MENTAL HEALTH & SUICIDE PREVENTION REGIONAL PLAN

central and eastern Sydney

IMPLEMENTATION EVALUATION

Oct 2019 – Jun 2022

CONTENTS

We would like to acknowledge the Traditional Custodians and Sovereign People of the Aboriginal land on which we work. We recognise their continuing connection to land, water and community and pay respect to Elders past, present, and emerging.

We would like to acknowledge people, families, and carers with lived experience of mental health issues and a lived experience of suicide and recognise the valuable contributions of all community members in helping shape the support systems in our region.

COMMITMENT TO RECOVERY-ORIENTED LANGUAGE

Language is powerful and has the potential to shape individuals' experiences both positively and negatively. The regional planning partners have committed to using person-centred language and are guided by the Mental Health Coordinating Council (MHCC) Recovery Oriented Language Guide (Third Ed.)

ACKNOWLEDGEMENTS

We would like to thank all individuals and organisations involved with the development and implementation of the Central and Eastern Sydney Mental Health and Suicide Prevention Regional Plan and their commitment to improving the mental health, physical health, and wellbeing of people with or at risk of mental health issues or vulnerable to suicide living in our region.

We would like to thank Candice Fuller, Lyn Anderson, and Sandie Stebbings for their assistance with the development of this report ensuring that we continued our commitment to engagement with lived experience representatives at all stages of regional planning.

We would also like to thank the Matilda Centre Research Mentoring Program, in particular Dr Louise Birrell, for supporting Wilhelmina Brown with the evaluation of the implementation of the Central and Eastern Sydney Mental Health and Suicide Prevention Regional Plan.

FROM THE CHAIR OF THE STEERING COMMITTEE

In June 2022, we reached a significant milestone – the conclusion of our implementation of the Central and Eastern Sydney Mental Health and Suicide Prevention Regional Plan (the Plan).

Reflecting on the implementation of the Plan I am proud of our ongoing commitment to improving the mental health, physical health, and well-being of people with or at risk of mental health issues or vulnerable to suicide.

To accompany our Implementation Report, this report has been developed to provide an evaluation of the implementation process.

The evaluation has resulted in key findings and learnings that can be used to inform future regional planning activities. We identified several key internal and external factors that impacted the implementation of the Plan. Each factor could function as an enabler or a barrier, or both to the implementation of the Plan.

We look forward to sharing our insights with you in this report and seeking your support on the recommendations set out for the next phase of regional planning.

Mariam Faraj

Chair of the Regional Plan Steering Committee
General Manager - Clinical Services, CESPHN

Graphic 1 - Steering Committee (2019)

SECTION ONE: INTRODUCTION TO REGIONAL PLANNING

The Plan aimed to improve the mental health, physical health, and well-being of people with or at risk of mental health issues or vulnerable to suicide across the CESPHN region. The Plan had a three-year focus, with implementation beginning on 1 November 2019 and concluding on 30 June 2022.

The Plan was developed in partnership with:

- 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),
- Being Mental Health Consumers NSW,
- NSW Mental Health Carers, and
- Mental Health Coordinating Council (MHCC).

Governance of the implementation of the Plan was established in a joint terms of reference developed in late 2019 by the Implementation Committee. The Implementation Committee remained responsible for implementation oversight, with the steering committee providing executive sponsorship. The Plan consisted of 97 actions, all of which were assigned to a committee or working group for completion. On a need basis, additional consultation with existing stakeholder groups was sought, or new working groups were formed (see Figure 1 - Implementation Governance).

