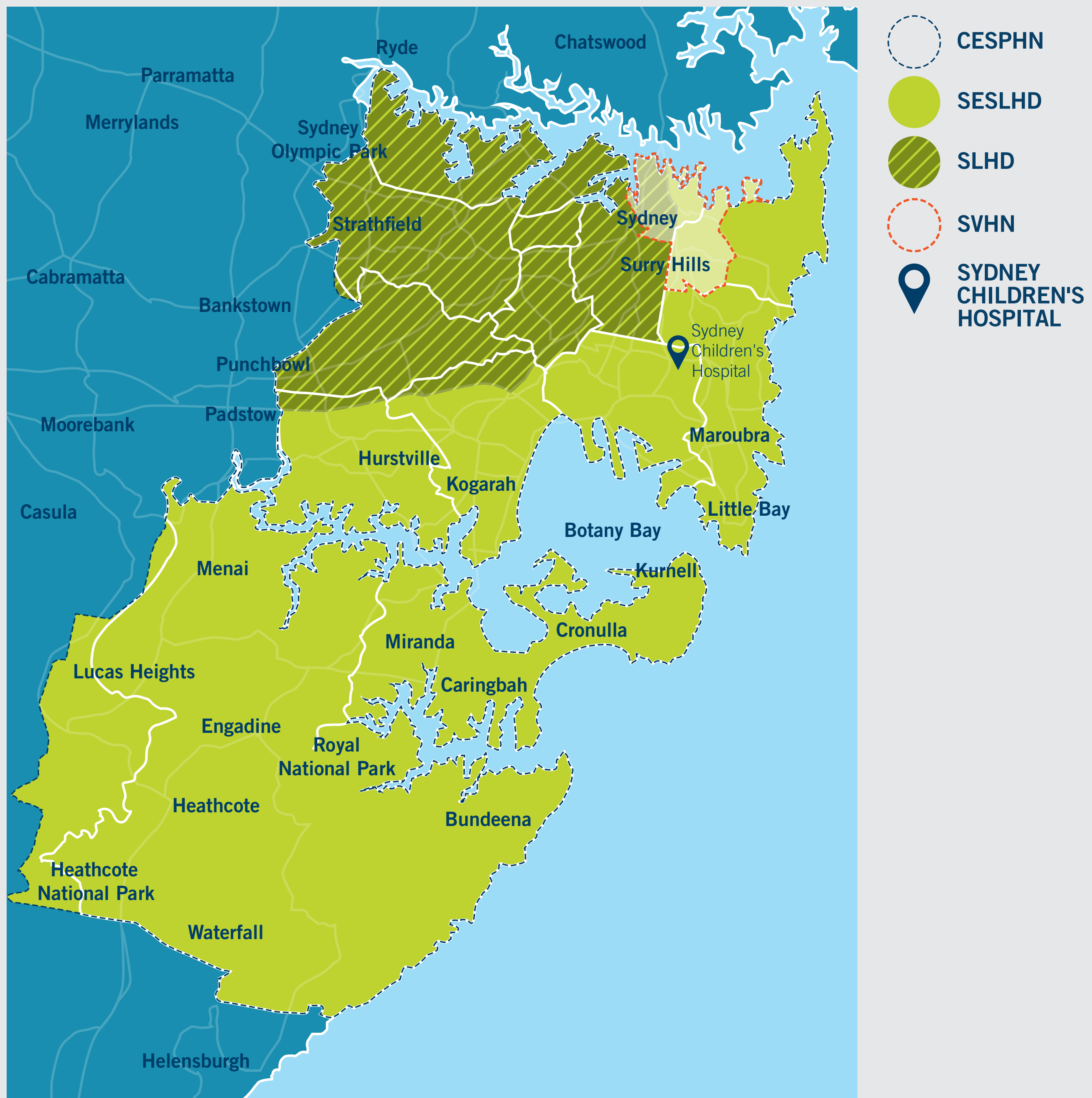
Central and Eastern Sydney

2019 - 2022

CENTRAL AND EASTERN SYDNEY



KEY READING:

- Fifth National Mental Health and Suicide Prevention Plan and Implementation Plan
- Living Well - A Strategic Plan for Mental Health in NSW
- Equally Well Consensus Statement
- Gaya Dhuwi (Proud Spirit) Declaration Implementation Guide
- Strategic Framework for Suicide Prevention in NSW 2018-2023
- NSW Strategic Framework and Workforce Plan for Mental Health

THIS PLAN HAS BEEN DEVELOPED BY:

CENTRAL AND EASTERN SYDNEY PHN
www.cesphn.org.au

SOUTH EASTERN SYDNEY LOCAL HEALTH DISTRICT
www.seslhd.health.nsw.gov.au

SYDNEY LOCAL HEALTH DISTRICT
www.slhd.nsw.gov.au

ST VINCENT'S HEALTH NETWORK
www.svhs.org.au

SYDNEY CHILDREN'S HOSPITAL NETWORK
www.schn.health.nsw.gov.au

BEING NSW
www.being.org.au

MENTAL HEALTH CARERS NSW
www.mentalhealthcarersnsw.org

MENTAL HEALTH COORDINATING COUNCIL
www.mhcc.org.au

FOREWORD

The Fifth National Mental Health and Suicide Prevention Plan was endorsed by the Australian Government and State and Territory Health Ministers in August 2017. This plan establishes an expectation about the development of regional mental health and suicide prevention plans by Primary Health Networks, Local Health Districts and Speciality Health Networks.

As a joint plan, this Regional Plan commits the Central and Eastern Sydney PHN, Sydney Local Health District, South Eastern Sydney Local Health District, St Vincent's Health Network and the Sydney Children's Hospital to work together to achieve integration in planning and service delivery. Joining this consortium in developing and implementing this Regional Plan, are the peak bodies for people with lived experience (Being NSW), for carers (NSW Mental Health Carers), and community managed organisations (the Mental Health Coordinating Council). This Regional Plan establishes a platform from which we will engage with other key agencies and stakeholders to work together and combine resources in the pursuit of shared priorities identified by the community.

As you will see throughout the Regional Plan, we take seriously our obligation to ensure that consumers and carers are central to the way in which services are planned, delivered and evaluated.

This 2-year Regional Plan for the Central and Eastern Sydney region is the outcome of extensive consultation conducted throughout 2018, involving people with lived experience of mental illness and distress, the mental health and suicide prevention sectors, Aboriginal and Torres Strait Islander organisations, and a range of stakeholders. We would like to extend our sincere thanks to all individuals and organisations who contributed to this Regional Plan.

We look forward to working with you as we begin implementation.

Dr. Michael Moore - Chief Executive Officer, Central and Eastern Sydney Primary Health Network

Dr. Teresa Anderson - Chief Executive, Sydney Local Health District

Tobi Wilson - Chief Executive, South Eastern Sydney Local Health District

A/Prof. Anthony Schembri - Chief Executive Officer, St Vincent's Health Network

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Jonathan Harms - Chief Executive Officer, Mental Health Carers NSW Inc

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KEY TERMINOLOGY

Carer	Carers are people who provide unpaid care and support to family members and friends who have a mental illness.
Chronic disease	Chronic diseases are long lasting conditions with persistent effects (Australian Institute of Health and Welfare).
Clinical Governance	Clinical Governance is responsibilities set by a service to ensure good clinical outcomes. Clinical Governance helps to ensure that systems are in place to deliver safe and high-quality care, and continuously improve services. More information about Clinical Governance in Australian Healthcare services can be found here.
Co-design	Engagement of consumers, carers and people with lived experience as partners in development and delivery of stepped care services is vital to get the best results and ensure that stepped care genuinely promotes person centred care. Ideally, consumer and carer co-design commences at the beginning of service design and must be appropriately resourced.
Commissioning	Commissioning is a term used to describe how services are purchased or funded. Commissioning includes needs assessment, priority setting, procurement through contracts, monitoring of service delivery, and review and evaluation (Department of Health, 2016).
Consumer	A person who is currently using, or has previously used, a mental health service. A consumer may also be used to describe a person who might need to use mental health service (National Standards for Mental Health Services).
Discrimination	Discrimination happens when a person or group of people are treated less favourably than another person or group of people because of their background or certain personal characteristics (e.g., age, gender, sexuality, health status) (Human Rights Commission of Australia) and includes homophobia and transphobia.
Head to Health	Is an online gateway to mental health information, resources, and services.
Integration	There are various definitions of integration and integrated care. In its simplest form, integration is how services work together, communicate, and create an experience of care for the consumer that is seamless and connected.
Models of care	A model of care is a defined way of delivering a service. The model of care describes the tasks, activities and the way the service is delivered.
Multi-agency	Where a group of agencies work together and combine resources.
Multi-disciplinary care	Multi-disciplinary care occurs when professionals from a range of disciplines bring complimentary skills, knowledge and experience to provide the best possible care for an individual.
National Mental Health Services Planning Framework	The NMHSPF is used by governments and service providers to estimate need and expected demand for mental health care and the level and mix of mental health services required for a given population.
No wrong door	The National Mental Health Commission describes a "no wrong door" approach as "every door in the service system should be the right door with a range of services being accessible to everyone from multiple points of entry. This commits all services to respond to the individual's needs through either providing direct services for both their mental health and drug and alcohol problems or linkage and case co-ordination, rather than sending a person from one agency to another."
Peer work	A mental health peer worker is someone employed on the basis of their personal lived experience of mental illness and recovery (consumer peer worker), or their experience of supporting family or friends with mental illness (carer peer worker) (Peer Work Hub, NSW Mental Health Commission).
Primary mental healthcare	Primary mental healthcare has general practice at its core. Primary mental healthcare services are based in the community, are broad-ranging and include health promotion, prevention and screening, early intervention and treatment.

