Submission No 58

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Organisation: NSW ACT PHN Mental Health Network

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

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

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Introduction

This submission is made by the NSW/ACT PHN Mental Health Network in response to the NSW Parliament (Health Committee No. 2) Inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW.

Primary health networks (PHNs) have two significant roles in mental health and suicide prevention:

- Regional planning
- Commissioning mental health, suicide prevention, and alcohol and other drug services

We have a strong commitment to working with local health districts and NSW Health to deliver an integrated health system in NSW.

The NSW/ACT PHN Mental Health Network has jointly coordinated this response. The network is comprised of the following eleven PHNs:

- Australian Capital Territory
- Central and Eastern Sydney
- Hunter New England and Central Coast
- Murrumbidgee
- Nepean Blue Mountains
- North Coast
- Northern Sydney
- South Eastern NSW
- South Western Sydney
- Western NSW
- Western Sydney

As part of this submission, all PHNs (excepting ACT PHN) provided insights reflecting on the findings of their regional mental health and suicide prevention needs assessment and experience as commissioners of mental health services.

Executive summary

This submission explains that in order to ensure equity, accessibility, and appropriate delivery, mental health services including community and outpatient services, the entire mental health and primary health system must be included in the joint planning, coordination, integration and implementation process. A lack of services in one area (for example, the current lack of general practitioners) will have a deleterious flow-on effect on other aspects of mental health and suicide prevention services such as emergency care, community services and outpatient services.

This submission explains the government and local planning mechanisms that have been designed to overcome gaps in services, reduce duplication and ensure that funding from both the Commonwealth and NSW Government is utilised to its best effect. PHNs have a key role in bridging the gap between the Commonwealth and state government service delivery. It is essential that the joint planning process is supported and enabled to continue.

The submission specifically addresses the term of reference and explores:

- TOR a. Equity of access to outpatient mental health services and capacity of mental health services
- TOR b. Navigation of outpatient and community mental health services
- TOR d. Integration between physical and mental health services, and between mental health services and providers
- TOR e. Appropriate and efficient allocation of mental health care workers
- TOR g. Benefits and risks of online and telehealth services.

The submission begins with a discussion of joint mental health and suicide prevention planning and data sharing as we consider these key to ensuring effective community mental health care.

The recommendations in this submission are captured here for reference:

Recommendation 1 – Commit to joint mental health and suicide prevention plans.
Recommendation 2 – Conduct an annual assessment of statewide mental health data assets.
Recommendation 3 – Expand data-sharing agreements to include primary health networks.
Recommendation 4 – Undertake needs assessment, planning and commissioning for eating disorders.
Recommendation 5 – Increase child mental health services.
Recommendation 6 – Address social and emotional wellbeing of First Nations peoples.
Recommendation 7 – Invest in interoperable information and communication technology.
Recommendation 8 – Explore the development of an integrated triage and referral process.
Recommendation 9 – Invest in navigation services for hardly-reached groups.
Recommendation 10 – Expand Psychiatry workforce.
Recommendation 11 – Renew and expand the NSW Workforce Plan for Mental Health.
Recommendation 12 – Conduct a mental health workforce census.
Recommendation 13 – Invest in the peer workforce.
Recommendation 14 – Implement telehealth Hubs to facilitate access to digital healthcare.
Recommendation 15 – Expansion of telepsychiatry.

Background

PHNs were established in 2015 by the Australian Government Department of Health with the two key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving the coordination of health services and increasing access and quality support for people to ensure patients receive the right care in the right place at the right time.

Under the 5th National Mental Health and Suicide Prevention Plan, each PHN working jointly with its Local Health Districts (LHDs) produced joint regional mental health and suicide prevention plans, targeted to each unique regional area. These joint plans address the fragmentation of services and pathways, gaps, duplication and inefficiencies in service provision, and opportunities for improved coordination, integration, consumer experiences and outcomes.

The Joint Commonwealth-NSW Implementation Plan (the Joint Plan) for the bilateral schedule between the Commonwealth and NSW on mental health and suicide prevention (the bilateral schedule) commenced on 24 July 2023. The Joint Plan outlines the agreement to work together to strengthen the joint regional planning and commissioning of mental health and suicide prevention and psychosocial services to provide person-centred and place-based care.

Joint mental health and suicide prevention service planning

Mental health services are funded by both the Federal Government and the NSW Government, which can lead to siloed planning, confusion as to roles and accountability, gaps in some services and duplication in other services. To overcome this situation, LHDs and PHNs have collaboratively undertaken joint needs assessment and regional mental health and suicide prevention plans. This work is key to ensuring an integrated approach to mental health service delivery.

There is a need to continue and develop the progress, lessons, and partnerships established over this time to drive further advancements and improvements in regional planning.

Regional planning needs clearly defined roles, responsibilities, and accountability. Joint planning would be most effective with strong stewardship from the NSW Ministry of Health and an expanded role for InforMH to provide centralised access to aggregate and timely data. InforMH is the team in the System Information and Analytics branch of the Ministry of Health that provides data management and analytical expertise to support key decision-makers within NSW Health by providing high quality, timely information on the performance, service utilisation, activity forecasting and modelling of health services.

