will be a clear expectation of their role.

The following section outlines detailed actions against these priorities. It also gives the rationale for their selection, the desired outcome and offers some key performance indicators against each priority.

3.2 Detailed Actions and Priorities

Regional Mental Health and Suicide Prevention Plan Detailed Actions and Priorities	
1. Ensuring consumers are at the centre of planning, delivery and review of services	**Rationale** – All three organisations have a strong commitment to consumer focused care and to increasing the role of the peer workforce. Strong evidence underpins the effectiveness of engaging consumers in planning and delivery of services. The catchment also has higher than state and national proportional figures of residents living with high levels of psychological distress. **Desired outcome over the life of the plan** – A regional mental health service system designed around and responsive to the diverse needs and views of people requiring services and supports. **Key actions** ISLHD, SNSWLHD and COORDINARE will: a. Include people with lived experience of mental illness in governance arrangements supporting planning, delivery and review of services; b. Involve people who are likely to use services in the co-design of those services across the spectrum of stepped care; c. Strengthen the role of peer support workers in the region through expanding the workforce, promoting opportunity for networking and mentoring, and ensuring clear and consistent competencies and accreditation; d. Increase the responsiveness and reach of services to consumers with particular needs, including people from LGBTI or culturally diverse backgrounds or people who have experienced trauma; e. Require funded organisations to provide feedback from service users as part of the review of services.
2. Integrated planning and governance at a regional and local level to deliver stronger healthcare neighbourhoods, and service improvement.	**Rationale** - All three organisations support the importance of shared planning, needs assessment and appropriate data exchange, in line with the expectations of the Fifth National Mental Health Plan. The diversity of the region means that local planning and collaboration is especially important to address specific sub-regional consumer needs. The catchment has over 60 small population health areas within 12 Governmental administrative regions and two Local Health Districts. This can exacerbate the risk of health service fragmentation and increase the challenges of matching local circumstances. **Desired outcome over the life of the plan** –Well planned, integrated services, seamless pathways for consumers and the capacity to prevent and respond to system failures and challenges locally through system redesign and service development. **Key actions** ISLHD, SNSWLHD and COORDINARE will: a. Maintain a joint regional working group to meet regularly to review the progress of this Plan against key indicators and support its implementation, to oversee and support local system redesign, and to share regional data on mental health and suicide prevention. b. Trial the establishment of new collaborative networks at a local level in key sub-regional centres to facilitate networking and information exchange and to undertake service development and redesign. These networks should include representatives of primary care and community mental health services with consumers, carers, NGOs and other key local service providers including ACCHOs. c. Undertake detailed service mapping, and update HealthPathways to ensure providers are aware of the private, NGO, primary care and government funded services available locally for people with mental illness in the health care neighbourhood. d. Use feedback from HealthPathways and input from consumer and carer experience to identify system failures and support redesign and service development for people with mental illness at a regional and local level. e. Undertake shared needs assessments, to support collaboration and information exchange on ways of addressing needs.

3. Providing services across the spectrum of mental illness and across the lifespan to match the broad range of needs in the region.	**Rationale** – Like other health issues, a public health approach to mental health should be embedded in the region which recognizes the importance of mental health prevention and promotion activity and providing appropriate services to people with mild to moderate symptoms of common mental disorders as well as those with severe mental illness. By providing services across the lifespan and across the spectrum of need, the impact of their mental illness on families, relationships, vocational goals and wellbeing, and the risk of their illness increasing in severity will be reduced. Over 80,000, people in the region are likely to have some form of mental illness, of which most will have mild to moderate illness. The region experiences a very high rate of use of mental health medications, particularly in areas where psychological services are not easily accessed. **Desired outcome over the life of the pla**n – A strong, integrated primary mental health care system will be available to promote mental well being and provide services matched to the needs of people with mild to moderate forms of common mental disorders, to intervene early to reduce the impact of mental illness and suicide and to help to identify people with more severe mental illness who require additional support. Services will be available across the lifespan. Links between primary care and specialist community mental health services will facilitate integrated care and pathways for people who move between service systems as their needs change over time. **Key actions** COORDINARE in partnership with ISLHD and SNSWLHD will: **a.** Strengthen the role of primary care in referring people with or at risk of mental illness to the service which best meets their needs through an integrated service system. **b.** Support opportunities for promoting mental health and building resilience at a population level through evidence based parenting programs, partnerships with schools, and community groups and promoting low intensity support options for people experiencing situational distress. **c.** Promote the availability of digital and face to face psychological therapies across the region including in under-serviced areas, as an alternative to prescription of medication for people with mild to moderate mental illness. **d.** Target services to groups and locations which are harder to reach and not well serviced by MBS mental health services **e.** Ensure appropriate services are available across the age spectrum, including addressing the needs of older people with mental illness.