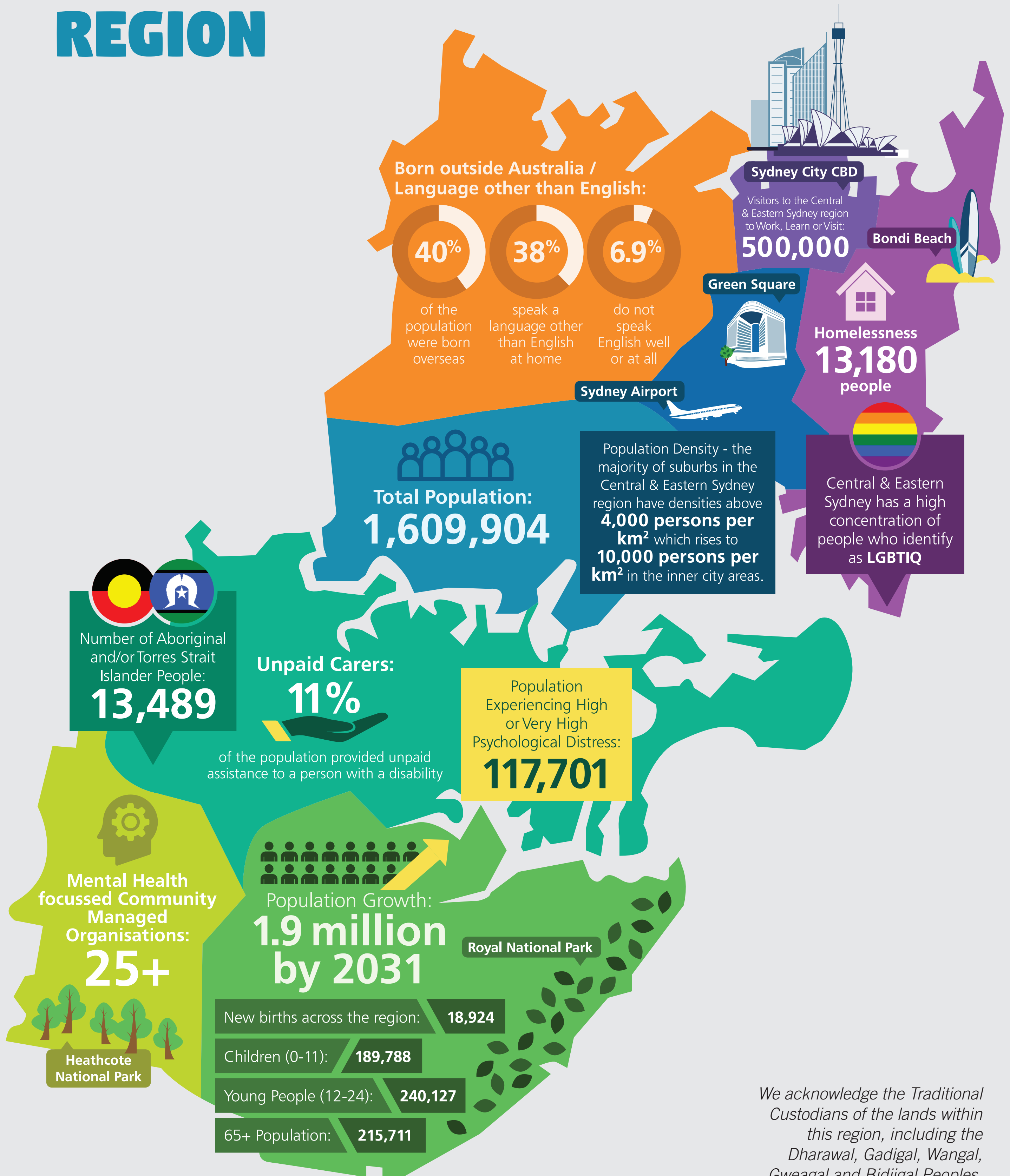
Referral pathways	A referral pathway is a resource that helps consumers and referrers to understand their assessment and intervention options and provides information on how to refer to local services.
Shared decision making	In partnership with their clinician, patients are encouraged to consider available screening, treatment, or management options and the likely benefits and harms of each, to communicate their preferences, and help select the course of action that best fits these (Australian Commission on Safety and Quality in Healthcare).
Stepped care	A stepped care approach promotes person centred care which targets the needs of the individual. Rather than offering a one size fits all approach to care, individuals will be more likely to receive a service which more optimally matches their needs, does not under or over service them, and makes the best use of workforce and technology. A stepped care approach also presumes early intervention – providing the right service at the right time, and having lower intensity steps available to support individuals before an illness develops or gets worse (Department of Health, 2019).
Stigma	Stigma against people with mental illness involves a variety of myths, prejudices, and negative stereotypes about mental illness. Stigma includes inaccurate or harmful representations of people as violent, comical or incompetent (SANE Australia).
Systems approach to suicide prevention	In addition to clinical services, a wide range of activities have been shown to assist in reducing suicide rates and these are outlined in Priority Area 5 of this Regional Plan.
Trauma	Trauma can arise from a single or repeated event that threatens to overwhelm a person's ability to cope. When it is repeated and extreme, occurs over a long time, or is perpetrated in childhood by care-givers it is called complex trauma (Blue Knot Foundation).

ACRONYMS

ACCHO	Aboriginal Community Controlled Health Organisation
ACI	Agency for Clinical Innovation
AMS	Aboriginal Medical Service
AOD	Alcohol and Other Drugs
CALD	Culturally and linguistically diverse
CESPHN	Central and Eastern Sydney PHN
CMO	Community Managed Organisation
GP	General Practitioner
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer
LHD	Local Health District
LHN	Local Hospital Network
MHCC	Mental Health Coordinating Council
NDIS	National Disability Insurance Scheme
NMHSPF	National Mental Health Services Planning Framework
PREM	Patient reported experience measure
PROM	Patient reported outcome measure
SCHN	Sydney Children's Hospital Network
SESLHD	South Eastern Sydney Local Health District
SLHD	Sydney Local Health District
STARTTS	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Victims
SVHN	St Vincent's Health Network
TMHC	Transcultural Mental Health Centre
YES	Your Experience of Service

A SNAPSHOT OF THE CENTRAL AND EASTERN SYDNEY REGION

The region covered by this Plan extends from Sydney's Central Business District to the Royal National Park in the south and from Strathfield in the inner west to Bondi Beach in the east, spanning 626 square kilometres and 13 Local Government Areas with a population of over 1,630,000 people.



We acknowledge the Traditional Custodians of the lands within this region, including the Dharawal, Gadigal, Wangal, Gweagal and Bidjigal Peoples.

SECTION ONE: ABOUT THIS REGIONAL PLAN

The Central and Eastern Sydney Regional Mental Health and Suicide Prevention Plan (the Regional Plan) is an agreement about what needs to change, by when, how, and who will be responsible for making the change happen. The Regional Plan has a 3-year focus (2019-2022) and will guide high quality decision making, ensuring that resources are targeted to best respond to local mental health and suicide prevention needs. The Regional Plan is underpinned by 7 key priority areas (see Figure 1 below).

Figure 1: Regional Plan Priority Areas

The aim of the Regional Plan is to improve the mental health, and physical health and wellbeing of people with (or at risk of) mental health issues or at risk of suicide. This Regional Plan provides a regional platform for addressing many frustrations which people with lived experience of mental health issues or suicide risk and their carers and families currently face when accessing (or attempting to access) the local system. This includes fragmentation of services and pathways, gaps, duplication and inefficiencies in service provision, and a lack of person centred care.

This Regional Plan also acknowledges that there is some exceptional work underway in Central and Eastern Sydney and seeks to expand what is working well.

This Regional Plan will inform the coordinated commissioning of services across the lifespan, using a stepped care approach (see Appendix One).