A process for monitoring PHN/LHD regional planning outcomes and impact will confirm insights gained, progress made, and lessons learnt.

Recommendation 1 – Commit to joint mental health and suicide prevention plans.

1.1 That NSW Health clearly articulates responsibilities and expectations for LHD leadership for regional planning.
1.2 That NSW Health invests in the LHD role in regional needs assessment and planning.
1.3 The NSW Health invests in an expanded role for InforMH in regional planning.
1.4 That NSW Health and PHNs partner on a review of the regional planning process to date to inform future improvements to partnerships, processes, and planning.

Data sharing

Improved data sharing between NSW Health, local health districts and primary health networks will lead to improved service planning and monitoring. Data sharing helps to ensure locally commissioned health services are:

- Located where they are most needed and have the most significant impact.
- Funded to address the specific priorities for the region.
- Planned sensibly to reduce gaps and duplication between different types of services and provide people with a better experience in the healthcare system.
- Inform system and practice improvement priorities and activities.

Data sharing is a priority identified in the *National Mental Health and Suicide Prevention Agreement*. Key data-sharing commitments include:

- Recognition of the commitment to share public sector data where it can be done securely, safely, lawfully, and ethically, made under the *Intergovernmental Agreement on Data Sharing between Commonwealth and State and Territory governments*.
- Agreed up-to-date data items to be shared between governments and with commissioning organisations and service providers, at least quarterly or more frequently where required.
- Data are to be shared with as much geographic and demographic detail as possible according to the “Five Safes” principles.
- Jurisdictions will continue to collect and share state and territory-delivered mental health service data.
- The Commonwealth will continue to collect and share data on Commonwealth-funded mental health and suicide prevention services.

More use could be made of the NSW Health data linkage asset Lumos that links data across the NSW Health system with data from participating general practices and can provide insights into patterns of care.

Recommendation 2 – Conduct an annual assessment of statewide mental health and suicide prevention data assets.

LHDs and PHNs should undertake a joint annual data asset assessment to articulate high-value data for regional planning, determine the existence, location, quality, and feasibility of access to the data referenced and create a data/information asset register/catalogue/inventory.[1] A data catalogue does not store the actual data; it stores metadata (the data that describes the underlying data).

Recommendation 3 – Expand data-sharing agreement to include primary health networks.

In July 2021, the NSW Government entered into an Intergovernmental Agreement on Data Sharing to improve how public sector data is shared between Commonwealth and State and Territory Governments. This intergovernmental agreement must be expanded to include PHNs recognising their role in planning and commissioning services.

TOR a. Equity of access to outpatient mental health services and capacity of mental health services

Too many people in NSW are missing out on mental healthcare care because it's too expensive, too far away, or doesn't exist. In locations where mental health services are available, accessing them proves difficult or, for some people, impossible due to extended waiting periods or excessively stringent eligibility requirements, or high out of pocket costs. As a result, some people do not seek care or seek assistance in emergency or outpatient departments, an environment that may amplify distress rather than reduce it.

Delayed access to mental healthcare may lead to prolonged distress, deterioration of symptoms, missed opportunities to mitigate against harm and reduce suicide risk, prolonged impact on quality of life and economic participation, and a requirement for more intensive or specialist services in the long run. Whilst the burden of unmet mental health treatment needs is most significant for the person experiencing mental ill health, the impact on carers, family, and kin is immeasurable. Early access to resources and treatment is critical.

The drivers of these access issues are multi-faceted, but those with the highest impact are:

- Failure to invest in services, with service investment inadequate compared to illness prevalence and treatment needs estimates (per the National Mental Health Services Planning Framework). NSW has one of Australia's lowest per capita expenditures for assisting individuals with mental health conditions.[2]
- Critical shortages across psychology, general practice, and psychiatry, with projections indicating these shortages will likely worsen. This includes maldistribution of the workforce, with a lack of specialists in rural, regional, and remote areas.
- Poor visibility of available services, with community members typically having trouble locating the services they need in time.
- Excessive eligibility partitioning where criteria for access are based on age, diagnosis, level of risk, and acuity rather than a system designed to be as responsive as possible to requests for help. A lack of flexibility in the system will inevitably compound the poor access

[1] Designing and maintaining an information asset register | naa.gov.au, https://www.datacommissioner.gov.au/launch-data-catalogue

[2] https://mhcc.org.au/wp-content/uploads/2022/11/Shifting-the-Balance-MHCC-2022.pdf

experience of hardly reached groups[3] (e.g., children, older adults, First Nations People, and people with diverse cultural identities and experiences).

Beyond generalist mental health services, PHNs have identified the following major service gaps in outpatient mental health services:

Services for people experiencing disordered eating and eating disorders.

