Primary Health Network (PHN) NSW/ACT Mental Health Network

Response to Question with Notice

NSW Parliament, Health Committee No. 2, inquiry into equity, accessibility, and appropriate delivery of outpatient and community mental health care in NSW.

6 December 2023

For further information
Craig Parsons
General Manager, Partnership and Innovation
Sydney North Health Network

Chair of the NSW/ACT PHN Mental Health Network

Dear Committee Members,

Thank you for the opportunity to give evidence at the hearing for the inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales on the 17th of November 2023. The Committee documented a question on notice. This response includes the question from the transcript, an excerpt from our submission, and further information in response to the question on notice.

Question on notice from the committee

Can I ask a follow-up question on exactly this topic? I share concerns, as a former GP, of GPs being given the responsibility to do things without being given resourcing to do things. I was interested in your submission on page 14. There's a really interesting example of the Central and Eastern Sydney PHN project, which was GP-shared care. I was wondering if you could explain in a bit more detail how that works if you know. I apologise if you need to take it on notice. I'm also wondering if that program has been evaluated.

Submission reference

Spotlight – General Practice (GP) Shared Care, Central and Eastern Sydney PHN

CESPHN jointly commissions GP Shared Care programs with LHD and LHN partners. The Shared Care program aims to provide people engaged with Community Mental Health Treatment Teams, increased access to primary health care. The focus is to achieve improved physical health care for consumers and to develop partnerships between GPs and LHD mental health services.

The model utilises a Mental Health Clinical Nurse Consultant working in a Liaison capacity to support GPs, working towards formalised share care arrangements. The expected outcome of the program is better management of physical health in the primary care setting, earlier detection of physical health co-morbidities and a decrease in preventable chronic disease in the consumer cohort.

The benefits of the model include:

- Participating clients experience improved health outcomes as a result of GP shared care arrangements.
- Increased number of referrals to health and social services for consumers.
- Positive experience of service reported on the YES survey.
- Improved working relationships between Community Mental Health teams and local GPs including maintaining some bulk billing arrangements for consumers in the program.

There are several significant challenges in delivering this model which require additional resources to overcome. These include:

- Lack of technology to enable shared care: There is hesitancy to install additional and unfamiliar software in GP practices. It also requires training and support resources from the LHD/N on an ongoing basis.
- Consumers experience challenges in attending GP appointments due to illness related factors such as amotivation and anxiety as well as practical factors such as the cost of transport and financial costs of a GP appointment.
- Shared Care teams experience a continual reduction in the availability of bulk billed GP appointments and the lack of a regular GP for consumers to access.
- CNC positions which are central to the Shared Care model have been challenging to recruit to due to covid and post covid demand on this workforce.

Response 1 – How the Mental Health Shared Care (MHSC) Program Works

As a collaboration between Sydney Local Health District Mental Health Services, South Eastern Sydney Local Health District Mental Health Services, St Vincents Hospital Network and the Central and Eastern Sydney Primary Health Network (CESPHN), MHSC operates across fourteen community mental health teams responsible for care coordination.

Driving MHSC's implementation are care coordinators and peer support workers, supported by sector-based clinical nurse consultants. This team orchestrates care across disciplines, engaging consumers, GPs, allied health professionals, and support networks to ensure robust primary and preventive care engagement, focusing on whole-of-health (physical and mental health).

Each person's journey in the program is dependent on their unique circumstances and treatment needs, but typically the Care Coordinator will:

- Collaborate with the consumer, carers, family, and kin to systematically identify essential stakeholders for engagement in shared care initiatives.
- Formulate a comprehensive longitudinal history encompassing individual circumstances, co-existing conditions, and other pertinent information to inform and guide care planning.
- Establish communication with care team members and facilitate an inaugural planning meeting, typically conducted within the General Practitioner (GP) clinic.
- Develop a shared care plan and agreement as a tangible outcome of the initial planning meeting, outlining the responsibilities and contributions of each stakeholder. This includes setting clear parameters around information sharing.
- Assist the consumer, carer, family, and kin in the effective implementation of the care plan while proactively addressing and resolving any early issues that may arise.
- Sustain ongoing oversight and periodic review of the care plan to ensure its relevance and effectiveness over time.
- Proactively identify and address conflicts that may arise between stakeholders, fostering a collaborative and harmonious care environment.

The essence of MHSC lies in fostering effective communication between mental health services and GPs, delineating clear roles in screening, information exchange and physical health interventions while always respecting the consumer's role in their healthcare planning.

Ensuring effective GP linkage and comprehensive health screening throughout an individual's journey within mental health services lays the foundation for enduring physical health care.

This continuity safeguards the individual's holistic well-being and sets a precedent for a future characterised by proactive health management, where both mental and physical health receive the attention they deserve.

Evaluation of the SLHD/CESPHN Mental Health Shared Care Program

Current research into shared care projects is progressing, focusing on digital technologies enhancing shared care protocols. The 12-month Shared Health Arrangements Research & Development (SHAReD) study commenced in 2022 and, following a number of Covid-related delays, is due to finish in June 2024. More information about this research is available here: SHAReD: Shared Health Arrangements Research & Development (unsw.edu.au)

The University of NSW leads the research in partnership with SLHD and CESPHN. The research investigates the adaptability, effectiveness, cost-effectiveness and replicability of a web-based shared care plan and telehealth in NSW Health mental health and primary care settings while implementing shared care processes for primary care and mental health practitioners to effectively solve numerous competing demands.

As part of the trial, the patients who have agreed to be part of the study will have the data from PMS extracted, and the data will then be linked to MBS/PBS hospital data and a patient survey.

Emeritus Professor Mark Harris is the Chief Investigator and can be reached on

Many thanks and please do not hesitate to make contact if further information is required.