1.1 DEVELOPING THIS PLAN

This Regional Plan has been developed in partnership with local communities and stakeholders over a 12-month period. The Steering Committee first undertook an analysis of the most recent data to examine local treatment and service needs. The Steering Committee then considered and mapped the expectations outlined in National and NSW Government policies. Along with the expectations of local service providers, people with lived experience, carers and communities, the Regional Plan includes actions identified by Government as requiring regional attention and brings together a range of strategies and ambitions under one plan. Policies and existing strategies relevant to this planning process are included in Figure 2 below.

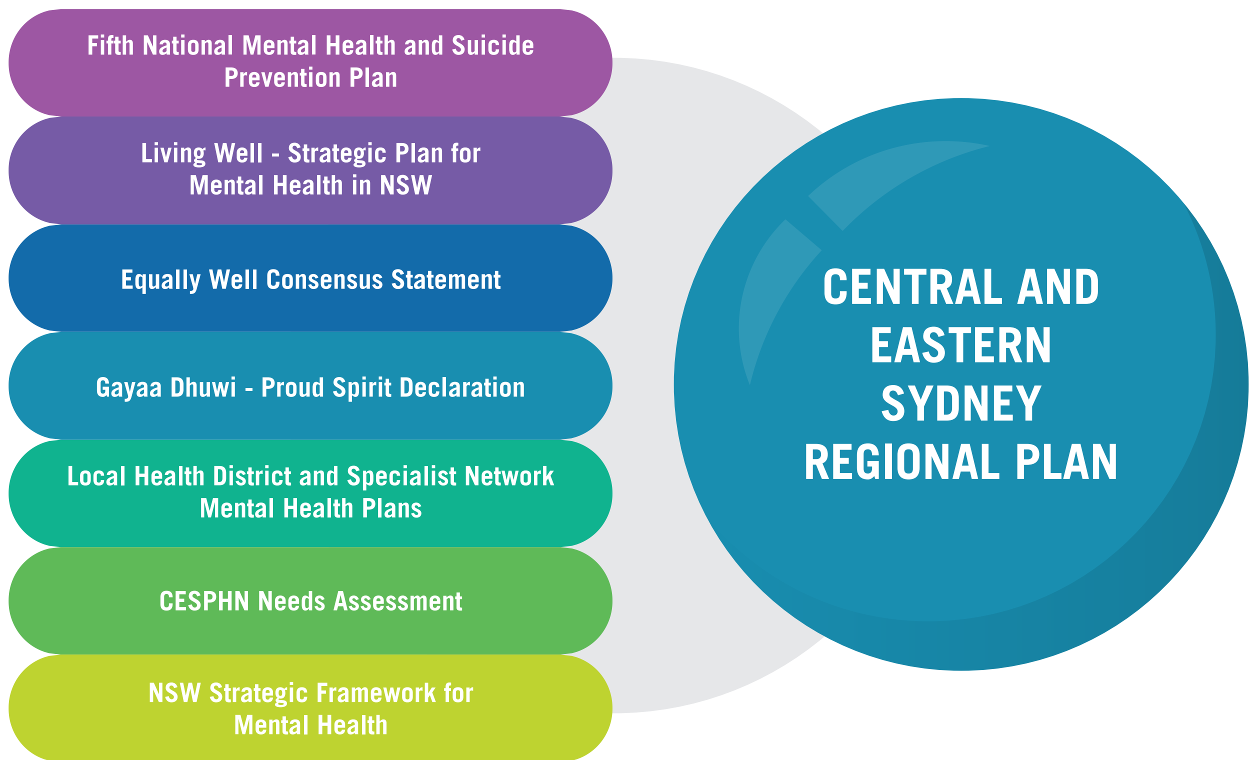


Figure 2: Relevant policies and strategies informing the Central and Eastern Sydney Regional Mental Health and Suicide Prevention Plan

In November 2018, the Steering Committee embarked on a community consultation process. The community consultation process involved discussions with (and input from) more than 250 local stakeholders and included health service providers, people with a lived experience, carers and family members. These consultations were incredibly important to understand more about treatment and service needs, working with the community to develop possible solutions and prioritising actions.

Following an extensive community consultation process, the Steering Committee developed the Consultation Draft of the Central and Eastern Sydney Regional Mental Health and Suicide Prevention Plan and sought feedback via public consultation.

From April - June 2019, the Steering Committee released the Draft Actions and invited the community and stakeholders to provide feedback on the Draft Actions via an online survey, interviews and written submissions. See Appendix Two for a summary of key themes emerging from the consultations.

1.2 THE VISION

Our vision is for a mental health system that:

- Promotes mental and physical health and wellbeing.
- Prevents mental ill health and distress, and provides timely early intervention.
- Detects mental illness and distress early and enables recovery.
- Provides effective, appropriate, timely and integrated treatment and support.

1.3 GUIDING PRINCIPLES

We uphold the principle articulated in the National Mental Health Policy that acknowledges that people with a lived experience of mental health issues, and their carers, have vital contributions to make and are key partners in planning and decision-making.

Our view is that people with a lived experience of mental health issues, and carers must be at the centre of, and enabled to take, an active role in shaping the way in which services are planned, delivered and evaluated.

We acknowledge the statements in the Strategic Framework for Suicide Prevention in NSW (2018-2023) that there are many factors that influence suicidal thoughts and attempts. Mental illness is not always a factor. There are a range of factors including individual, situational, and social/cultural factors that can contribute to suicidal thoughts and attempts. Factors including trauma, substance use, job loss, and relationship breakdowns are just some examples.

1.4 OVERARCHING COMMITMENTS

In accordance with the expectations of the Fifth National Mental Health and Suicide Prevention Plan, the following core actions are central to the entire Regional Plan:

a) Undertake joint regional mental health needs assessment using timely, local and comparative data to identify gaps, duplication and inefficiencies to make better use of existing resources and improve sustainability.

b) Establish 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.

c) Implement the National Framework for Recovery-Oriented Mental Health Services.

d) Undertake pro-active, genuine and supportive engagement and co-design with people who have a lived experience of mental health issues or suicide risk, and their carers, and routinely evaluate engagement activities.

e) Continue to encourage and embed a no wrong door approach across the mental health sector and beyond.

f) Support the development and implementation of future state-wide and national plans to improve mental health and wellbeing.

g) Implement shared clinical governance mechanisms and quality processes including:

    - Routine monitoring of comprehensive assessment.
    - Collaborative treatment planning.
    - Provision of tailored evidence-based interventions.
    - Supported referral processes that address the holistic service needs of consumers.
    - Rates of disengagement.
    - Review of adverse events.

1.5 GOVERNANCE ARRANGEMENTS

The Central and Eastern Sydney Regional Mental Health and Suicide Prevention Plan has been jointly developed by:

- Central and Eastern Sydney PHN (CESPHN)
- Sydney Local Health District (SLHD)
- South Eastern Sydney Local Health District (SESLHD)
- St Vincent's Health Network (SVHN)
- Sydney Children's Hospital Network (SCHN)
- Mental Health Carers NSW Inc
- Being NSW

The Mental Health Coordinating Council (MHCC) participated as an associate member of the Steering Committee, providing excellent expert advice and input. The Steering Committee has received considerable input and advice from the Central and Eastern Sydney PHN Mental Health and Suicide Prevention Advisory Committee.

These organisations form the Steering Committee responsible for development, implementation, monitoring, evaluation and reporting of the Regional Plan.

The Steering Committee will meet regularly throughout the life of the Regional Plan to:

a) Undertake plan-level monitoring - focussed on monitoring overarching commitments within the Regional Plan and those actions where progress is disrupted.

b) Co-opt and engage additional members as required throughout the implementation of the Regional Plan, if doing so would improve progress against actions or the quality of the outcomes.

c) Address significant barriers to implementation of the Regional Plan (e.g. funding, policy directives, pockets of resistance).

d) Ensure that the Regional Plan is appropriately funded and resourced.

e) Provide ongoing guidance and advice to the Implementation Committee (including advice about the evolution of the Regional Plan and rationale for associated actions).

f) Undertake internal and public reporting on the progress of the Regional Plan.

The Steering Committee will be supported by an Implementation Committee, who will be responsible for developing an Implementation Plan. The Implementation Plan will include performance indicators, responsibilities and timeframes. The Implementation Committee is also responsible for:

a) Undertaking action-level monitoring - focussed on monitoring progress against individual actions within the Regional Plan and reporting to the Steering Committee.

b) Addressing operational barriers to implementation of individual actions (e.g., insufficient resources, lack of data, disengaged stakeholders).

c) Lobbying, advocating and applying for funding and/or resources where required by a working group.

d) Providing ongoing guidance and advice to the working groups.

Significantly, there will be a need to form or build upon strong partnerships with agencies like Family and Community Services, Justice, Education and others.

The Governance arrangements for this Regional Plan are captured in Figure 3 below.