NSW PHNs highlight specialist and community services for people experiencing disordered eating and eating disorders as having insufficient capacity and a limited remit. Regional and rural PHNs in NSW noted a complete absence of services beyond a single FTE funded in each LHD region – whose role is to work alongside health professionals (consultation model) rather than provide direct therapeutic intervention. Metropolitan PHNs mapped some eating disorder services but noted that high demand and insufficient supply meant early intervention was a seemingly impossible pursuit.

Per the NSW Eating Disorders Service Plan, the investment in services for people with eating disorders highlights the inequities between LHDs (with a predictable disadvantage observed in regional and rural LHD regions), with metropolitan LHDs having inpatient, outpatient, community, and day programs (e.g., WSLHD, SCHN, SLHD, HNELHD, CCLHD). At the same time, only consultation advice and management are available in the communities of NNSWLHD, MNCLHD, FWLHD, WNSWLHD, MLHD, and SNSWLHD – where no inpatient, outpatient, community, or day programs exist.

Recommendation 4 – Undertake needs assessment, planning and commissioning for eating disorders.

Explore and address barriers impacting access to timely eating disorders assessment, diagnosis, and intervention and develop an action plan specific to each LHD region. Investment from all levels of Government must follow planning.

Child mental health services.

Earlier onset of illness is associated with poorer outcomes, an increased likelihood of mental ill health persisting into adulthood, and a significant risk to a child's developmental trajectory. An estimated 50% of adult mental illness begins before 14 years of age. All PHNs have observed an increase in demand for child mental health services, which is not currently met by community mental health or outpatient services.

Note - headspace services, are designed for youth aged from 12 to 25 years old; so are not designed to address child mental health issues.

Key challenges through community consultations facilitated by PHNs include:

- The burden of health system navigation commonly falls on parents, caregivers, families, and kin, with an absence of navigational and care coordination options when the primary concern is mental health.
- Service eligibility partitioning by age, rather than by the stage of the child's development regardless of age, is seen as superficial and arbitrary not just by parents and families but also by services. Current and future models must prioritise the child's stage of development over chronological age for the most significant therapeutic benefit.
- Access to psychiatrists for children is a statewide gap. Particularly for children experiencing mental illness with biological and cognitive origins (rather than social and environmental causes/associations), timely access to specialist psychiatric review is critical to thoroughly assess and develop a plan that accounts for biomedical, psychological, environmental, and social interventions. At a minimum, GPs and mental health clinicians need improved access to paediatric psychiatry consultation-liaison and, ideally, psychiatric assessment and planning.

[3] The term *hardly reached* is preferred over *hard to reach* because the latter suggests that fundamental qualities of the group and its members, rather than the interventions trying to reach them, are responsible for members not being reached by health services.

PHNs have also observed:

- The capacity of child and adolescent mental health services (CAMHS) is significantly reduced with tighter eligibility criteria, making referral to such services difficult.
- CAMHS services are typically under-resourced, and the significant consequence is a lack of capacity to provide therapeutic care (e.g., psychological intervention).

Recommendation 5 – Increase child mental health services.

Head to Health Kids[4] is rolling out in four locations in NSW. However, investment in child mental health services in NSW requires a more significant and systemic investment. Collaborative commissioning represents a unique opportunity to develop, trial, test, and upscale an improved child mental health model of care for NSW. An improved child mental health model of care should prioritise:

- Information, resources, and evidence-based child mental health services.
- Parenting programs for families and carers.
- Assessment and treatment planning.
- Evidence-based therapeutic intervention.
- Urgent community assessment pathways and multidisciplinary team care for children experiencing severe symptoms, severe functional impairment, or other complexities.
- Specialist paediatric psychiatry consultation and liaison options for GPs and mental health clinicians.

Culturally safe therapeutic models of care for First Nations Australians

The need for models of care developed and co-designed by Aboriginal peoples and underpinned by trauma-informed healing models is acknowledged in the NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025. PHNs have observed examples of promising practice but report a failure to upscale - promising practice must become business as usual in NSW and must be led by First Nations communities and peoples.

Spotlight – Indigenous mental health provider contracts

Recently, HNECCPHN initiated new contracts with Indigenous Mental Health (IMH) providers to serve the Hunter, New England, and Mid Coast communities. Seven IMH providers were selected to serve these regions, with the program divided into two distinct contracts.
The Therapeutic Group Program comprises a comprehensive 12-week holistic group program that includes various activities such as weaving, art, music, fishing, on-country experiences, and other engaging pursuits. These groups are designed to primarily address mental health topics and equip clients with strategies to autonomously manage their mental well-being while fostering social interaction.
The Care Coordination, Peer Navigation, and Suicide Postvention contract offers essential support to clients grappling with severe mental health conditions.

- The Care Coordinators undertake clinical care planning and coordination.
- The Peer Navigators provide one-on-one support to establish links and facilitate access to mental health services, psychosocial support systems, community resources, and mainstream support avenues.
- The Suicide Postvention Program delivers community-based education, establishes links to counselling and additional support services, developing suicide safety plans, reducing stigma, providing family education, and offering support to affected families.