4. A collaborative and systematic approach to suicide prevention, including clear arrangements for follow up.	**Rationale** – The importance of a planned, systems based approach to suicide prevention which promotes evidence based action is promoted through national, state and local policies and plans. People who have attempted suicide are at extremely high risk of suicide over the period following discharge from care. Provision of timely, regular and appropriate follow-up services in the community over this period protects against this risk. With higher than national and state mortality rates, suicide is the 15th leading cause of death for the catchment with pockets of alarmingly high numbers of annual suicide deaths. **Desired outcome over the life of the plan** – Health and non-health services will be better able to identify and respond to the needs of people at risk of suicide, and timely follow up care in the community after a suicide attempt will always be provided. **Key actions** ISLHD, SNSWLHD and COORDINARE will: **a.** facilitate the agreement of clear procedures and roles between acute services, community mental health and services commissioned by COORDINARE to ensure that people who have been discharged from acute services after a suicide attempt are actively referred to appropriate follow-up care in the community; **b.** maintain a commitment to a systems based approach to suicide prevention through continued implementation and review of the Illawarra-Shoalhaven Suicide Prevention Collaborative, and through strengthening a similar sustainable collaboration to reduce the impact of suicide in the SNSWLHD area; **c.** provide opportunities for training and capacity building for GPs managing people at risk of suicide and/or self harm through Lifespan and COORDINARE funding and through ensuring appropriate links to specialist advice and support; and, **d.** raise the skills and confidence of the broader non-health workforce to identify and respond to people at risk of suicide and/or self-harm.

5. Better coordinated care for people with complex and severe mental illness including management of physical health needs	**Rationale** – National, state and local policies and plans point to the importance of better communication, cooperation and joint care planning between services to improve mental health, physical health and social outcomes for people with severe mental illness. The relationship between specialist and acute services and GPs is especially important. Mental health consumers in the catchment are not consistently monitored for physical health and well-being. Less than half of consumers receiving mental health services are screened for physical health checks. **Desired outcome** - Reduce preventable hospital admissions and improve physical, psychological and social recovery for people with severe and complex mental illness through shared care planning and shared care arrangements. **Key actions** ISLHD, SNSWLHD and COORDINARE will: **a.** Promote development and implementation of a single multiagency care plan for people with severe and complex mental illness who receive care from both primary and specialist care, which includes consideration of physical health, mental health and psychosocial support needs. **b.** Establish clear coordination, communication and referral protocols between community mental health services, and primary care services for people with severe mental illness, including telephone based emergency advice, and shared assessment. **c.** Engage peer support workers as a way of increasing care coordination and psychosocial support to people with severe mental illness in the community and supporting GPs in their care. **d.** Position local mental health services to refer to and work with NDIS service providers in provision of joined up care for people with psychiatric disability **e.** Augment access to psychosocial support for people with severe and complex mental illness who do not qualify for the NDIS and who have reduced psychosocial functional capacity.