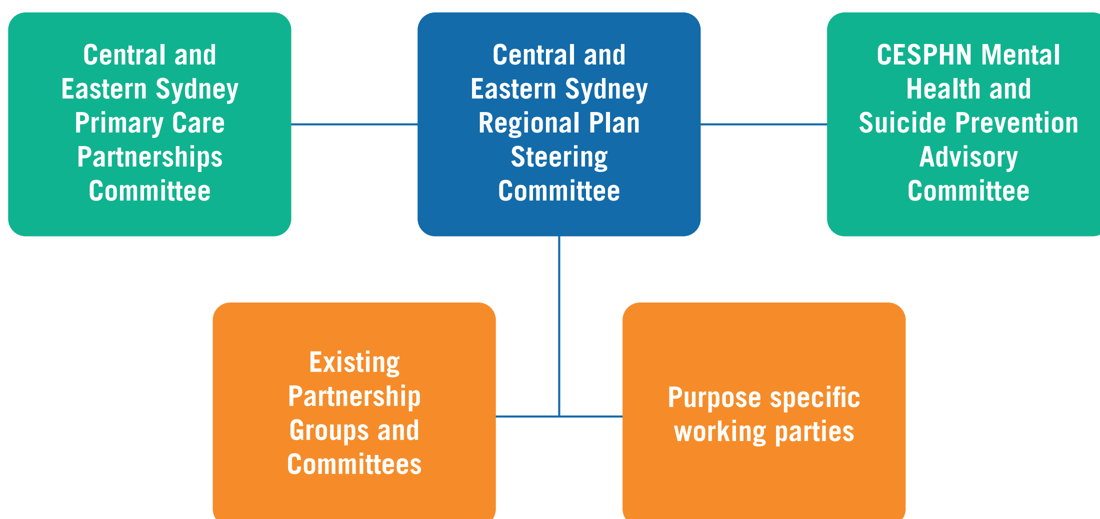


Figure 3: Regional Plan Governance Arrangements

PLAN ON A PAGE

VISION

Our vision is for a mental health system that:

- Promotes mental and physical health and wellbeing.
- Prevents mental ill health and distress and provides timely early intervention.
- Detects mental illness and distress early and enables recovery.
- Provides effective, appropriate, timely and integrated treatment and support.

GUIDING PRINCIPLES

- People with a lived experience of mental health issues, and carers, have vital contributions to make and are key partners in planning and decision-making.
- People with a lived experience of mental health issues, and carers must be at the centre of, and enabled to take an active role in shaping, the way in which services are planned, delivered and evaluated.
- Many factors influence suicidal thoughts and attempts.

OVERARCHING COMMITMENTS

In accordance with the expectations of the Fifth National Mental Health and Suicide Prevention Plan, the following core actions are central to the entire Regional Plan:

a) Undertake joint regional mental health needs assessment using timely, local, and comparative data to identify gaps, duplication and inefficiencies to make better use of existing resources and improve sustainability.

b) Establish innovative funding models, such as joint commissioning of services, and fund pooling for packages of care and support.

c) Use the National Mental Health Services Planning Framework to inform resourcing and funding decisions.

d) Undertake pro-active, genuine and supportive engagement and co-design with people who have a lived experience of mental health issues or suicide risk, and carers.

e) Continue to encourage and embed a no wrong door approach across the mental health sector and beyond.

f) Support the development and implementation of future state-wide and national plans to improve mental health and wellbeing.

g) Implement shared clinical governance mechanisms and quality processes.

PRIORITY AREAS

1. An accessible and equitable system
2. Improving the mental health of priority population groups
3. The physical health of people with mental illness
4. Aboriginal mental health and suicide prevention
5. Suicide prevention
6. Integrated services
7. Workforce

SECTION TWO: PRIORITIES AND ACTIONS

PRIORITY AREA ONE: AN ACCESSIBLE AND EQUITABLE SYSTEM

OBJECTIVE:

People in Central and Eastern Sydney have access to the information and services they need, when they need them. Importantly, this priority area reinforces a commitment to a service system that adopts a no wrong door approach.

A lived experience perspective – JENNY

Mental illness has been a family affair for over 25 years. It started with my father having a few psychotic episodes back in 1992 - when no one really talked about mental illness. As a family we weren't given any information which made the experience of mental illness very difficult. If someone at the time had explained it to us, we would have better understood what we were dealing with. My sister also started experiencing suicidal thoughts, panic attacks, self-harm, and attempted suicide. Following discharge from hospital, the support my sister and family received was not helpful.

When I was in my 30's my own mental health took a turn for the worse and I became very depressed. I wasn't coping with life. I had no confidence. I gave up on everything I previously enjoyed. I knew there was something wrong and I had to act, so I saw my GP who was really helpful. My GP started me on anti-depressants and organised some counselling.

Over the last 12-years, my Mum, sister and I have been involved with a non-profit organisation. We joined their education team as speakers. I also joined the consumer committee and volunteered on their helpline for over 2-years and have recently become a member of the Board of Directors.

This priority area is important to me because having accurate information and access to appropriate services and supports a person needs, when they need them, is vital. Otherwise it can be a challenging and confusing time for both families and individuals. There are many services and programs funded by governments - but these are constantly changing, have stringent criteria, and long waiting lists. Coping with ineligibility is hard when you need help. The current system is difficult to navigate, and can be a bit like going around in circles - you keep coming back to the same point and don't achieve an outcome.

I am hopeful that the actions in this Regional Plan will focus on alleviating the confusion that is often experienced when seeking the right service and supports. My hope is that we see the right amount and type of services available in the area and that services are provided at a time and place best suited to the individual. These actions also have the potential to address the lack of awareness about services available and how to access them. Most of all, I am hopeful that people with a lived experience of mental illness will have more control about the services and types of treatment or support they may need.

PRIORITY AREA ONE – ACTIONS

SERVICE AWARENESS

1.1 Promote the various mental health service directories available for use by local communities (including Head to Health).

1.2 Provide clearer information and undertake a communication campaign about services available for people to use in a crisis.

1.3 Prioritise funding (and advocate for more funding) for services and resources that assist consumers, carers and families to navigate the system.

1.4 Continue to build and promote healthcare pathways and other tools, so that GPs and other stakeholders have information about services available throughout the region. Pathways will include health, social and other support services (e.g. peer support groups).

1.5 Explore how to make information about local health pathways more readily available to community members.

SERVICE AVAILABILITY

1.6 Use the National Mental Health Service Planning Framework (NMHSPF) to determine the mix of services needed for the population and work collaboratively to achieve service levels that match community needs.

1.7 Continue to build a system around stepped care and regularly evaluate progress.

1.8 Encourage services to provide a "no wrong door" approach to people who are not eligible for their service and, wherever possible, the service provides support to find a suitable alternative service.

1.9 Promote and support evidence-based virtual and telehealth services to expand access.

SERVICE RESPONSIVENESS

1.10 Maintain an expectation of compliance and/or accreditation with the National Standards for Mental Health Services.

1.11 Undertake a range of community training and skill development initiatives to improve consumer and carer confidence in shared decision making.

1.12 Promote and advance the use of experience of care measures and involve people with a lived experience (e.g. peer workers and lived experience researchers) to plan and implement improvements. This will include the use of:

- The Your Experience of Service (YES) survey;
- The NSW Agency for Clinical Innovation (ACI) Patient Reported Outcome Measures (PROMs); and
- The NSW ACI Patient Reported Experience Measures (PREMs) and carer experience surveys.

1.13 Facilitate service design, implementation, delivery and evaluation that are co-designed by people with a lived experience and carers - and provide support so participation is meaningful, including through remuneration for time, access to mentoring, and training.

1.14 Engage people with lived experience (e.g. peer workers and lived experience researchers) as part of the quality improvement cycle (from problem identification through to solution implementation).

1.15 Advocate for new and existing service models to have improved flexibility and responsiveness, with broader eligibility criteria, a variety of modalities (e.g. digital, telephone, group) and with varying operating times (including weekends and after hours). This action also includes promoting the services of those providers that already provide flexible options.

1.16 Explore opportunities to increase access to affordable primary mental healthcare.

1.17 New service models will be piloted and evaluated, using peer researchers where possible.

1.18 Explore and establish benchmarks for recovery orientated culture to inform ongoing quality improvement.

PRIORITY AREA TWO:
IMPROVING THE MENTAL HEALTH OF PRIORITY POPULATION GROUPS

OBJECTIVE:

The service system delivers informed and responsive services that meet the needs of the diverse communities in the Central and Eastern Sydney region. The priority groups identified are:

- Children and young people
- Culturally and linguistically diverse communities
- Older people
- People who are homeless
- People experiencing mental illness
- People with co-existing drug and alcohol issues
- People who are lesbian, gay, bisexual, transgender and/or queer
- People experiencing a disability
- People experiencing chronic ill health
- Parents experiencing perinatal mental health issues
- People leaving custodial arrangements
- Refugee and asylum seekers

A lived experience perspective – VERONICA

I have a 30-year lived experience of mental health issues and have been diagnosed with complex trauma and a generalised anxiety disorder (which manifests in depression and disordered eating). My first contact with the mental health system was in 1999 when I was diagnosed with anorexia nervosa. A good rapport with a GP has made access to psychological services, medications and other therapies possible. I have accessed services through the public and private health sectors, in inpatient and outpatient treatment settings, hospital emergency departments, rehabilitation services, and through social support provided by Community Managed Organisations (CMOs).