[4] https://www.health.gov.au/resources/publications/head-to-health-kids-national-service-model?language=en

Recommendation 6 – Address social and emotional wellbeing for First Nations peoples.

PHNs recommend:

6.1 Additional investment in and expansion of the NSW Government's *Building on Resilience in Aboriginal Communities Initiative*. This initiative is part of Towards Zero Suicides in NSW. The outcomes and impact across the existing 12 sites (in only 8 LHDs) should be measured, and further investments should be initiated.
6.2 Prioritised resources and funding for First Nations-led healing programs for the 27,200 survivors of the Stolen Generation living in NSW.
6.3 Continued investment in ongoing professional development of all workforces in delivering culturally safe care with an increased emphasis on the integration of traditional healing and Western concepts.

Innovative service models

There have been a range of recent reforms and investments in mental health services by the NSW Government including:

- Safe Havens: The Safe Haven initiative provides a calm, culturally sensitive and non-clinical alternative to hospital emergency departments for people experiencing distress or suicidal thoughts. Safe Havens are staffed by peer-support workers, and you can be connected to other mental health professionals. There are 19 Safe Havens across NSW.
- Recovery Colleges: Recovery Colleges provide mental health educational programs to people living with mental health conditions, as well as carers, families, friends, workers or volunteers in the mental health and community sector.
- Police, Ambulance, Clinical, Early, Response (PACER): PACER is a Police and MHS response activated by Police, targeting peak demand times, offering on-scene and telephone providing mental health assessment in the community at the time of crisis.
- Community Living Support Program (CLS): CLS is a state-wide program that supports people with a severe mental illness to live and recover in the community in the way that they want to. CLS is part of a suite of community-based psychosocial programs for adults called the NSW Mental Health Community Living Programs.
- Housing and Accommodation Support Initiative (HASI) packages: HASI is a statewide program that supports people with a severe mental illness to live and recover in the community in the way that they want to. HASI is part of a suite of community-based psychosocial programs for adults called the NSW Mental Health Community Living Programs.
- Step-up, step-down services (24-hour support in a residential setting prevent hospitalisation (step-up) and following discharge from hospital (step-down)).

While not solely focused on mental health the implementation of a range of urgent care services across NSW should also improve access to care.

Unfortunately, most of these initiatives are limited to a single LHD or a few LHDs. They are not universally available to the residents of NSW or require additional investment in capacity. PHNs would like to see the expansion of these services and service models.

TOR b. Navigation of outpatient and community mental health services from the perspectives of patients and carers

No Wrong Door is a concept that no person should be turned away from treatment; when a person presents at a service that cannot provide a particular type of service or is at capacity, they should be guided to the appropriate service using warm referral and follow-up.

However, despite this decade-old rhetoric, all too often, there are too many wrong doors and not enough right ones. While the terminology ‘no wrong door’ is intended to be aspirational, unfortunately, the terminology comes across as superficial and contradictory to lived experience.

During regional consultations held by PHNs over the past eight years, the consumer experience of finding the right door is an outlier event. Far more common are stories of confusion, overwhelm, and disorientation. Moving beyond the platitude of 'no wrong door,' remedying this issue requires a commitment to:

- Documenting care pathways for providers and making these pathways visible to the community.
- Reviewing and refining eligibility and appropriateness criteria and making this information readily accessible/understood.
- Redesigning service models to build more flexibility to meet diverse needs (reducing the likelihood that the service will be the 'wrong fit.').
- Continued investment in navigational supports concentrated on support for hardly reached groups (e.g., children and families).

Technology solutions exist with the potential to provide LHDs and PHNs with unprecedented opportunities to respond as "one system" to the mental health treatment needs of communities in NSW. The National Digital Health Strategy of Australia emphasises that digital data is essential for world-class healthcare. The strategy underscores the substantial and persuasive advantages for consumers, such as the prevention of hospital admissions, decreased risk of harm, minimised repetition, improved management of conditions that are chronic or severe, and enhanced point-of-care decision-making.

Technology solutions are available that:

- Assist with secure and timely referral, intake, triage, receiving, and processing referrals.
- Auto-route referrals to providers based on treatment needs and consumer eligibility/preferences.
- Automate bidirectional feedback loops for referrers, consumers, and providers.
- Enable a referrer or consumer to know the real-time status of their referral.
- Provide supply data (e.g., capacity and wait time) to inform alternative pathway decisions and improve visibility of demand bottlenecks and capacity.

There are isolated examples of successful use of technology to improve access and navigation that have not yet been scaled across to the mental health sector. From the primary care perspective, a notable gap exists in integrating clinical information and technological (ICT) systems across most NSW Primary Health Networks (PHNs). These integrations should be interoperable with existing patient/client management systems and e-referral technology in primary care (e.g., general practice software) and technology in NSW Hospitals (e.g., Cerner).