6. Reducing the impact of mental illness and suicide on Aboriginal and Torres Strait Islander people.	**Rationale** – Aboriginal and Torres Strait Islander people in the region are disproportionally represented in hospital admissions for mental illness and suicidality. Joined up, culturally appropriate services are required which recognise the determinants of mental health and social and emotional wellbeing for Aboriginal and Torres Strait Islander people are a priority at state and national level. Rates of intentional self-harm hospitalisation amongst Aboriginal persons are almost three and a half times more than those of non-indigenous persons in NSW. **Desired outcome** – Reducing the impact of mental illness and suicide on Aboriginal and Torres Strait Islander people in the region. **Key actions** ISLHD, SNSWLHD and COORDINARE will: **a.** Partner with regional Aboriginal community controlled health services to build their capacity to provide mental health and social and emotional wellbeing services and to develop alternative culturally appropriate models of care. **b.** Ensure services offer cultural competency training for staff involved in delivering services to Aboriginal and Torres Strait Islander people. **c.** Continue a focus on the needs of Aboriginal people in suicide prevention through engagement of ACCHOs in collaborations including Lifespan and suicide prevention planning for the Southern NSW catchment. **d.** Collaborate to improve access to social and emotional wellbeing and mental health services for Aboriginal and Torres Strait Islander children. **e.** Improve referral pathways between GPs, ACCHOs, drug and alcohol services and specialist services **f.** Engage with the broader Aboriginal community to promote acceptance and understanding of the role of mental health services, promote social and emotional wellbeing and increase responsiveness of services.

7. Early intervention through low intensity services, through targeted child and youth mental health services and through digital services	**Rationale** – National, state and local plans and policies recognize that the provision of timely and appropriate low intensity services, particularly to children and youth can reduce the risk and impact of mental illness and suicide and are an important part of stepped care. Developments in digital mental health services have increased availability of evidence based low intensity services for people with early or mild mental illness. Almost 30% of all intentional self-harm hospitalizations and close to 36% of self-harm emergency presentations in the catchment are estimated to be for persons aged 15 – 24 years old. **Desired outcome** – Promote the availability of low cost, easy to access low intensity services and facilitate partnerships in provision of youth mental health services. **Key actions** ISLHD, SNSWLHD and COORDINARE will: **a.** Promote the availability within the region of online, phone and app based self help, peer support and clinician directed mental health services which target people with low intensity needs or mild mental illness, including the Head to Health digital mental health gateway. **b.** Promote partnerships between headspace youth and CAMHS services to ensure seamless collaborative care and referral pathways for young people with or at risk of mental illness, through the commissioning of new services in Bega as well as through existing services in Queanbeyan, Goulburn, Nowra and Wollongong. **c.** Liaise with regional educational authorities and NGOs delivering school based mental health or suicide prevention activity to review planning and implementation of school based support and programs and ensure duplication and overlap is reduced. **d.** Promote local collaboration between mental health and broader services in providing early intervention for young people with severe mental illness and multiagency needs, including those associated with early psychosis, comorbid substance misuse problems or eating disorders.

8. Collaborative action to improve access to services for people in rural areas and other communities experiencing locational barriers to access.	**Rationale** – The region has particular challenges in terms of diverse geography and scarce workforce in sub-regional areas. Making the best use of the available workforce and emerging technology will be important to achieving the best outcomes for rural consumers. This could be a priority area for testing approaches to integrated service delivery. More regional parts of the catchment have significantly higher rates of mental health related hospitalisations, self-harm emergency department presentations and suicide mortality. **Desired Outcome** – More equitable and timely access to assessment, primary care and specialist support should be available to people living in rural areas of the region (or other areas experiencing locational barriers to access) through implementation of innovative and cost effective approaches to making best use of available resources. **Key actions** ISLHD, SNSWLHD and COORDINARE will: **a.** promote the availability of digital self help and clinician supported services to people in rural areas of the region and to GPs who provide services to them. **b.** consider opportunities to share available mental health workforce in rural areas through joined up service provision, and jointly plan to address workforce shortages in these areas **c.** explore innovative approaches to workforce supply in rural areas which focus on the competencies needed to deliver services, rather than seeking staff from particular professional backgrounds. **d.** expand the use of telehealth, including acute psychiatric review, tele-psychology and tele-psychiatry, and remote monitoring and medication management **e.** Ask the continuing joint regional working group on mental health to identify and promote discussion on ways of responding to the needs of newly emerging communities at risk within the region, where there is a spike in mental health or suicide presentations.