I have probably encountered fewer barriers to accessing mental health treatment than many Australians from culturally diverse, migrant and refugee backgrounds. For example, I have not experienced the language barriers that exclude many people from CALD backgrounds from accessing relevant mental health information, supports and treatment.

Nonetheless, cultural misunderstandings have often undermined my treatment. I would have experienced better outcomes if the system had situated my mental health in the context of my parents' migration experiences, the impact of intergenerational trauma upon my identity, sense of self and belonging, and recognised my illness as the product of a lifelong struggle to adapt to and live between two cultures. To the extent that my culture has been recognised, it has only ever been in relation to the important (but limited) context of personal or individual distress. Services have also failed to address the importance of family and cultural connections.

In an increasingly culturally diverse region like Central and Eastern Sydney, mental health services need to be developing more effective ways of responding to cultural difference. Services need to recognise that interpretations of mental distress vary and that support seeking behaviours are shaped by cultural difference. The system will be able to engage more effectively with culturally diverse communities if culturally responsive approaches are embedded in service priorities and healthcare practices, and if services/programs can target their strategies to respond to increasingly diverse cultural experiences.

We do not know enough about the mental health of people from CALD backgrounds living in our region, how they access mental health support or experience the health system. We do know that people from CALD backgrounds have lower rates of service use and access, as a result of a range of cultural and language barriers. This suggests a need for coordinated efforts to understand the experiences of this population group.

Without coordinated action we will continue to see CALD communities remaining excluded from the same quality and standards of mental healthcare as other Australians.

It is my hope that this Regional Plan will contribute to building a system that adopts more culturally competent approaches to mental health.Where services implement culturally inclusive practices, and we work closely with community members to address access barriers confronting people from culturally diverse backgrounds living with mental health issues.

PRIORITY AREA TWO – ACTIONS

INFORMED AND RESPONSIVE SERVICES

2.1 Be informed by the experiences and service needs of people who are part of a priority population group and:

- **2.1.1** Work with peak bodies and lived experience representatives to develop service models, procurement activities, projects, referral and transitional care pathways and evaluation activities that are safe, appropriate and relevant.
- **2.1.2** Address discrimination, stigma, and racism within the health and mental health workforce, and within the broader community, through strong lived experience leadership, workforce diversity and education opportunities.
- **2.1.3** Grow the proportion of the workforce who identify as being part of a priority population group (e.g. LGBTIQ).
- **2.1.4** Improve data collection and analysis to understand the differences in access rates, service experiences and outcomes for people from priority population groups and use that data to make better decisions about service models, planning and availability (e.g. collection of cultural background, sexuality and gender).
- **2.1.5** Support communities, community-controlled organisations, and peak bodies to take the lead in designing and delivering services relevant to their specific priority population.

2.2 Develop healthcare pathways for general practice and other providers regarding assessment and treatment for priority population groups within a stepped care approach and:

- **2.2.1** Develop healthcare pathways that focus on the critical transition points between mental health and other key services:
  - » Between youth services to adult services
  - » From out-of-home care settings to family of origin or independent living
  - » From hospital to community/primary care
  - » From AOD rehabilitation settings to community
  - » Between public, private and community managed mental health services
  - » Throughout the perinatal stages for parents
  - » Between custodial settings and community
  - » Between mental health services and disability services

2.3 Facilitate professional development activities focussed on working therapeutically with priority population groups. This includes supporting the development of new training programs.

2.4 Establish and/or promote additional clinical/consultancy services to enhance quality of care provided by general practice, mental health services, drug health services, hospital emergency departments and community services.

2.5	Explore opportunities to integrate services with public and community housing where many tenants experience mental health issues - with a focus on areas where there is a gap in services.
2.6	Encourage the use of Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers and facilitate professional development in the recognition, assessment, referral pathways and treatment for clinicians working with people with an intellectual disability and mental health issues.
2.7	Support the implementation of the NSW Older People's Mental Health Services SERVICE PLAN 2017-2027.
2.8	Support the implementation of the Blueprint for Improving the Health & Wellbeing of the Trans & Gender Diverse Community in NSW and build the capacity of GPs to provide gender affirming care for trans and gender diverse people.
2.9	Establish and formalise a region-wide collaborative structure focussed on improved mental health outcomes for people at risk of entering or leaving custodial arrangements. This collaboration will focus on supporting existing diversionary efforts and supporting transition to community for people who experience mental health issues.
2.10	Improve the identification rate for people from priority populations through simple registration processes including traditional methods such as forms and technologies.
CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES	
2.11	Enhance partnerships and improve communication with the Transcultural Mental Health Centre (TMHC) and the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Victims (STARTTS).
2.12	Establish and maintain effective links with Community Managed Organisations (CMOs) that provide initial support for refugees and asylum seekers to enhance the provision and coordination of services.
2.13	Continue to facilitate and prioritise cultural competency training for mental health staff and general practice.
2.14	Implement the Transcultural Assessment Module developed by the TMHC for outcome assessments and care planning in conjunction with the Transcultural Referral Guide and the Assessment Checklist.
2.15	Promote access to and use of interpreters and enhance the provision of interpreter services where gaps are identified.

PRIORITY AREA THREE:
THE PHYSICAL HEALTH OF PEOPLE WITH MENTAL ILLNESS

OBJECTIVE:

Services work together with consumers and implement actions that will improve quality of life and life expectancy for people with mental health issues.

A lived experience perspective - CAMERON

My experience is of a mood disorder, and I think bio-chemistry has been the driving factor of my depression. I'm fit and well, have a university degree, I'm a widely published freelance travel writer, guitar player, currently a tennis coach (Tennis Australia certified) and Head Trainer for Mood Active.

Through 1997-2001 I experienced panic attacks and crippling depression and Bondi Junction Community Mental Health referred me to the Black Dog Institute (BDI). I tried various medications as we searched for the best solution. I also volunteered for a Transcranial Magnetic Stimulation treatment trial, attended one or two bipolar support group meetings, and regularly consulted with a clinical psychologist. I felt then, and still do, that I was fortunate to have access to excellent clinical support.

My own experience using exercise to boost mental health was the catalyst for creating the Mood Active program, which today runs multiple group exercise classes targeted to people diagnosed with depression/anxiety/bipolar and other diagnoses. I have seen the enormous impact of exercise on a huge variety of people; however, it is still such an under-utilised and under-prescribed treatment option. I am determined to shift public awareness and healthcare policy in this area. Physical health interventions for mental health issues can make all the difference to a person's functioning. There are not enough programs that do something practical to boost a person's mental health.

Exercise has a mighty impact on three fronts - it's proven to help manage symptoms; it can provide a mental health boost (and can keep potential mental ill-health at bay) and; it can help manage the physical "side-effects" (better overall health, self-esteem, physical self-confidence, side-effects of medications).

It's important that GPs and other health professionals invest in interventions other than medications, and I hope this Regional Plan helps us to realise the power of health in both mind and body. Physical health interventions for mental health conditions can make all the difference in the world to a person's functioning in a family, workplace, and life.

PRIORITY AREA THREE – ACTIONS

INVESTING IN PROMISING PRACTICE

3.1 Work with local services to explore how they can expand their service models to improve their focus on physical health and their engagement with general practice.

3.2 Advocate for funding to build upon models that deliver multi-disciplinary comprehensive care in close collaboration with general practice.

3.3 Explore and define the role of peer workers in supporting improved physical health outcomes - recognising the strong connection between peer support, social interaction and physical activity.

EXCELLENCE IN PRIMARY CARE

3.4 Seek opportunities to build partnerships between specialist mental health services, hospitals, general practice, pharmacy and community services - to support the early detection and treatment of physical illness, prevention of chronic disease, and promotion of a healthy lifestyle.

3.5 Expand consumer access to comprehensive and multidisciplinary health expertise in partnership with GPs.

3.6 Promote and expand existing evidence-based healthy lifestyle, prevention and population health programs including exercise, weight loss, smoking cessation, sexual health and hepatitis C treatment programs.

3.7 Prioritise training for GPs and practice nurses on the risks and benefits of medications (including nicotine replacement therapy), and how to communicate these risks/benefits with consumers, carers and family members.

3.8 Provide community education and disseminate resources for consumers, carers and family members that help them to create a meaningful dialogue with GPs, pharmacists and other health professionals about medication, allied health and lifestyle changes.

3.9 Identify and introduce strategies that encourage timely and relevant communication across general practice, other primary care, specialist and community managed organisations.