Even essential elements of care integration, such as the provision of hospital discharge summaries, continue to have notable shortcomings. Pertinent observations from the Southern NSW PHN region underscore the severity of this failure, revealing that a mere 65% of discharge summaries successfully find their way to their intended primary care providers. Addressing this issue can be effectively achieved by enhancing the information technology systems that link the diverse tiers of healthcare services and with:

1. The implementation of automatic notification systems alerting primary care providers and mental health services when a consumer is admitted to or discharged from the hospital.
2. The establishment of a feedback mechanism for primary care providers and mental health services to report missing or incomplete discharge summaries. This feedback can help identify issues in the system and prompt continuous quality improvements.

Despite the ongoing dedication of Local LHDs and PHNs to progress ICT interoperability collaboratively, the progress in adoption and dissemination has been sluggish due to costs, regulatory constraints, and bureaucratic obstacles. Failure to progress ICT implementations will result in errors, inefficiencies, and clinical discrepancies, as critical data is not exchanged in real-time. With the implementation of the Single Digital Patient Record in NSW it is vital to allow access for primary care providers including general practice.

Recommendation 7 – Invest in interoperable information and communication technology to optimise clinical workflows across the mental healthcare system.

eHealth NSW to enable investment in interoperable information and communication technology to be fast-tracked to optimise clinical workflows and patient care pathways in mental healthcare.

Recommendation 8 – Explore development of an integrated triage and referral process across primary health care and LHD community mental health services.

NSW Health, LHDs and PHNs work together to link LHD access points/triage (e.g., Mental Health Line) with primary care access points (e.g., PHN central intake services).

The value of service models that deliver navigational support to consumers and carers was highlighted by PHNs. Care navigation services focused on the needs of hardly-reached groups are identified by PHNs as the highest priority.

SPOTLIGHT – Care Navigation Service (Hunter New England and Central Coast Primary Health Network).

In 2017, Armidale was chosen as a regional humanitarian resettlement location. Resettlement commenced in 2018 with the arrival of Ezidi humanitarian refugees, with more than 650 people settling across Armidale to date. HealthWISE is funded by the Hunter, New England, and Central Coast Primary Health Network to deliver a Care Navigation service to assist individuals and families to identify their health goals and to build their health agency and capacity to make empowered health decisions for their future.

Working alongside general practitioners and local specialists, the Care Navigator acts as a partner to assist clients with interpreting the Australian healthcare system, navigating the health services, managing referrals to support groups or other organisations, and providing knowledge and agency to manage their health outcomes.

Equipping existing services with additional navigator roles represents a new workforce pipeline for mental health services. No specific clinical qualifications are required. Instead, navigators are supported to become system specialists and may come from any walk of life.

Recommendation 9 – Invest in navigation services for hardly-reached groups.

Navigation services for hardly reached groups involve both levels of government addressing the significant unmet need for navigational support, with PHNs highlighting the specific following groups for navigational support:

- People with mental illness experiencing or at risk of homelessness.
- Migrants, refugees, and new entrants
- Children, young people, and families
- People with disability (including cognitive impairment, intellectual disability, neurodevelopmental conditions).
- People with co-occurring conditions (e.g., mental illness, chronic disease, and addiction).
- First Nations Peoples.

TOR d. Integration between physical and mental health services and between mental health services and providers

On average, individuals experiencing mental illness have a life expectancy of 20 years shorter than that of the general population. This emphasises the pressing need to enhance the physical well-being of those with mental health challenges. This objective is prominent in the Fifth National Mental Health and Suicide Prevention Plan and the Equally Well National Consensus Statement.

It has also been designated as a "Priority Reform" and a "Start Now" reform in the Productivity Commission Mental Health Inquiry Report.

- Annually, more than 11,000 Australians grappling with mental health challenges experience premature mortality caused by the top 10 factors contributing to death. This translates to over 30 individuals per day. Suicide, though a significant concern, accounts for merely 8% of these untimely deaths.
- Most fatalities result from preventable conditions such as heart disease, diabetes, lower respiratory ailments, and cancer. Preventative measures could significantly reduce the incidence of these premature deaths.
- An overwhelming 80% of individuals managing severe mental health conditions simultaneously grapple with at least one co-existing chronic physical health issue.
- Thus, it is imperative to emphasise prevention, screening, early detection, and treating physical health conditions in individuals with mental ill-health.

A Review of Physical Health and Mental Healthcare in Australia by Equally Well and Lived Experience Australia makes recommendations informed by consumers and carers. NSW PHNs recommend the report to the Committee.[5] The review is informed by the perspectives and experiences of 212 mental health consumers and 76 mental health carers. The review argues for:

1. Further training, resources, and guidance for mental health professionals to improve understanding of a consumer's physical health needs, including a focus on whole health or holistic health care.
2. Further training for health professionals regarding including consumers in decision-making about medications and responding to concerns is required to ensure that consumers are heard and taken seriously in their physical and mental health care.
3. Health professionals should routinely ask consumers about smoking, providing the opportunity to provide guidance and advice should the consumer be interested in quitting.
4. All health professionals (including mental health professionals) should regularly ask about health screening for cancer, heart disease, lung disease, and vaccination status. Health professionals should be ready and equipped to support and advocate for consumers to access the necessary screening and, if needed, follow-up treatment. All clinicians should adopt a model such as the 'Ask, Advise, Assist' model when supporting people with mental ill-health. This model does not impinge on consumers' agency but can help consumers attain equal access to information and decisions regarding their physical health.
5. With the consumers' permission, chronic health information must be shared between GPs and others involved in the consumer's care. All health professionals need more significant engagement with and involvement of carers to support a 'whole of health' approach for consumers.
6. There is an opportunity to gather further lived experiences and knowledge from consumers and carers who have expressed interest in developing a physical and mental health care resource that aims for holistic, whole of health care. Such resources could be created for consumers, carers, and health professionals.