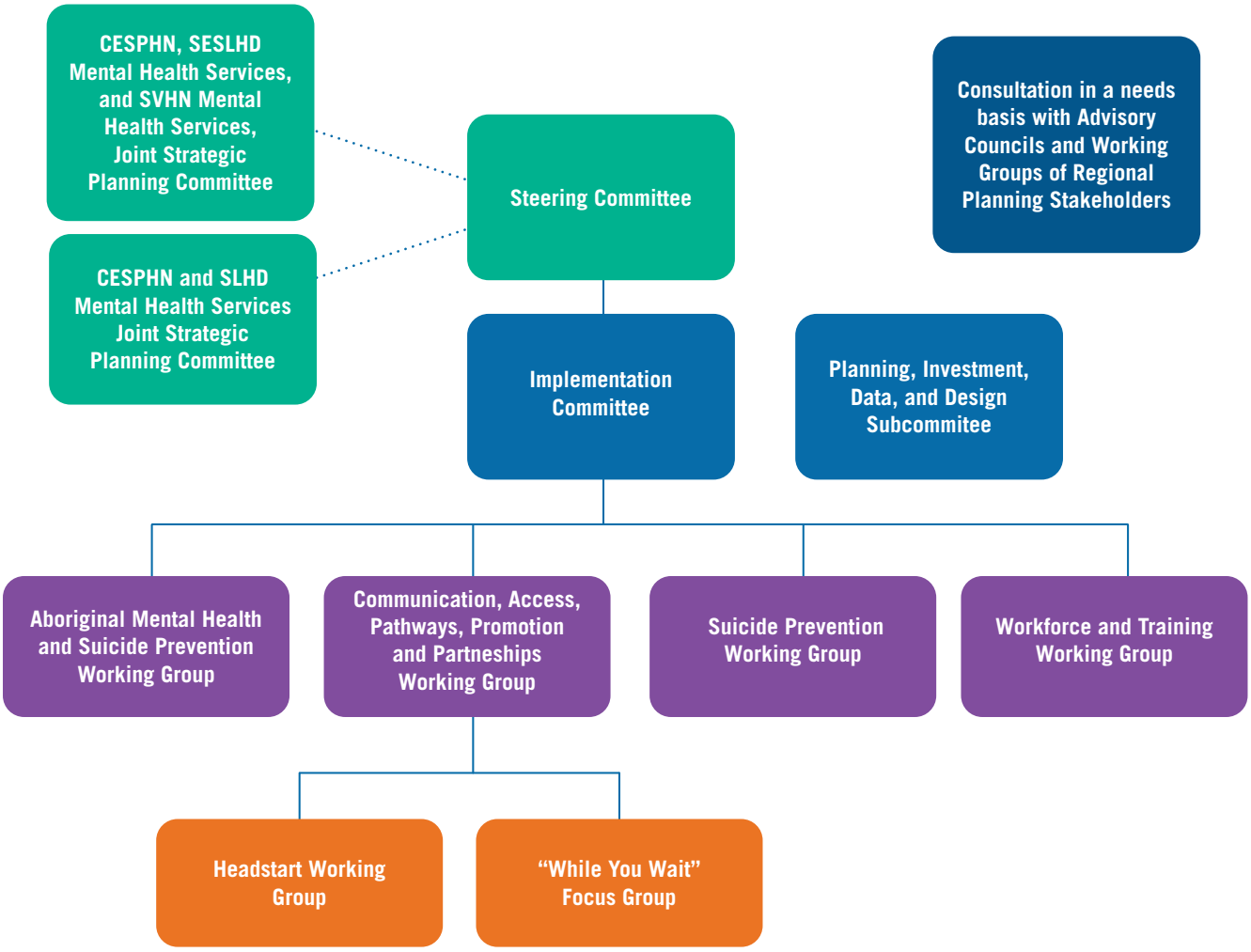

Figure 1: Implementation Governance

Overall, implementation of the Plan was a success, with 84 per cent of actions assessed as being completed or as substantial progress being made against implementation.

Implementation was undertaken collaboratively through activities by the committees and working groups or through individual activities by partners. This contributed to significant developments in the provision of mental healthcare resources, tools, and services in the CESPHN region (see Figure 2 - Implementation Outputs).

Figure 2: Implementation Outputs

SECTION TWO: INTRODUCTION TO THE EVALUATION

EVALUATION PURPOSE

To review the process of implementing the Plan.

EVALUATION OBJECTIVES

The evaluation aimed to identify and understand the following:

- What enabled the implementation of the Plan?
- What presented a barrier to the implementation of the Plan?
- Did the identified enablers and barriers fall within the control of the implementation partners?
- What learnings can be applied to future regional planning activities?

EVALUATION FRAMEWORK

An evaluation framework was used to guide the evaluation, based on contextual factors, enablers and barriers to implementation and how they intersect (see Figure 3 - Evaluation Framework). A program logic model was developed to help guide this process. The logic model was used to collate information around the inputs, activities, audience, outputs, and outcomes of the Plan (see Appendix Three: Implementation Program Logic).

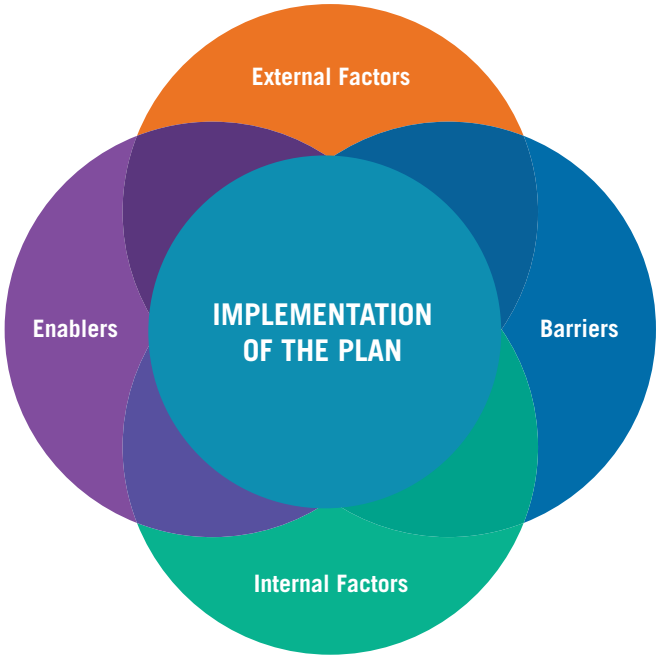

Figure 3: Evaluation Framework

METHODOLOGY

Several data sources were identified for inclusion in the evaluation of implementation (see Table 1 - Implementation Data sources). In addition to these data sources, the Implementation Committee was invited to participate in a focus group to generate additional qualitative data to assess implementation outcomes.