EQUALLY WELL

The Equally Well Consensus Statement outlines six essential elements and a range of actions that provide guidance to health service organisations to improve the quality of life of people living with mental health issues. By pledging to the principles of the Consensus Statement organisations will collectively bridge the life expectancy gap between people living with mental health issues and the general population.

3.10 Support and uphold the principles of the Equally Well Consensus Statement and play an active role in the implementation of Equally Well actions, with a focus on those actions identified as requiring regional leadership:

- **3.10.1** Work together to coordinate and integrate specialist mental health services, general practice and community services - to support the early detection and treatment of physical illness, prevention of chronic disease and promotion of a healthy lifestyle.
- **3.10.2** Prioritise (or advocate for) funding to help provide targeted, personalised lifestyle care packages, and coordinated care.
- **3.10.3** Continue to guide, facilitate and establish care planning and collaborative care mechanisms to improve local integration and facilitate better coordination of relevant services for physical and mental health care.

PRIORITY AREA FOUR:
ABORIGINAL MENTAL HEALTH AND SUICIDE PREVENTION

OBJECTIVE:

Aboriginal and Torres Strait Islander Peoples experience improved emotional wellbeing and have improved access to, and experiences with, mental health and wellbeing services.

OVERARCHING COMMITMENT:

To support the implementation of Gayaa Dhuwi - a declaration on Aboriginal and Torres Strait Islander leadership across all parts of the local mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

ABORIGINAL KNOWLEDGE AND WISDOM DRIVING SERVICE DESIGN AND DELIVERY

4.1 Support and advocate for funding for service models that are informed by and consistent with the Aboriginal Social and Emotional Wellbeing Framework.

4.2 Support Aboriginal community members, Elders, Aboriginal Community-Controlled Organisations and peak bodies to take the lead in designing and delivering services (including the development of more meaningful performance indicators).

4.3 Ensure that there is strong presence of Aboriginal and Torres Strait Islander representation on local mental health service and related area service governance structures.

4.4 Enhance responsiveness to new or emerging issues within Aboriginal communities by establishing and continuing to build upon formal and informal partnerships, engagement, and consultation mechanisms with communities.

4.5 Invest in training delivered by Aboriginal Instructors for staff involved in the delivery of mental health services across a variety of settings. Training will incorporate historical, cultural and contemporary experiences of trauma.

4.6 Service providers are encouraged and supported to partner with Aboriginal communities to develop suicide prevention and response plans.

4.7 Service providers are encouraged and supported to partner with Aboriginal communities to develop sustainable and longer-term strategies for improving engagement with Aboriginal communities.

4.8 Partner with Aboriginal Peoples to develop strategies that can be applied during the commissioning process to determine suitability of providers seeking to deliver services to Aboriginal Peoples.

INVESTING IN THE ABORIGINAL COMMUNITY AND WORKFORCE

4.9 Partner with Aboriginal communities to explore opportunities to grow the Aboriginal mental health and peer workforce and locate Aboriginal workers at key transition points within the system (e.g. leaving hospital, release from custodial arrangements, during perinatal stages).

4.10 Utilise service models that engage the Aboriginal mental health workforce and ensure that training, supervision and mentoring arrangements are formalised and in place to adequately support this workforce.

4.11 Support education, supervision and mentoring for Aboriginal mental health clinical leaders, educators and clinicians.

4.12 Work with Aboriginal community members to identify and implement activities that help them to continue to support each other - particularly Elders and older community members who provide incredible and invaluable support to younger people in the community.

PRIORITY AREA FIVE: SUICIDE PREVENTION

OBJECTIVE:

Integrated and coordinated suicide prevention activities across multiple sectors and settings, using a systems approach to prevent suicide attempts and reduce suicide deaths.

OVERARCHING COMMITMENT:

To support the implementation of the Strategic Framework for Suicide Prevention in NSW 2018-2023 and the Towards Zero Suicide initiatives.

A lived experience perspective – PETER

I suppose I should start with the events that led up to my first suicide attempt. From the age of 11, I was physically and sexually abused. The sexual abuse stopped when I was 14-years-old. However, the physical abuse continued until I moved out of home at the age of 16. I did not tell anyone about what had happened for many years, things gradually worsened for me emotionally.

I had been married for approximately 15 years when I began to experience bad anxiety and depression. I thought that things would not get better so one night, after not being able to sleep for approximately 5 days, I attempted to take my own life. My wife called for an ambulance and I was taken to hospital where I stayed for 3 months. During this admission, other than medication, the only other treatment I received was a 20-minute talk with the social worker once a week.

After leaving hospital I continued to see the social worker as an outpatient. This helped immensely and continued for approximately 6 months. I have seen many psychologists about suicide and sexual abuse. Finding a clinician who was informed about mental health, suicide, and trauma seemed impossible. One psychologist did more harm than good. I did some research for myself and finally found a psychologist who had experience working with people who had experienced sexual abuse.

There have been times where I have attended hospital seeking help - this is often accompanied by long period of waiting. I have walked out and been turned away from hospital many times due to shortage of beds. The importance of timely and responsive services in a crisis cannot be under-estimated. No-one should be left without a service when they are thinking about suicide and in distress.

I hope that this plan results in suicidal crisis being considered as just as important as people presenting with physical health issues. Governments, policy makers and services need to ensure that support is available, timely, trauma-informed and of high quality.

PRIORITY AREA FIVE – ACTIONS

A SYSTEMS APPROACH TO PREVENTION

5.1 Prioritise resources (and advocate for more funding) to implement an integrated, systems approach to suicide prevention and invest in:

- **Surveillance** - coordinate access to better, more timely information about suicide deaths and attempts that occur in Central and Eastern Sydney. This means information and data would be available in days and weeks rather than months and years.
- **Means restriction** - reduce the availability and accessibility of the means to suicide. This will include expanded or new partnerships with local councils, emergency services and transport providers throughout the region.
- **Media** - promote local implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.
- **Access to services** - promote increased access to comprehensive services for those vulnerable and remove barriers to care. This will include a focus on services available for people experiencing a crisis (as well as carers and families).
- **Training and education** - maintain and facilitate a comprehensive training program for identified gatekeepers. Gatekeepers are approachable and respected community members, such as GPs, sports coaches, teachers, emergency services personnel, youth workers, clergy, pharmacists, aged care workers, leaders of community groups, and others who are likely to be in contact with individuals at risk of suicide.
- **Treatment** - improve the quality of care and access to therapeutic interventions. This will include equipping general practice to identify and provide evidence-based support for people in distress. This also includes exploring options to expand the availability of the peer workforce for people at risk of suicide or following an attempt.
- **Crisis interventions** - equip and support communities to respond safely to suicide-crises with appropriate and protective activities and interventions.
- **Postvention** - improve responses to individuals who have attempted suicide and advocate for additional funding to expand successful post-hospital service models. In the future, design services to better target carers and family members who have been bereaved by suicide.
- **Awareness** - reinforce and support public information campaigns to improve the knowledge that suicides are preventable.
- **Stigma reduction** - promote the importance of talking honestly about mental health and the importance of using mental health services.
- **Oversight and coordination** - prioritise suicide prevention and work with key stakeholders to coordinate needs assessment, planning and responses.

ALTERNATIVES TO HOSPITAL

5.2 Advocate for investment in a broader range of service options for Central and Eastern Sydney that include:

- A less restrictive care environment and protocol.
- Delivery in a comfortable and safe environment in the community (rather than a hospital).
- World-class therapy including cognitive behavioural therapy for the suicidal person and dialectical behavioural therapy.
- A strong multi-disciplinary team with specialist mental health support and consultation liaison available 24/7 including access to psychiatry, medical care, and peer support.
- Practical support to address underlying issues such as accommodation, employment, and personal finances that contribute to distress.
- Safety planning led by the individual and supported by families, carers and friends.

PRIORITY AREA SIX: INTEGRATED SERVICES

OBJECTIVE:

Services are integrated and tailored to the needs of consumers and carers. Services are easier to navigate and are delivered in the most effective and efficient way possible.

A lived experience perspective - NATTALEE

I was diagnosed with bipolar disorder 1 at the age of 16 and I am currently supported by a private psychiatrist and psychologist. I've had more than 10 hospitalisations and have been on the medication merry-go-round. There are some really important factors that have helped on my journey with mental illness and recovery - friends, an understanding family, my own illness research, good medication, my clinical team, helplines and the mental health crisis team.

Getting help hasn't always been easy. I found it difficult to find clinicians I felt comfortable with, or who had the right expertise to assist me. There are many services I have found on my own through online research. I believe these supports should be more readily available for all people experiencing mental illness. Human contact is beneficial to recovery so if these supports were provided by a nurse, caseworker or peer worker I think there would be a higher chance of patients accessing and engaging with these services.