9. Build the capacity and confidence of the mental health workforce to achieve the actions in this plan through embedding a culture of collaboration and integration.	**Rationale** – A strong and capable workforce with an imperative to achieve integrated service delivery is vital to delivering the plan. All three organisations face shortages now and into the future of key mental health workforce, and problems with morale, and skill deficits can significantly impact on consumer care. A shared workforce strategy to regular review deficits in availability and skills of the workforce and to promote capacity and confidence will be important to effective planning and service delivery within the region. GP capabilities to support people with mental illness will be vital to this strategy, as will addressing stigma towards mental illness in the broader health and non health workforce. There is an overall lack of key mental health professionals such as psychiatrists in the catchment. There is an uneven distribution of mental health clinicians such as psychologists and mental health nurses within sub-regions of the catchment which impacts on access to services. **Desired Outcome** – A collaborative approach to delivering the integrated services consumers need will be embedded in the culture of the three organisations and the siloed approach to service delivery should become a thing of the past. A joined up approach to workforce planning, recruitment and capacity building will underpin service development. Mental health professionals in the region should be skilled, confident and required to work as part of a joined up system. Peer workers should play a key role in helping to link the role of GPs and specialist services in meeting the needs of people with mental illness. **Key actions** ISLHD, SNSWLHD and COORDINARE will: **a.** Collaborate regularly on the future workforce needs of the region, and ways of jointly addressing short and long term workforce shortages and skill deficits, including through competency based approaches to job descriptions. **b.** Embed expectations of joined up service delivery and clear communication between in-patient services, specialist community mental health services, GPs and other primary care services and NGO support services in formal descriptions of duties and service expectations. **c.** Promote opportunities for professional networking, mentoring, career advancement and skill development, including through proposed new local collaborative networks, to assist staff to transition to new collaborative arrangements. **d.** Build capacity of GPs and other primary care providers to identify escalation of symptoms and to recognize markers of deterioration and suicide risk in partnership with specialist community mental health services and psychiatric liaison support. **e.** Liaise on establishment of arrangements to ensure the expanding peer workforce receives necessary support, governance and career pathways and is embraced as part of the multidisciplinary team, within both primary care and LHD mental health services. **f.** Explore opportunities for workforce exchange to support professional development and better longer term networking **g.** Seek opportunities to address stigma in the broader health workforce regarding mental health issues, and raise capacity of other services to respond to the needs of people with mental health problems. **h.** Promote use of on-line treatment modalities by workforce

10. Provide a coordinated and collaborative regional mental health response to disasters and public health emergencies. (This additional priority area for collaborative action was ratified for inclusion in May 2020)	**Rationale** – The SE NSW Primary Health Network, and the two Local Health Districts (Illawarra Shoalhaven LHD and Southern NSW LHD) which operate within the region, acknowledge the importance of a timely, agile, and coordinated response to the mental health challenges of national disasters and other emergencies. The region has already been severely impacted by the 2019/2020 bushfires, which have resulted in loss, grief, trauma and varying levels of distress to community members. The subsequent impact of COVID-19 has been associated with loss of income, social isolation and heightened levels of anxiety and uncertainty, compounding the impact of the bushfires in many sub-regions. There is a need for collaborative approaches to responding swiftly and appropriately to the different levels and stages of needs arising from these and other natural disasters which may impact the community over the duration of the Joint Regional Mental Health and Suicide Prevention Plan. **Desired Outcome** – Agreed governance and processes to support a joint and collaborative approach to responding swiftly to reduce the mental health impact of current and future disasters on people within the region and making optimal use of available resources. This should include strategies to provide an immediate response but also agreed approaches to providing coordinated medium to long term support and clear service pathways to address different levels and types of needs of individuals impacted by disasters. **Key actions** ISLHD, SNSWLHD and COORDINARE will: **a.** Utilise governance associated with implementation of the Joint Regional Plan and other disaster response specific governance to promote regular communication, and ensure clear roles and responsibilities in relation to responding to disasters. **b.** Work within the framework of the NSW State Disaster Recovery Plans, particularly in terms of ensuring the lead of the State Government is followed on coordination of the emergency response to disaster. **c.** Engage with key stakeholders including through Clinical Councils, consumer and carer consultation and partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) to develop appropriate joint responses to disaster. **d.** Promote a community development approach to supporting recovery from disasters including through promotion of social connectedness and building capacity of communities. **e.** Ensure a spectrum of responses is available to meet the needs of people impacted by disaster including: **a.** Low intensity support and self-help information for people experiencing a level of situational distress as a result of the disaster; **b.** Short term mild to moderate psychological counselling for individuals experiencing ongoing mental health problems resulting from or exacerbated by disaster;