The focus group was undertaken through a semi-structured workshop. Members of the Implementation Committee were invited to provide feedback on the enablers and barriers of regional planning. Supplementary Interviews were held with individuals to then clarify any discussion points as required. Inductive thematic analysis identified key themes present in the data (Thomas 2006, 238).

All data sources were then reviewed, and key themes were identified. Each theme was then aligned with one or more evaluation objectives in the Evaluation Framework (see Figure 3 - Evaluation Framework).

DATA SOURCE	CONTENTS
Implementation Tracking Log	The Implementation Tracking Log detailed implementation progress across all 97 actions in the Plan. Bi-monthly, the committees and working groups of the regional plan would review an action, write a brief paragraph providing an implementation update, and then evaluate implementation progress using a traffic light model.
Bi-Monthly Implementation Reports to the Steering Committee	Bi-monthly reports to the steering committee were submitted. These reports focused on highlighting key achievements and the identification of areas of work that had faced significant challenges. .
Meeting Attendance Logs	Attendance at all regional plan meetings was logged by the committee or working group secretariat. In the event a member was unable to attend, the committee or working group secretariat saved any correspondence relating to the absence.
Continuous Improvement Feedback Log	Throughout the implementation process, any feedback was collated by the Regional Plan Program Officer for future reference. Sources of feedback include committee and working group meetings, anonymous surveys, and correspondence.
Focus Group Transcript	A transcript of the Focus Group session.

Table 1: Implementation Data Sources

SECTION THREE: EVALUATION FINDINGS

The evaluation resulted in key findings and learnings that can be used to inform future regional planning activities (Future Directions in Section Four). We identified several key internal and external factors that impacted the implementation of the Plan. Internal factors were those components inside the control of the implementation governance structure including the design of the plan, membership, engagement, and resourcing. External factors were those components outside of the control of the implementation governance structure and included the mental health system, COVID-19, and access to data. Each factor could function as an enabler or a barrier, or both to the implementation of the Plan.

THE IMPACT OF INTERNAL FACTORS ON IMPLEMENTATION

ACTIONS AND DELIVERABLES

The scale and ambition of the Plan presented a barrier to successful implementation. The Plan set out to implement 96 actions over three years. Whilst considerable progress was made, 12 per cent of actions were postponed, and four per cent were not achieved. The primary reason for the delay was the scope of the work required to make change. As one member of the implementation committee reflected:

> *"We had a lot of actions that were quite broad. They gave us a lot of scope to maybe interpret them but that made it quite difficult for us to actually do anything with them." – P1*

Therefore, it is recommended that future regional planning should be streamlined with a small number of actions with clearer deliverables and milestones that are within the scope of influence of regional planning partners. This would include a commitment to the resources required to progress work from all regional planning partners before implementation commenced.

An additional challenge lay in the scope of actions that lay beyond regional governance structures. Several actions in the regional plan were postponed, or not achieved as they required substantial partnership work with other stakeholders, potentially at a state-wide level. These stakeholders include the National Disability Insurance Scheme (NDIS), social housing, Justice Health, the Department of Education, and others. With the timeframes and resourcing available, as well as the additional pressures from COVID-19, engagement with these organisations was limited and this work could not progress. Due to the importance of these stakeholders and their intersections with the mental health sector, these were identified as priorities for future work. It is therefore recommended that a complementary "state-based" planning between the Ministry and NSW /ACT PHNs would be an enabler in the next phase of regional planning.

MEMBERSHIP

Stakeholder engagement was both an enabler and a barrier to the implementation of the Plan. Diverse engagement led to creative problem solving. However, a lack of clarity in stakeholder roles led to frustration and a lack of engagement.

98 individuals representing 16 organisations were involved in the joint regional planning from 1 November 2019 – 30 June 2022 (see, section Appendix B - Regional Planning Engagement Partners). The organisations involved were diverse and included state and federal agencies, advocacy peak bodies, mental health community managed organisations and alcohol and other drug community managed organisations. The aim was to have a wide range of expertise consulting on implementation projects. As one member stated:

> *"[It is] very rare that a diverse group that includes all those providers gets to sit at one table," – P8*

The diversity of voices allows for greater collaboration and problem-solving.