The support from my psychiatrist and psychologist has been exceptional. Having the space to ask questions about my condition and the medications is very important to me. I now understand the importance of taking medication, how to take my medication, the side effects, and their interactions with other drugs. I hope this Regional Plan will help improve communication between clinicians such as GPs, pharmacists, hospital staff, and case workers. I've had great clinicians, but I've never been confident that they are working as a "team" for me.

Improving integration will, in turn, improve recovery and potentially prevent relapse for some people. Integration will also mean better support for carers, family and friends. The "system benefits" of integration are enormous - integration can improve cost-effectiveness (especially if it leads to fewer hospital admissions).

A lived experience perspective - MAG ELI

I was a fulltime carer until 3 months ago. For 8 years I have been caring for a beautiful young adult, who stumbled into the world of mental health in his teens. He entered hospitals and rehabs more times than one should and could ever imagine. The National Disability Insurance Scheme (NDIS) finally accepted him after a long wait, he is now provided with 24hr supported accommodation. This arrangement has not only saved his life but has also seen him improve in a structured environment.

When I stepped into this industry, I was a novice, and was not given any information about the system. Once I joined the carers group in the hospital, I asked how I could help more. Very quickly the facilitators encouraged me to participate more, and I found myself embraced in a web of support and knowledge. I cannot emphasize enough on how wonderful the carers support teams and organisations are and how crucial their role is in our survival.

I have mostly met fantastic caring and concerned professionals. I am so grateful for their help and empathy in the most difficult times. The Support Workers, Peer Workers and Carer Advocates were our lifeline. Honestly! How is one supposed to cope without their warmth, sense of humour, knowledge and shoulder to lean on? They are the unsung heroes.

There were also numerous frustrations like delays accessing services, failing to review medications and manage symptoms, lack of communication with carers, and services not communicating with each other.

I hope that this plan will lead to:

- Carers being involved as part of the care team and directed to services and support groups early in their journey.
- Better transmission of information across the system.
- A focus on simple strategies - like clear large information boards in all receptions of hospital wards.
- Better discharge planning with GP and peer worker involvement.

This system is complex and confusing - it's so important that we take the time needed to make sure consumers and carers are equipped with the knowledge, language and resources needed to get to the right care at the right time.

PRIORITY AREA SIX – ACTIONS

SERVICES WORKING TOGETHER

6.1 Implement a regional coordination function to:

- Connect state and commonwealth funded health service providers (e.g. LHDs/LHNs, PHNs, General Practice and CMOs) to plan and deliver integrated models of care.
- Develop and/or strengthen existing region-wide multi-agency agreements to improve integration.
- Ensure seamless continuity of care across acuity and care settings.
- Examine innovative funding models, such as joint commissioning of services and packages of care and support.
- Explore opportunities to focus on prevention, early intervention and recovery.

6.2 Explore opportunities for technology enabled access, care planning and care.

6.3 Ensure local intake systems are aware of the range of services available and are able to equip consumers and carers with information about the range of services available - helping people to connect with the right service for them.

LOW INTENSITY SERVICES

6.4 Support the expansion of easy to access low intensity mental health services. A range of evidence-based models will be available within the region including models appropriate for a range of community groups (e.g. people from culturally and linguistically diverse communities, older people living in Residential Aged Care Facilities).

6.5 Increase awareness and uptake of low intensity services - targeting communities most at risk of psychological distress including identified priority population groups.

6.6 Low intensity services will complement the variety of interventions available through the Digital Mental Health Gateway, using the resources within the Gateway to:

- Supplement local services.
- Target people who may benefit from early intervention.
- Step-down as an option.
- Support people to minimise the risk of relapse following exit from local services.

6.7 Low intensity interventions will have streamlined and simple referral arrangements and step-up/step-down protocols supporting people, whose treatment needs change, avoiding re-referral and re-entry into the system.

MODERATE INTENSITY SERVICES

6.8 Provide access to an improved amount and range of psychological therapies for people from under-serviced and priority population groups.

6.9 Investigate opportunities to expand referral pathways across the region ensuring that self-referrals and referrals from a range of professionals are encouraged.

MULTI-AGENCY CARE

6.10 Address the barriers encountered by people experiencing severe and complex mental health issues when accessing therapeutic interventions (including psychological interventions, peer support, group-based interventions and psychosocial supports) within primary care.

6.11 Implement strategies that provide options for people with severe and complex mental health issues who are ineligible for NDIS and prioritise this group for alternative service models.

6.12 Use NDIS uptake data to understand if eligible individuals with psychosocial disability are gaining access to the NDIS and work closely with key agencies to develop strategies that improve access to the NDIS for eligible individuals.

6.13 Continue to support shared care arrangements between LHDs/LHNs, GPs and Aboriginal Medical Services to support optimal mental health and physical health outcomes.

6.14 Advocate for funding to introduce more multi-service hubs where a range of mental health, general health, living skills, and social service needs can be addressed in one place.

6.15 Explore opportunities to embed mental health services within general practices to improve the experience of care for the consumer and enhance opportunities to multi-disciplinary shared care.

6.16 Equip general practice with the knowledge and skills required to identify and provide evidence-based support for people with severe mental illness.

SPECIALIST AND HOSPITAL SERVICES

6.17 Invest in systems that improve the timeliness and relevance of communication between hospitals, LHDs/LHNs, GPs, specialists, and CMOs to improve the quality of care experienced by consumers who access multiple services.

6.18 In collaboration with each LHD/LHN, the NSW Ministry of Health, GPs, specialists and CMOs (where appropriate), develop strategies for improving clinical handover processes.

6.19 Continue to resource psychiatry consultation liaison and assessment services for general practice.

6.20 Explore opportunities to increase access to bulk-billing and rebatable tele-psychiatry services.

PRIORITY AREA SEVEN:
WORKFORCE

OBJECTIVE:

The workforce is skilled, experienced, and supported to deliver high quality mental health care and support in a way that is valued by consumers, carers and family members and results in optimal recovery outcomes.

A lived experience perspective – ANTHONY

My experience with mental illness has lasted over 10 years. For the most part of this time, I was afraid of speaking about my illness (depression and anxiety) - particularly within the workplace and around my close friends, and I hid my experience from others. My turning point was telling my girlfriend. This was the first time I had ever told anyone about what was going on. This started the cascade of events where I began to tell others (best mates and family). I then went and saw my GP who put me on a mental health plan, soon after I went to see a psychologist and psychiatrist simultaneously.

The GP did well to recognise what was going on and to start some form of treatment. I was completely unaware of the mental health plan under Medicare before going to see him. He explained this service and put me in touch with a psychologist in my area. Having a "gatekeeper" who identified what was happening, explained my options and helped me to access services was important. I know from listening to others, that my initial experience accessing the system was much better than others. Working hard to make sure "gatekeepers" have the ability to identify, assess, and refer is a really important action.

For me, the game-changer was my first real conversation with my workplace manager at the time, who gave me the opportunity to open up in a safe environment, by asking the famous "R U OK" question. Honestly, this conversation could not have gone better. It really did change my entire life and changed me forever. After this, I started working in the psychological safety space for the company. This gave me purpose - I wanted to create and design an environment where people could speak up about their own struggles with mental health.

When we talk about building awareness, reducing stigma and developing capabilities, we need to think about the potential "first responders" - like friends, family, and workplaces. In the future, I hope that seeking help is not as difficult as it was for me. I would like to see more avenues, methods and touch points for people to seek help.

I hope the actions in this Regional Plan help to equip services in and out of the mental health sector with the skills needed to respond to and support people with mental health issues. This is especially important as there are many people who may not want to, or can't, access a mental health clinician in a "formal" setting. There are many ways that individuals can get help, and we need to look inside and outside of the mental health sector for these solutions.