The implementation of MyMedicare, where people can enrol with the general practice of their choice, has potential to address some of the challenges faced by mental health consumers in addressing physical health care as well as encouraging greater continuity of care.

Spotlight – My Care Partners, South West Sydney PHN (SWSPHN)

My Care Partners is an innovative new program for general practices in SWSPHN. Eligible general practices joining My Care Partners become part of a medical neighbourhood, providing enhanced care to patients with chronic and complex conditions at risk of frequent hospitalisations. My Care Partners was co-designed by SWSPHN (SWSPHN), South Western Sydney Local Area Health District (SWSLHD) and community members. The aim of the program is to:

[5] https://www.equallywell.org.au/wp-content/uploads/2022/07/Review-into-Mental-and-Physical-Health-in-Australia.pdf

- Improve coordination between the patient's medical home (regular general practice), primary and community services, and acute care.
- Improve outcomes for patients with complex and chronic conditions at risk of potentially preventable hospitalisations.
- Improve patient and provider experience by encouraging continuity of care and team-based care to reduce the risk of omission or duplication of services.

This program is evaluated and demonstrates potential learnings for future mental healthcare models.

Spotlight – Keeping the Body In Mind, Central and Eastern Sydney PHN

Keeping the Body In Mind (KBIM) is a life skills and lifestyle program for individuals with severe mental illness. Through funding made available by CESPHN, participants can access eight face-to-face sessions with an exercise physiologist and eight sessions with a dietitian at no cost. The service operates from the UNSW Lifestyle Clinic in Randwick or KBIM and extends to telehealth services when face-to-face is not readily accessible.

The KBIM program includes:

- One-on-one exercise physiology and dietitian consultations adapted to individual needs and preferences.
- Participant-led goal setting and barrier identification.
- Education on the physical and mental health benefits of a healthy diet and participation in a structured exercise program.
- Development of a mental health-informed and personalised physical activity program and dietary advice.
- Accessible and effective home-based exercise programs with or without equipment.
- Assistance with meal planning, shopping tours and cooking sessions.
- Pathways into other community-based services for longer-term support, as required.

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

CESPHN jointly commissions GP Shared Care programs with our 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.

TOR e. Appropriate and efficient allocation of mental health care workers

Demand for clinicians is fast exceeding the supply, and workforce projections indicate a significant imbalance. Recent research indicates that a modest increase in the proportion of people seeking help for mental health difficulties, coupled with Australia's projected population growth, would produce a cumulative increase in the use of mental health services ranging from 135 per cent to 160 per cent for select mental health professions, over 15 years.[6] The mental health system faces troubling projected shortages of GPs, psychiatrists, and psychologists.[7]

Recommendation 10 – Expand psychiatry workforce

Increasing access to psychiatry is a statewide priority. The NSW Government developed the NSW Psychiatry Workforce Plan 2021-2025.[8] The development of the plan did not include NSW PHNs. Given that 70% of psychiatrists in NSW work wholly or partly in private settings, a joint strategy is highly desirable to maximise the reach of the workforce and avoid cannibalising this important workforce. NSW PHNs welcome future opportunities to be involved in the implementation of the plan and the development of future versions.

The difficulties confronting the mental health workforce in NSW are magnified in rural and remote regions, where the inequitable distribution of the mental health workforce is felt most severely. The scarcity of adequately skilled and qualified professionals in these areas is a persistent dilemma eluding current policy. Strategies, campaigns, and incentives to encourage the mental health workforce to practice in regional and rural settings are an urgent priority for the NSW government.

The Productivity Commission recommended that workforce planning in mental health should be guided by the preferences of consumers and caregivers and the practical capabilities of governments and providers. It should extend beyond simply addressing imbalances and scarcities through recruitment and staff retention. Recommendation 9 (below) recognises the solution is not in recruitment alone.