A challenge, however, was in finding a suitable representative to drive work when the scope of work was broad. This can be demonstrated through a comparison of the Suicide Prevention Working Group, and the CAPPP Working Group. As one member described:

> *"I think some of the working groups worked really well. But where it was a challenge was groups like the CAPPP where there was a very broad focus and so it didn't necessarily fit one person's work role from an organization." – P1*

The Suicide Prevention Working Group had a clear scope of work underpinned through the implementation of the Strategic Framework for Suicide Prevention in NSW 2018-2023 and the Towards Zero Suicide initiatives. The working group membership included the managers of the Towards Zero Suicide initiative from the Local Health Districts (LHD) and Hospital Networks and other key stakeholders in the region. As a result, 100 per cent of the actions assigned to the working group were completed or had significant progress made.

In contrast, the CAPPP Working Group had a broad scope and diverse membership. Actions that the working group were responsible for included service integration, the intersection of physical health and mental health and supporting priority populations. This diverse portfolio meant it was hard to identify an appropriate member to sit on the working group and stay invested in progressing activity. As one member described:

> *"I found the CAPPP working group difficult… I was not able to contribute much to the content due to no direct involvement in the areas of discussion." – p10*

As a result, only 81 per cent of the actions assigned to the working group were completed or had significant progress made.

Therefore, it is recommended that when considering future regional planning activities, diverse membership is considered from the initial planning stages through to project evaluation. Each representative should also have their role and responsibilities associated with the activities outlined and aligned with clear project deliverables.

ENGAGEMENT WITH LIVED EXPERIENCE REPRESENTATIVES

Similarly, strong engagement with lived experience representatives was a strength of the implementation of the Plan. 17 lived experience representatives including consumers, carers, Aboriginal community members, and peer workers were involved in regional planning between 1 November 2019 – 30 June 2022. This commitment to engagement was co-funded by CESPHN, SESLHD, SLHD, SCHN and SVHN and resulted in the development of two co-designed resources and a service navigation platform. As one lived experience representative shared:

> *"The support of CESPHN for lived experience representatives has been wonderful and as a carer representative I am grateful for the opportunities offered to us by the planning partners." – P4*

This demonstrated that joint financial commitment itself is an enabler for implementing regional planning actions. It is therefore recommended that joint funding be applied not only to engagement with lived experience representatives but to all future regional planning activities to ensure they are adequately resourced to deliver intended outcomes.

Another key enabler for participation in the implementation process was the induction process. This included the development and sharing of an orientation handbook, funding participation in SESLHD Safe Story Telling training, and a one-on-one or group introduction session with the Regional Plan Project Officer. As part of the quality improvement cycle, two anonymous surveys were conducted in 2020 and 2021 to gather feedback on this induction process from lived experience representatives.

Feedback from the 2021 survey was positive, with some areas of improvement identified. Overall, the orientation handbook was received favourably by all survey respondents, with no recommendations for changes to the resource noted. Similarly, all survey respondents indicated that they received sufficient information before attending their first meeting. In addition, all respondents to the survey stated that they felt comfortable expressing their views or opinions during meetings. As one lived experience representative commented:

> *"I am in constant awe of the dedication of practitioners to help those with mental health conditions. I have been listened to and respected and I very much appreciate being given a voice." - P10*

Areas of improvement that were identified in the 2021 survey included greater transparency on the implementation governance, including a better understanding of who we work with and what each of the committees and working groups are responsible for. Additionally, there is a need to continue to provide support for lived experience representatives by supporting them with access to further training on committee work. As well as providing ongoing support through email and phone conversations over the onboarding process as representatives begin to understand their roles and the aim of committees or working groups that they are members of.

Whilst further work can be undertaken to strengthen engagement with lived experience representatives, and the diversity of the pool of representatives that is called upon, the commitment to date with all stakeholders has ensured that a diverse range of voices has been heard when progressing work implementing the Plan.

RESOURCING

Resourcing for implementation of the Plan was limited, presenting a barrier that was overcome to some extent by goodwill. The 16 organisations who contributed to regional planning provided in-kind support through their attendance at regional plan meetings and out of session activities. As a result of this goodwill, creative problem-solving was applied to lead to the successful completion of actions. As one committee member explained:

> *"We had many aspirational actions that we wanted to find resources as they came to hand, and you know either repurpose them or use them to meet our specifically identified needs". – P2*

This commitment to resourcefulness was driven by the reality that there was limited financial investment in regional planning. There was no additional funding for mental health and suicide prevention regional planning and existing planning funding is not commensurate with the scale of expectations of the policy. As a result, CESPHN committed funding for a Regional Plan Project Officer and Manager (approximately 0.4 FTE each) and consultancy (approximately 0.1 FTE). This staffing allowed for considerable progress to be made in implementing actions. For example, the development of joint protocols, mapping exercises, and other materials were developed out of session and then brought to meetings for consultation. This presented a barrier with actions requiring significant investment such as the co-commissioning of services, or reform around sector intersections such as mental health and the justice system. This sentiment was summarised by one member:

"We've done all we can with goodwill, and we need maybe a little bit more help [with resourcing]." – P2

For future regional planning activities, the focus should be on advocating to the various federal and state government agencies for additional resources to support the next phase of regional planning.