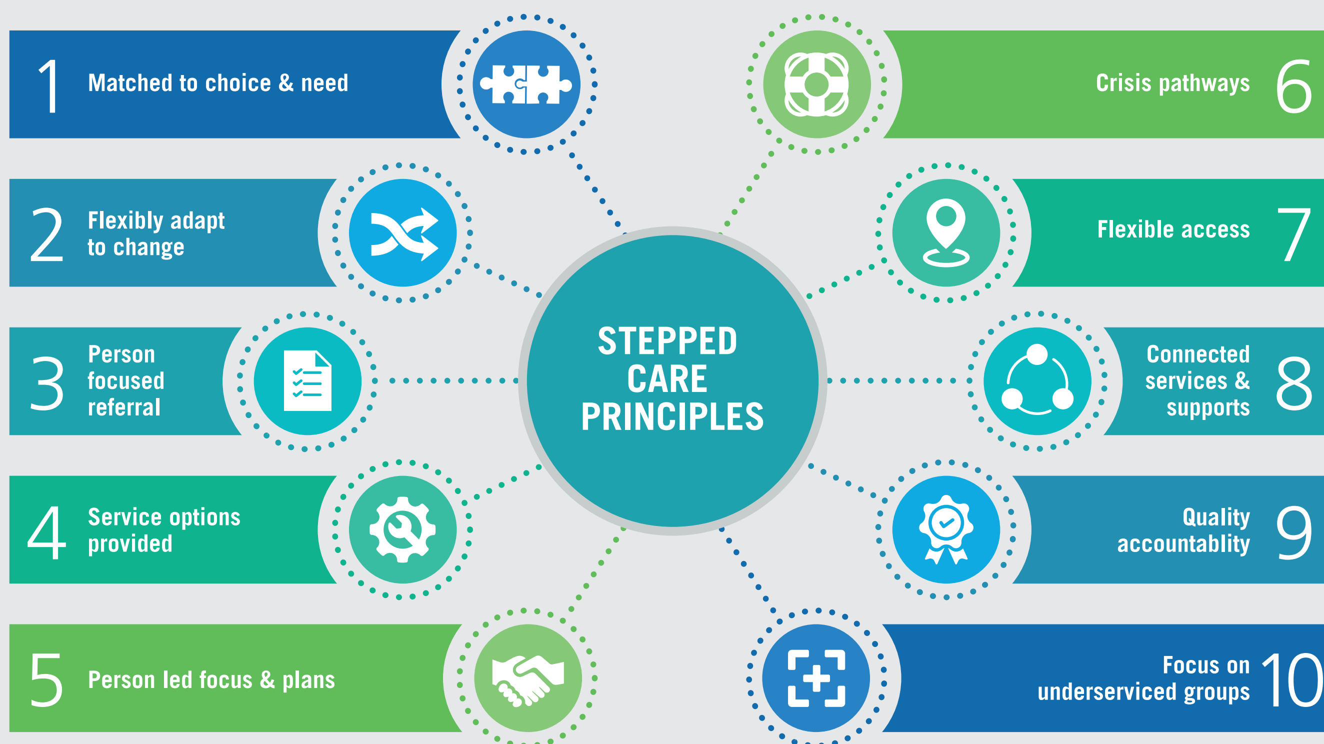
PRIORITY AREA SEVEN – ACTIONS

WORKFORCE CAPACITY AND CAPABILITY	
7.1	Explore ways to increase workforce capacity in the region in instances of workforce shortage. Priorities include peer workers, Aboriginal and child mental health professionals, and the community sector mental health workforce.
7.2	Promote and increase the proportion of mental health professionals from diverse backgrounds delivering services across the region (e.g. bi-lingual mental health professionals).
7.3	Increase the capacity and capability of key stakeholders (particularly GPs) to assess, navigate, refer and provide services in a stepped care approach.
7.4	Continue to facilitate mental health and suicide prevention focussed continuing professional development that is informed by workforce priorities and development needs.
7.5	Facilitate and support activities that improve workforce and sector capacity and capability to refer in to and/or deliver NDIS services.
THE PEER WORKFORCE	
7.6	Define local benchmarks, adopt relevant guidelines and seek opportunities to grow and improve access to the peer workforce - with a focus on peer workers in community settings at key transition points.
7.7	Develop a multi-agency strategy to better support and connect peer workers across the region, and facilitate access to training, supervision, mentoring and support. This strategy will be consistent with the policies of the NSW and National Mental Health Commissions.
7.8	Advocate for funding for peer workers to be available to provide support to consumers, carers and family members during a presentation to an emergency department.
SYSTEM LEVEL ENABLERS	
7.9	Support the priority actions identified in the NSW Mental Health Workforce Plan and work together to ensure the workforce is experienced, skilled and supported.
7.10	Use the National Mental Health Services Planning Framework to analyse and determine the workforce required to meet changing and growing population treatment needs.
7.11	Monitor the growth of the Peer Workforce and Aboriginal Mental Health Workforce, adjusting strategies as required to meet performance benchmarks.

APPENDIX ONE: STEPPED CARE

In a stepped care approach, a person presenting to the health system is matched to the least intensive level of care that most suits their current treatment need.

The following stepped care principles (Figure 4) are central to the Central and Eastern Sydney stepped care approach.



Stepped Care Principles developed by NSW/ACT PHN Mental Health Network, guided by the 2016 Australian Government framework, PHN Primary Mental Health Care Flexible Funding Pool

Implementation Guidance: Stepped Care, available from the Department of Health website at www.health.gov.au.

Figure 4: Stepped care principles

APPENDIX TWO: CONSULTATION THEMES

The Regional Plan has been informed by people with a lived experience, carers, clinicians and key stakeholders. Consultation workshops were held throughout the Central and Eastern Sydney region between October 2018 - March 2019. More than 160 people participated in the consultation workshops. Following on from these consultations, the Steering Committee developed and published a draft set of regional planning actions. A total of 586 people reviewed the draft set of regional planning actions, and 40 people completed an online survey providing additional feedback to the Steering Committee. The survey responses led to refinement and finalisation of the actions.

A summary of the key themes from the consultation process is provided below:

- Extra effort is needed to promote and build **awareness of available mental health and wellbeing services** by community members. In particular, community members are seeking better information about services available to help when someone is experiencing a mental health crisis.
- **Service navigation and care coordination supports** are highly valued and help people to navigate what can be a confusing and complex system.
- **Flexible and responsive service models**, with broad eligibility criteria, a variety of modalities (e.g. digital, telephone, group) and with varying operating times (including weekends and after hours) are keys to improving access to services. Many participants identified the threshold to access care is too high or stringent.
- Reform in the disability sector (e.g. National Disability Insurance Scheme) and mental health reform are bringing about many positive changes for some, but for others **there is a gap in services** that they once benefited from.
- Across all consultations, participants emphasised the importance of services that value **both mental health and physical health**, celebrating the exceptional examples of integrated whole-of-person services available locally. Participants prioritised actions that will lead to an increase in these approaches throughout the region.
- **Difficulty accessing services and resources to support good physical health** was highlighted. This was linked to lack of awareness about services and resources available, and lack of affordable care options.
- Connected, team-driven, **multi-disciplinary care** is an aspiration shared by consumers, carers and clinicians alike. It was widely acknowledged that when clinicians work together, and in genuine partnership with consumers and carers, better outcomes follow.
- Participants highlighted the importance of consumers, carers and family members (where appropriate) having support to **carefully consider the benefits and risks of the medication**, and an opportunity to regularly assess medication (considering alternatives or ways of minimising risks).
- **Increased support during periods of transition** (e.g. during discharge from hospital) is needed. Where this happens there are better outcomes and experiences for consumers and carers.
- Participants emphasised that there needs to be **alternative services** located in the community (instead of hospital) **for people experiencing suicidal ideations or behaviours**.
- **Post-discharge support** (that is inclusive of families) should be available to anyone who has attempted suicide.
- Primary care clinicians indicated a **strong desire to be more involved in discharge planning** for people who have had a mental health related hospital admission.
- Carers, family members, and friends who have been **bereaved by the suicide of a loved one**, need **timely, appropriate and tailored support**. Participants highlighted that there must be a better way of reaching out to people to assist with the grief and loss process.
- Prevention and early intervention are important, but so is having **well-resourced and well-funded services** that provide support to people during a mental health crisis - particularly if it helps people to avoid hospital admission.

- The community has embraced the **enormous potential of the peer workforce** - emphasising that service models should incorporate intelligent use of peer workers, combined with strategies that improve support and training for the peer workforce.
- The value of **multi-service hubs** was reinforced - where people can easily gain access to a variety of health and wellbeing services. Multi-service hubs were considered particularly useful for people who experience access barriers or have more complex needs.
- Referral pathways need to be **re-imagined** from the perspective of people with lived experience, carers and families. Referral pathways must be simplified and as smooth as possible.
- **People with lived experience**, working inside and outside the system, **need to be meaningfully included in quality assessment and improvement** activities. In addition, there is a drive to utilise peer researchers and evaluators.
- **Performance indicators for services should be co-designed** with people who have a lived experience, carers and families.
- Training was frequently cited as a way of improving the quality of care and experience of care received. **Training with a focus on interpersonal and rapport building skills** was consistently reinforced.

During consultations with Aboriginal and Torres Strait Islander representatives, several strong and consistent themes emerged. These included:

- Investment in services that deliver care that is consistent with the **Aboriginal Social and Emotional Wellbeing Framework**.
- Service models **developed by Aboriginal and Torres Strait Islander Peoples**, using culturally based interventions with a focus on connection with culture, healing, inter-generational mentoring, arts, dance and storytelling.
- The **medical model and current clinical models are insufficient** and not meeting the needs of Aboriginal and Torres Strait Islander Peoples.
- Grow the Aboriginal Mental Health and Aboriginal Peer Workforces.
- Work harder to engage Elders and Aboriginal community members in a culturally-informed way and support communities to support Elder wellbeing.
- Forge closer relationships with Aboriginal peak and professional bodies.
- Invest in cultural competency and safety training, facilitated by Aboriginal People.

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CENTRAL AND
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An Australian Government Initiative

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