[6] https://www.nswmentalhealthcommission.com.au/sites/default/files/old/Strategic%20Plan%20-%20Section%208a.pdf
[7] https://www.nationalskillscommission.gov.au/sites/default/files/2022-10/Care%20Workforce%20Labour%20Market%20Study.pdf
[8] https://www.health.nsw.gov.au/workforce/medical/Publications/psychiatry-workforce-plan-2020-2025.pdf

Recommendation 11 – Renew and expand the NSW Workforce Plan for Mental Health

The NSW Workforce Plan for Mental Health (2018-2022) has concluded. Whilst PHNs were identified as partners in the plan, a future joint workforce strategy is highly desirable. With the finite human resources and significant workforce constraints outlined above, there is a risk that failing to produce a coordinated workforce strategy will lead to persistent difficulties in attracting and retaining talent across the system. A joint workforce strategy will help ensure that LHDs and PHNs work together to:

- Attract new talent.
- Support the existing workforce.
- Support the sustainability and availability of general practitioners, especially in non-metropolitan areas. GPs are already the main providers of mental health services in Australia. A lack of access to GPs will have a flow-on effect to the other sectors of the health system, including hospital emergency departments and specialists.
- Remunerate students completing a placement in mental healthcare.
- Coordinate training and development opportunities and invest in more joint training and development opportunities across LHDs and PHNs (and including GPs and other primary care clinicians).
- Explore and implement future workforce models with shared role opportunities across services and settings.
- Coordinate workforce wellbeing initiatives.
- Maximise workforce networking and connectivity (connected workforces = connected services).
- Implement reforms aimed at increasing the use of self-management resources and low-intensity services.
- Introduce efficiencies, including integrating technology to reduce cost and inconvenience for consumers.
- Supplement the system with new and lower-cost professionals with comparable outcomes.
- A strong and coordinated investment in the consumer and carer peer workforce.

Recommendation 12 – Conduct a mental health workforce census

The need to tackle the systemic problem of workforce shortages persists. This process should commence with gathering quantitative data (pertaining to numbers and compensation of the existing workforce) and qualitative data (relating to categories and circumstances of the work type). This census will play a crucial role in the planning and assessment of the efficacy of the mental health workforce and lead to an improved understanding of the effectiveness of these strategies.

The peer workforce

A peer worker is employed based on their 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 workers are trained and qualified (for example, they have completed a Certificate IV in Mental Health Peer Work) to provide support to people with mental illness and their support network.

While many people in the mental health workforce have personal lived experiences or support family or friends with mental illness, they are distinguished from peer workers because they are not required to be open about and purposefully use or trained to share this lived experience in the course of their job. Peer workers draw on their lived experience of mental illness and subsequent recovery in conversations, documentation, decision-making and advocacy.[9]

[9] https://www.nswmentalhealthcommission.com.au/content/peer-work-hub

Extensive evidence suggests that peer workers have an observable positive impact on the safety and quality of mental health and suicide prevention services. The Health Workforce Australia literature scan[10] found that peer workers complemented traditional teams in delivering mental health services in a variety of ways:

- Peer workers help deliver effective outcomes for service users.
- Peer workers help drive positive culture change.
- Peer workers help deliver better outcomes for families and carers.
- Peer workers are essential to recovery-oriented services.
- Peer workers help reduce hospitalisations.

Recommendation 13 – Invest in the peer workforce

It is imperative that the mental health and primary health sectors respect and recognise the contribution of peer workers. Peer work must be recognised as an evidence-based, highly effective practice delivered by people with considerable expertise and skill, equal to the medical, allied health, and clinical disciplines typically engaged in health and mental health services. This recognition should be coupled with:

- A NSW Peer Workforce Development Plan
- Articulated pathways for peer work career progression
- Investment in a scholarship and bursary program for career development opportunities for peer workers.
- The development of a supervisory framework for peer workers in NSW
- Creating a formal network of peer workers to reduce role isolation and increase peer-led learning and knowledge exchange.

First Nations mental health workforce

Mental health and suicide prevention practitioners from First Nations communities have been recognised as a top-priority occupation within the framework of the National Mental Health and Suicide Prevention Agreement. Numerous initiatives influenced by the strategy are currently being implemented to enhance the mental health workforce.[11]

PHNs strongly recommended a renewed investment in the number of funded positions for Aboriginal mental health trainees in the Bachelor of Health Science (Mental Health) Djirruwang Program and clear pathways to their employment in mental health services.

Spotlight – Aboriginal Mental Health Workforce Initiative

In 2022, Aboriginal and Torres Strait Islander Students interested in entering the first year of the Diploma of Health Science – Mental Health (Djirruwang Program) at Charles Sturt University were offered an opportunity to get thousands of dollars of support for their studies.

The Western NSW Primary Health Network (WNSW PHN), through the Charles Sturt Foundation Trust, offered first-year students in 2023 $8,000 scholarships to assist in their efforts to bring more expertise to regional and remote NSW. The scholarship provides opportunities to enhance the mental health expertise within local communities of Western NSW.

In 2017, WNSWPHN initiated a Workforce Capacity Building project to provide scholarships and support to people who live in under-serviced communities to train as professionals.

Undertaken through the National Suicide Prevention Trial, the project recruited residents from each of six trial site Shires – Brewarrina, Bourke, Cobar, Lachlan, Walgett and Weddin – supporting them to complete a Certificate IV in Community Services. This broad qualification was chosen to maximise graduates' employment prospects, while predetermined electives in

[10] https://mhcsa.org.au/wp-content/uploads/2021/09/HWA-Mental-health-Peer-Workforce-Study.pdf
[11] https://www.niaa.gov.au/indigenous-affairs/closing-gap/implementation-measures/mental-health-workforce#:~:text=First%20Nations%20mental%20health%20and,boost%20the%20mental%20health%20workforce.