THE IMPACT OF EXTERNAL FACTORS

MENTAL HEALTH SYSTEM

Existing service planning structures and funding in the mental health sector have resulted in systemic problems for consumers and carers accessing mental health support. This presented challenges to the implementation of the Plan which aimed to use system reform as an agent of change. The need for system-wide change in mental health care provision is a complex issue and has been well explored (Mental Health Coordinating Council 2018) (Mental Health Commission of New South Wales 2020) (Rosenberg 2015) (Rosenberg and Hickie 2018). Despite numerous inquiries and attempts to implement change, many individuals still face barriers to accessing timely and appropriate mental health support (Rosenberg 2015).

One of the key issues impacting implementation was tied to the siloing of information, service provision and funding. as summarised by one member:

"There's an automatic tendency to go into a bit of a silo because of the way we manage services… Part of it is that we currently have very rigid walls between federally funded and state-funded services." – P2

Future regional planning should focus on strategic collaboration between Federal and State partners to better understand the mental health system and take joint action towards reform using planning, funding, and advocacy levers. Collaboration without optimising available levers will lead to similar limitations experienced in this phase of planning. When outlining the extent of the strategic collaboration required, the Collaborative Commissioning Program of the NSW Ministry of Health represents an excellent example.

Another key issue potentially impacting implementation is the focus of activities on and within the mental health system. Lived Experience Representatives who have been engaged in the regional planning process felt that this could be overcome by a greater focus on community and less on the mental health system. As one participant summarised:

"I believe we have learnt a lot from the response to Covid including the necessity to engage services within the local community rather than rely on state or federal intervention. Each community has their own and often very different needs. Planning and delivery of services is more efficient and responsive when policy planning and delivery is designed around those needs that are unique to every different area." – P4

Many Lived Experience Representatives felt that community-based interventions were an important part of the recovery journey as mental health services could themselves be a barrier to recovery as one lived experience representative explained:

"People get well in the community and planning partners could engage with local community groups and peer workers, who could play a large part in a person's recovery, rather than relying on many mental health service organisations who in themselves stigmatise and marginalise consumers just by being who they are." – P4

Lived experience representatives reiterated the importance of mental health literacy so that wellbeing could be addressed outside of the mental health system, for example

"Encouraging mental health literacy in the population, inside of families, inside of friendship groups, inside of sporting clubs, through churches and faith-based organisations, those kinds of supports." – P5

Future regional planning will need to balance the tension between community expectations and the directives that are set out for regional planning.

FIELD EXAMPLE – WORKING BEYOND THE HEALTH SYSTEM, COMMUNITIES SUPPORTING EACH OTHER

The Aboriginal Mental Health and Suicide Prevention Working Group repeatedly raised the importance of empowering community to support mental wellbeing for all. They identified a gap in the availability of Aboriginal Mental Health First Aid (MHFA) in our region due to a lack of instructors. The working group identified an opportunity to coordinate and fund an instructor course in Sydney. These new instructors would then play an essential role in educating the community. The Working Group identified several key organisations in the central and eastern Sydney region with Aboriginal staff who may be interested in the training. To share the expenses with other organisations that could benefit from a course held in Sydney, the working group has reached out to contacts in other PHNs, LHDs, Hospital Networks, the Department of Education, and the Department of Justice. We expect to host training in the second half of 2022. Members of the working group will continue to work together to ensure coordination of Aboriginal MHFA sessions delivered in the region and enhance the sustainability of this investment. With a new pool of instructors, more members of the Aboriginal community can gain the skills of MHFA and support each other.

ACCESS TO DATA

Access to data to inform the implementation of the Plan has been an ongoing barrier. To progress several actions in the Plan access to data on workforce composition, service utilisation, consumer and carer experiences, and other key metrics were required. Numerous barriers were encountered including delays in the release of public data, limited publicly available data at a regional level for analysis, and a lack of data sharing agreements in place between Federal and State partners. As reflected in the Planning, Investment, Data, and Design (PIDD) Subcommittee in the July and August 2021 meeting minutes, the resources required for each stakeholder to respond to ad-hoc requests for data to support regional planning work were too great and could not be met. To date, the barriers to data sharing remain and will need to be addressed before the next phase of regional planning can commence.

FIELD EXAMPLE - SHARED DATA REQUEST

Access to data to inform the regional mental health and suicide prevention plan implementation presented an ongoing barrier to population level regional planning. Initially, it was perceived that this challenge was due to the impromptu and ad hoc nature of our requests for data. As a result, the PIDD Subcommittee drafted a letter, endorsed by the steering committee, requesting InforMH to supply a six-month periodic data report to the committee. However, this request was declined with InforMH noting that they were not the custodians of the data and that an access request would need to be approved between the NSW Ministry of Health and all ACT and NSW PHNs. To date, no such agreement has been established.