	c. High intensity services for individuals experiencing complex trauma or anxiety associated with the disaster; d. Measures to ensure risk of suicide or harm to self or others associated with the impact of disaster is monitored, and that there is capacity for swift and appropriate response and follow up. f. Develop and jointly promote digital services to communities for which a workforce is not available due to restrictions associated with disaster response, or geographic isolation, whilst ensuring that provisions are in place for individuals for whom these services are not appropriate. g. Ensure communication protocols and referral pathways between primary care services and specialist State community health services are in place to ensure that people with complex trauma or who are existing consumers of state services are appropriately referred. h. Require service providers commissioned or engaged to deliver services to individuals impacted by disasters to establish lines of communication with other Commonwealth or State mental health service providers. i. Collaborate to address and reduce the cumulative impact of the 2019/2020 bushfire disaster and restrictions associated with 2020 COVID-19 on individuals and communities, and minimize further disruption to service delivery. j. Develop a collaborative framework to guide a joint, staged response to the 2019/2020 bushfires.

4. Implementing change

4.1 A phased approach to integration

The actions outlined in the above section can't all be implemented at once. Integration takes time and requires groundwork. Smaller, foundation steps need to be taken to establish and support partnerships at a regional and a local level before more joined up activity can take place.

The attached summary chart outlines how the plan may support a shift towards more integrated and joined up actions between LHDs and primary care to improve outcomes for people with or at risk of mental illness in the region over the five years of the plan. It separates actions by governance, suicide prevention, mental health and importantly those actions which support the workforce in the process of achieving change. In summary, the phased approach would involve the following:

The early years of the plan would focus on laying the groundwork and forming key partnerships– key governance arrangements, a focus on better communication of available services, trialing new integrated delivery models and putting in place local arrangements for supporting and networking the workforce, including the peer workforce. However from the second year onwards, models of integrated service delivery would be implemented, supported by shared needs assessment, workforce planning and governance arrangements.

The plan recognizes that the sphere of control of regional health organisations is on health services. However as the plan progresses, and partnerships mature, increasing influence and collaboration is sought with other sectors through governance arrangements.

It shows the approach to integration becoming more ambitious as the years move through, culminating potentially in joined up service delivery where this proves to be the best way to provide care in some parts of the region.

Importantly, it also shows the importance of an iterative performance measurement and review process throughout the plan, to stop and take stock of whether actions and strategies for joined up approaches are the most appropriate.

The phased approach to action presumes that there will be support to local agencies and service providers by way of technology, tools and data to help inform and progress integrated service delivery.

A proposed phased approach to integration and implementation

Year	Integration and governance	Suicide prevention	Mental health	Workforce	Measuring progress
2018 / 2019	• Information sharing and detailed service mapping • New local governance in place to support the plan (including consumers) • Continued regional working group	• Continued rollout • of Illawarra Shoalhaven suicide prevention collaborative and new Southern suicide prevention collaborative and plan. • MOUs/ agreements to embed/clarify • Aftercare referrals • following suicide attempt	• Renewed commitment to planning local collaboration in areas of shared service delivery (complex, youth) • Focus on promoting digital services	• Expand and support peer workforce • Strategies for better local networking and communication • Expectations of collaboration embedded in employment and service contracts	• Trial of 2-3 key innovative projects commences • Baseline information gathered • First annual report with focus on groundwork
2019 / 2020	• Joint needs assessment - gap analysis and systematic planning for coordinated service delivery	• Review of Lifespan and of suicide attempt Aftercare. Implementation of Southern plan	• New joint activity commenced and planned informed by needs assessment and national planning tools	• Joint workforce plan developed informed by national planning tools	• Review of innovative projects • Second annual report
2020 / 2021	• Implement coordinated service delivery	• Implementation of new strategies arising from review	• Commence collaborative engagement of other sectors	• Peer worker role in supporting coordinated delivery	• Mid term review of plan as part of third annual report
2021 / 2022	• Shared client data records and interoperable systems, performance management	• Renew and continue suicide prevention activity collaboratives	• Implement new strategies and joint projects (beyond health)	• Potential innovative funding models for workforce	• Fourth annual report • Commencing final evaluation
2022 / 2023	• Shared funding models implemented. Consumers in centre of care	• Joined up approach to preventing and responding to suicide helps to reduce impact of suicide in region	• Integrated system and pathways for mental health services with links to other sectors	• Workforce feels supported and optimal use of available workforce resources is achieved	• Evaluation to inform future shared planning arrangements