COVID-19

The repercussions of the COVID-19 pandemic on all aspects of society are still emerging. For regional planning, this has presented additional new barriers as the health care system shifted to an emergency response focus, however, the shift also provided opportunities for service innovation.

Implementation of the Plan required engagement with primary and secondary mental health services to generate sustained changes in service policy and delivery during this time. A recurring theme was a lack of availability of stakeholders to engage with regional planning. As one member explained:

> *"COVID showed our [Mental Health] system has been chronically under-resourced in some areas for years and there's barely enough system to put around the gaps in some places" – P2*

The average meeting cancellation rate across all working groups from 1 November 2019 – 30 June 2022 was 28 per

cent (31 meetings cancelled in total). A review of meeting cancellation correspondence indicated that the primary reason for the cancellation was staff having changed responsibilities during the COVID-19 pandemic. As staff were deployed to respond to the emerging crisis, strategic planning was placed on hold. As one member commented

> *"All the districts, networks and PHNs seem to also undertake their service planning at different times, which means limited collaboration in service planning, design and delivery." – P9*

Despite the lack of strategic planning that could be undertaken, the fast-paced and responsiveness of service delivery in the COVID-19 context allowed for service innovation which positively impacted the implementation of the Plan. As one member noted:

> *"Lots of things have been tried which weren't able to be pushed through previously." – P3*

As new service models were funded to support consumer wellbeing such as Head to Health Pop-up Hubs, and Telehealth services expanded across the region, several actions of the Plan progressed successfully and in an accelerated way.

Similarly, as priority populations were identified as being at greater risk from the impacts of COVID-19, new relationships were formed with grassroots organisations. This resulted in greater community trust in mainstream services and greater engagement with the health care system.

Therefore, it was recommended that future regional planning activities continue to advocate for these innovative services to continue in partnership with the community.

FIELD EXAMPLE – OPPORTUNITIES TO ENGAGE WITH CALD COMMUNITIES IN OUR REGION

In early 2020, mental health providers and community advocates identified that there was a need to provide additional support to the mental well-being of culturally and linguistically diverse (CALD) communities to minimise the impacts of COVID-19. In response, the CAPPP working group undertook several activities to understand how CALD communities in our region are being supported at that time.

As a starting point, the Transcultural Mental Health Centre (THMC) were invited to present to the CAPPP Working Group and share resources that the CAPPP could promote to service providers across the CESPHN region.

In mid to late 2020, in the context of service delivery during COVID-19 and the Beirut Explosion, a review of available resources was undertaken to:

- Identify available supports for CALD communities
- Identify current gaps in service provision for CALD communities, and
- Use available information to promote referral pathways for CALD communities.

It was hoped that through education and awareness, members of CALD communities had access to resources to support their well-being, and/ or make a self-referral.

This work was enhanced in 2021 when CESPHN received additional 'COVID-19 Boost' funding that allowed for the expansion of existing service models to continue to deliver support to priority populations' during the extended NSW lockdowns. Additionally, via a small grants program, CESPHN supported four grassroots organisations to commission wellbeing programs for CALD communities in the region. This provided an opportunity to strengthen ties with local organisations and better engage with CALD communities in our region.

SECTION FOUR: FUTURE DIRECTIONS

The development and implementation of the Plan indicate the end of one phase of regional planning. Activity will continue in line with state and federal policy directives.

In this phase, we have developed and implemented what is considered a 'foundational plan' with the requirement to develop a Joint Service Plan in the next phase of regional planning.

National Cabinet has endorsed the National Mental Health and Suicide Prevention Agreement (the National Agreement). The National Agreement is expected to strengthen collaborative planning and commissioning at the regional level.

Following the endorsement of the National Agreement, the Australian Department of Health will work with jurisdictions to develop national and regional planning and commissioning guidelines. The guidelines will be provided in March 2023, at which point the next phase will be planned and implemented in central and eastern Sydney. As a result of this evaluation the following seven recommendations have been identified:

MOVING BEYOND COLLABORATION

Collaboration has been the mechanism that has enabled joint regional planning to date, but it is not the solution. The next phase of regional planning should see us move beyond collaboration and to the implementation of systems and processes that enable joint action and shared investment. The Collaborative Commissioning Program of the NSW Ministry of Health represents an excellent example.

INTRODUCING COMPLEMENTARY STATE-BASED MECHANISMS

Complementary "state-based" planning between the Ministry and NSW /ACT PHNs is required to support future regional planning activities. Whilst regional planning must prioritise local priorities, in doing so there have been areas of work identified that need to be addressed at a state level. These included collaboration with key agencies including, but not limited to the National Disability Insurance Scheme (NDIS), social housing, Justice Health, Department of Education. A mechanism for reporting to and responding to matters that need to be addressed through "state-based" planning needs to be implemented.