4.2 Trialing new arrangements for integrated local service delivery

New approaches to working together need to be tested. The above phased approach to implementation proposes that trials of new ways of working together could be put in place commencing in the first year of the Plan. The trials will be a collaborative effort between COORDINARE and the LHDs and will be implemented in two locations.

- The first trial would model collaboration in supporting people with mental illness at risk of admission or readmission to hospital. It would include a strong focus on managing the physical health care of these people and on the role that peer workers and GPs can play in their care if well supported to do so. It would take place in the Illawarra-Shoalhaven area as a partnership between COORDINARE and ISLHD.
- The second trial would seek to establish a collaborative network of mental health and related services through a 'health care neighbourhood' focusing on better communication, collaboration and pathways to care in a regional area. This trial would also include a strong focus on supporting people with complex needs, promoting joined up services for young people and suicide prevention collaboration. Consumer involvement would be an important part of the network. This trial would take place in a rural location within the Southern LHD, again as a partnership with COORDINARE.

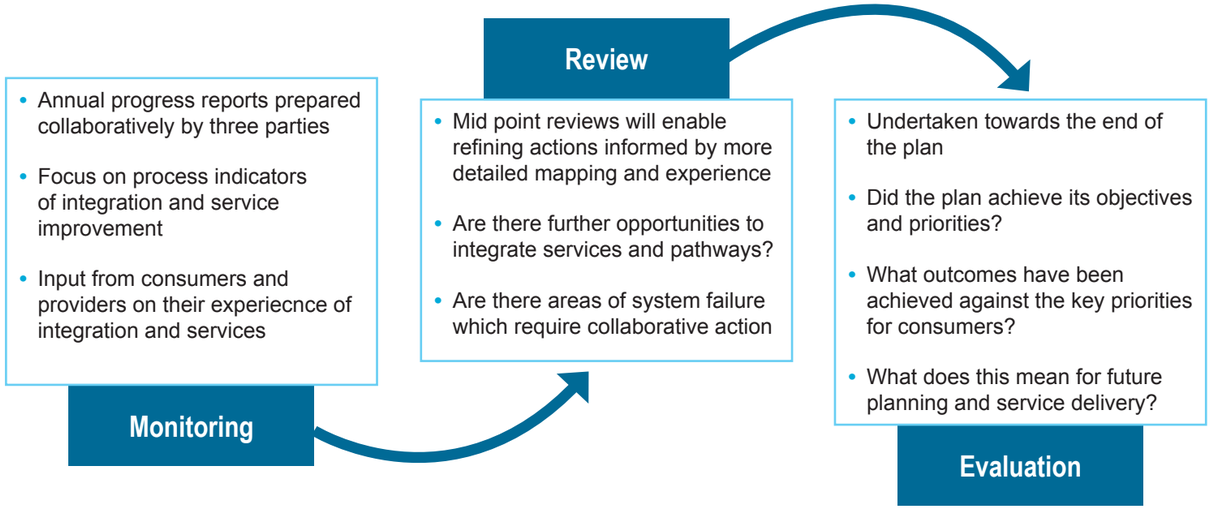
These trials would harness available resources and be subject to monitoring and review at their conclusion to inform broader collaborative activity.