PRIORITISING ACCESS TO DATA

To support the development of the next phase of regional planning, access to data needs to be addressed through the implementation of data-sharing agreements between State and Federal jurisdictions. Whilst significant advocacy work was undertaken, the progress to date has been stalled by a lack of access to data. Similarly, tools to support evidence informed regional planning has been significantly delayed. At the time of writing, regional planning partners are still waiting for resources detailed in the Fifth National Mental Health Plan and commissioned by the Department of Health and Aged Care to support the utilisation of the NMHSPF to be released. It is therefore recommended that a data sharing agreement is implemented between the Department of Health and Aged Care, the Ministry of Health, and PHNs.

JOINTLY FUNDED DELIVERABLES

The next phase of regional planning requires the development of clearly defined joint deliverables. Future regional planning should be streamlined with a small number of actions with clear deliverables that are within the scope of influence of the regional planning partners. This will ensure that ambition does not get in the way of progress. Once actions have been agreed upon and endorsed by partners, this needs to be supported through a joint commitment of funds. It has been evidenced that joint funding for initiatives is a mechanism for success. This has been demonstrated through the joint funding pool which was established by regional planning signatories. This funding has supported lived experience engagement in regional planning. It is therefore advised that before implementation there is a commitment of funds for each priority area and a contribution from each planning partner.

INNOVATIVE PROBLEM SOLVING

The COVID-19 pandemic placed strain on the health system. In response new and innovative care models were introduced, new communication channels opened, and community engagement with consumers and carers shifted. It is therefore recommended that future regional planning deliverables build upon this momentum continue to advocate for these innovative services to continue in partnership with the community.

DIVERSE AND STRATEGIC PARTNERSHIPS

To support the implementation of deliverables, regional planning activities should continue to support a diverse membership in future regional planning activities. Membership should be based on the alignment of project outcomes with members' existing roles and responsibilities. The aim of this is to ensure that the right people, with the right authority, and delegations have a seat at the table.

AUTHENTIC ENGAGEMENT WITH LIVED EXPERIENCE REPRESENTATIVES

In parallel with diverse strategic partnerships, future regional planning activities should continue to explore and strengthen engagement with lived experience representatives in all aspects of regional planning. As the evaluation has demonstrated, the contributions of an informed and supported pool of lived experience representatives has resulted in greater diversity at the planning table, the development of resources, alternative perspectives on joint regional planning activity and has contributed considerably to the overall success of regional planning. Consideration should be given to avoid bias in the representatives recruited in all stages of regional planning. This would include consideration for the diversity of experience (e.g., forensic experience), culture, and age so that a truly representative voice is supported to engage with regional planning partners.

APPENDIX ONE: COMMONLY USED ACRONYMS

CALD	culturally and linguistically diverse
CAPPP Working Group	Communications, Access, Pathways, Promotions, and Partnerships Working Group
CESPHN	Central and Eastern Sydney Primary Health Network
FTE	Full-time equivalent
MHFA	Mental Health First Aid
NDIS	National Disability Insurance Scheme
NMHSPF	National Mental Health Services Planning Framework
PCCGs	Patient Centred Co-commissioning Groups
PHN	Primary Health Network
PIDD Subcommittee	Planning, Investment, Data, and Design Subcommittee
SCHN	Sydney Children's Hospital Network
SESLHD	South Eastern Sydney Local Health District
SLHD	Sydney Local Health District
SVHN	St Vincent's Health Network
the National Agreement	National Mental Health and Suicide Prevention Agreement
The Plan	Central and Eastern Sydney Mental Health and Suicide Prevention Regional Plan
THMC	Transcultural Mental Health Centre

APPENDIX TWO: REGIONAL PLANNING ENGAGEMENT PARTNERS

ORG NAME	ENGAGEMENT STATUS
Central and Eastern Sydney PHN	Signatory
South Eastern Sydney Local Health District	Signatory
St Vincent's Health Network Sydney	Signatory
Sydney Children's Hospital Network	Signatory
Sydney Local Health District	Endorser
BEING Mental Health Consumers	Endorser
Mental Health Carers NSW Inc	Endorser
Mental Health Coordinating Council	Member
Flourish Australia	Member
LGBTIQ+ Health Australia	Member
Mission Australia - NSW	Member
Neami National	Member
Network of Alcohol and other Drugs Agencies	Member
Stand By Support Service	Member
Stride	Member
Weave Youth and Community Services	Member