4.3 Measuring our progress - How will we know we have made a difference?

COORDINARE, ISLHD and SNSWLHD will measure progress against the plan and review and evaluate the effectiveness and sustainability of actions at key milestones to inform future activity. A key focus of this measurement will need to be on whether systems and tools are available to support collaborative action as well as on how joined up actions have impacted consumer care and the workforce.

It is not intended that monitoring and evaluation activity should duplicate or replace existing reporting and review obligations or place additional unreasonable or resource intensive reporting obligations on services. Instead it should harness information available to the three organisations and capture the ongoing input of both service users and the workforce delivering services to achieve integration and shared service development have been achieved.

In general monitoring will inform regular review and refinement of actions and activities, and support moving to more joined up approaches to service planning and development through a phased approach, as the below diagram outlines.



Monitoring activity in relation to the plan will take place through an annual report towards which all three organisations will contribute. The report will address:

- Progress against the key priority areas and actions
- Progress in putting in place the foundations and infrastructure to support collaborative planning, such as local governance
- Progress towards integrated service planning and development such as joint needs assessments or new collaborative service models at a local level.
- Areas of emerging need and shared concern for which collaborative action is required.
- Perceived progress against process indicators.

The report will report against a small number of process indicators:

- Extent to which consumers perceive services to be better linked together
- Extent to which service providers and workforce perceive

Review activity will be informed by more detailed mapping and shared needs assessment foreshadowed in the summary implementation strategy and by the outcome of early trials of integrated service delivery. As more detailed information becomes available about the nature of needs, and the efficacy of shared actions to address them, the actions within the plan may be revised or extended.

Evaluation of the plan will take place at the end of the five years. This evaluation will draw information from all three organisations against both process and outcome indicators and consider whether the overall objectives of the plan have been achieved. The evaluation will also inform future planning activity. Baseline information collected for the preparation of this plan and through more detailed mapping in the first year of its implementation will help to inform this evaluation.

Shared measurement strategies may also provide a more accurate picture of how different service systems are working together to support consumers. For example, follow- up after discharge from hospital following presentation for suicide attempt or crisis can be provided by either LHD or primary care provided services. Measurement of performance in this area should pick up both types of follow-up – at present it may focus solely on follow-up by LHD funded services, which may present a disincentive for collaboration.

A small number of key performance indicators (KPIs) have been developed to assist the focus of monitoring and evaluation activity. A difficulty faced in regional plans of this nature is that there are limited measures and information on the integration of care between primary care and specialists care and Commonwealth/state funded services, as the Fifth National Mental Health Plan has observed. The Fifth Plan has given priority to developing better information and measures of integration. These measures may help to inform measurement efforts over the life of this regional plan.

For the purpose of this plan, 16 indicators are suggested, broken into four key areas of focus. The first three groups are largely process indicators and include consumer indicators, workforce indicators, system wide indicators particularly focusing on integration. The fourth category presents a small number of core outcome indicators to support the final evaluation, in which all three organisations have a keen interest. Some indicators address more than one priority area.

Consumer indicators:

- Proportion of mental health consumers who report a positive experience of care (Source – YES survey)
- The number/proportion of people with severe and complex mental illness in the region who have a single multiagency care plan.
- The proportion of people with severe and complex mental illness who receive regular physical health checks.

Workforce indicators

- Proportion of the total mental health workforce accounted for by the mental health peer workforce.
- Reported confidence and satisfaction of regional mental health workforce
- Number of specialised mental health professionals (psychiatrists, clinical psychologists, mental health nurses) providing services in rural locations.

System indicators

- The proportion of presentations to hospital for a suicide attempt for which there was a follow-up in the community within an appropriate time after discharge by either primary care or LHD funded services.
- The proportion of consumers who report that their services are linked together
- Proportion of service organisations offering or promoting on-line or telehealth services as part of their care.
- The proportion of admissions to a specialized mental health unit that are followed by an unplanned readmission within 28 days of discharge

Outcome indicators

- Proportion of adults over 18 with very high levels of psychological distress
- Proportion of Aboriginal and Torres Strait Islander people with very high levels of psychological distress,
- The number of people with a mental illness who have been hospitalised for an avoidable physical illness in the previous 12 months
- Number of suicides per 100,000 population.

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