APPENDIX THREE: IMPLEMENTATION PROGRAM LOGIC

PROGRAM NAME	Implementation of the Central and Eastern Sydney Mental Health and Suicide Prevention Regional Plan (the Plan)
AIM	Improved mental health, physical health, and wellbeing of people with or at risk of mental health issues or at vulnerable to suicide living and working in the central and eastern Sydney region (the region).
CONTEXT	The Fifth National Mental Health Plan set out an expectation for PHNs to work with Local Health District and Local hospital Network partners to develop and implement a joint "foundational plan" for mental health and suicide prevention. Over 12 months in partnership with over 250 local communities and stakeholders including health care service providers, sector peaks people with lived experience, carers, and family members the Regional Plan was developed. The plan detailed 7 priority areas and 96 actions that aimed to improve mental health and wellbeing in the region by addressing systemic issues. The Plan was launched in October 2019 with implementation over three years concluding on June 30, 2022.
INPUTS	» Time » In-kind support from regional planning members. » Joint funding of 11 lived experience representative positions per annum for three years. » CESPHN resourcing including Project Manager and Project Officer. » Regional Plan Governance Structure. » CESPHN funding of ~1 day/week consultant services.
PARTICPANTS	Signatories of the Plan: » CESPHN » SLHD » SESLHD » SCHN » SVHN Endorsers of the Plan: » Being Mental Health Consumers » Mental Health Carers Network NSW » Mental Health Coordinating Council Other Stakeholders involved in the Plan: » Lived experience representatives » Peer worker representatives » Community managed organisation representatives
ACTIVITIES	Monthly, bi-monthly, and bi-annual committee and working group meetings. Committees included: » Implementation of 96 actions in the Plan and tracking of progress in the reporting spreadsheet. » Biannual implementation reporting to the steering committee.

OUTPUTS	OUTCOMES		
	SHORT-TERM	MEDIUM-TERM	LONG-TERM
Development and implementation of joint protocols. These protocols included: » A regional approach to reviewing Your Experience of Service (YES) Survey Data » Joint review of adverse events protocol » Commissioning for cultural safety protocol » Commissioning to grow and develop the peer workforce protocol	Greater collaboration and information sharing within the region.	Mental health service delivery and service design consider local information and local data. Continuous improvement of commissioning process.	Improved mental health service planning through integration in the region.
Development and promotion of industry resources. Resources include: » Catalogue of training resource on the CESPHN website. » "While You Wait" resource pack for GPs. » Best practice waitlist management guide. » A report on mental health demand in the COVID-19 context. » Audit of GP mental health continuing professional development (CPD) opportunities and identify gaps. » Mapping of the peer workforce supports. » Mapping of suicide prevention initiatives in the region.	Increased resources and awareness of resources for service providers in the region.	Service Providers in the region utilise resources and can better support the mental health and wellbeing of the community living and working in the region.	A skilled and supported mental health workforce operates in the region.
Request for Information & Response to Papers. This included: » Responding to the call for information on suitable locations for Head to Health Hubs (Adult & Child). » Responding to the call for feedback on the Renewal of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy -Gayaa Dhuwi (Proud Spirit) Australia. » Responding to the call for feedback on the NSW Health Workforce Development Strategy. » Joint data request to InforMH » Joint data request submitted to the AIHW.	A joint submission is developed based on evidence and endorsed by regional planning members.	Relevant stakeholders are educated on the planning and support needs of the region.	The region is considered for state and federal government programs and initiatives.
Launch of Headstart Central and Eastern Sydney.	Increased consumer and carer knowledge of mental health services. Increased Service Provider knowledge of mental health services.	Increased efficiency for consumers and carers accessing mental health services in the region.	Improved mental health and wellbeing for people living and working in the region as they can better navigate the system and access appropriate mental health services.

OUTPUTS	OUTCOMES		
	SHORT-TERM	MEDIUM-TERM	LONG-TERM
Development of systems and resources to support lived experience representatives engage with regional planning.	Consumer, carer, and community representatives can contribute to the implementation of joint regional planning.	Joint regional planning partners value the contributions of lived experience representatives and call on their advice. Lived experience representatives living and working in the region learn to engage with strategic planning.	Authentic co-design is undertaken in the region with lived experience representatives input along all stages of the planning and commissioning cycle.
Implement a regional coordination function to: » Connect state and commonwealth funded health service providers 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. Note. This is action 6.01 of the Regional Plan	Identified systems and process for collaboration.	Improve the way PHN, LHD, and Hospital Networks work together to deliver services in the region.	PHN, LHD, and Hospital Networks work towards co-commission services based on regional needs.
EXTRENAL FACTORS/THREATS	**In-Kind Support** » No specific funding to implement actions of the regional plan. **COVID-19** » Disruption to the delivery of mental health services, and other health and social services in the context of COVID-19. » Members of the Plan were re-deployed and unable to engage with the implementation process. » New mental health services were established to respond to demand generated by COVID-19 (e.g., Head to Health Pop-Ups) » There was a delay in government resources that would enhance joint regional planning implementation (e.g., the National Mental Health Service Planning Framework (NMHSPF) and the National Lived Experience (Peer) Workforce Guidelines). **In-Kind Support** » Changes to the timeline for the development of joint comprehensive service plans. » Changes to the policy landscape.		

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