Crisis, Bereavement Support, Alcohol and Other Drugs and Working with Aboriginal and Torres Strait Islander Communities ensured they acquired core suicide prevention skills.

The first student intake was recruited in 2017, with selection based on commitment and strong community connections. The 16 successful candidates included Aboriginal and non- Aboriginal men and women from a wide age range, including many with lived experience of suicide or mental health issues and several who had not previously undertaken study beyond Year 10.

The program was led by the Western Plains Regional Development at Condoblin, under contract to the PHN, while the Cert IV education models were delivered through the non-profit training organisation Verto. Students were based with service providers in their local regions. In three of the six shires – Walgett, Brewarrina, and Bourke – this was an ACCHO.

Funding covered the employment of a part-time project officer, a computer and internet connection for each participant to support their participation in fortnightly classes by video-link, and travel costs for them to attend face-to-face meetings where they also completed short courses including Aboriginal Mental Health First Aid and ASIST and SafeTalk suicide prevention training. The program provided academic and personal support to help students manage the pressures and ambiguities they face in undertaking study and embarking on a formal role as a worker within their own communities.[12]

TOR g. Benefits and risks of online and telehealth services

A positive consequence of the pandemic was the increased acceptability of digital and telephone mental health services in the community. Interestingly, PHNs have observed a decline in the proportion of telephone and online services and an increase in the proportion of face-to-face sessions amongst commissioned mental health services. Therefore, the positive effect on access may be waning.

Recommendation 14 – Implement telehealth Hubs to facilitate access to digital healthcare.

LHDs and PHNs co-design and trial the concept of telehealth hubs where people can access a therapeutic, confidential, quiet, and tech-enabled space to engage with digital and telephone mental health services. Telehealth hubs may be as simple as a dedicated space in existing services. Telehealth hubs also have enormous philanthropic partnership potential.

Benefits of online and telehealth services

Benefits observed by PHNs include:

- Convenience for the consumer, carer, family, and kin.
- Improved availability and capacity of finite resources (e.g., psychiatry).
- A growing investment in various service models (e.g., intentional peer support and First Nations healing therapies).
- Enhanced options across the week, weekends, during and outside business hours.
- A strong uptake of e-referral and secure messaging by providers of online and telehealth services, with the benefit of enhanced connectivity with other members of the care team (e.g., GP).

Risks of online and telehealth services

PHNs identified the following risks:

- Inadequate access to internet and personal technology. Some households experience digital disadvantage and may lack access to the internet, computers, and telephones is critical. In some PHNs, up to 23% of households do not have access to the Internet.
- Perceptions amongst clinicians and community members that technology is disruptive to developing rapport, delaying the establishment of a therapeutic alliance.

[12] https://cbpatsisp.com.au/2021/04/06/western-nsw-phn-workforce-capacity-building-project/

- Mental health clinicians and health professionals may experience challenges associated with noticing or assessing nonverbal signals (e.g., fidgeting, crying, poor hygiene).
- Despite studies showing comparable experience and outcomes between face-to-face, online and telehealth services[13], there is limited evidence regarding the efficacy of online and telehealth services with people who are socially disadvantaged and people experiencing low prevalence mental health conditions (e.g., schizophrenia).[14]

Spotlight on Telehealth Psychiatry, Central and Eastern Sydney PHN, Nepean Blue Mountains PHN, South West Sydney PHN

Funded by CESPHN, NBMPHN, and SWSPHN and delivered by Dokotela, this service provides free tele psychiatry consultations, with psychiatrists also working collaboratively with GPs and primary care, community NGOs, and PHN services to ensure a holistic approach to a person's treatment and recovery.

The service addresses a major regional need in accessing affordable psychiatry support for people experiencing severe and complex mental health issues. There are very few bulk billing psychiatrists and current wait times for psychiatrists in the region (regardless of how they bill) are extensive. For those people most in need, psychiatry support is critical. Access to timely care by telehealth allows psychiatrists to consult from their practices (nationwide) and addresses location-based psychiatry recruitment barriers.

A key feature of the program is a collaborative care model that involves:

- Utilisation of a care coordinator integrated with psychiatry services.
- Focusing on engaging general practitioners and other members of the care team.
- Building capacity of the primary health workforce and primary care clinicians.
- Workforce development Case study education sessions with PHN's psychosocial and severe mental health providers to upskill and provide clinical advice.
- Providing a monthly Telehealth Hub ensuring equitable access for people who would otherwise not be able to utilise the program in a telehealth format.

As expected, demand for this service has far exceeded referral targets. In CESPHN, demand for neurodevelopmental assessment is high being approximately 50% of referrals to the service, with consumer and GP satisfaction reaching 94% and 91%, respectively, in recent reports.

Recommendation 15 – Expansion of telepsychiatry

The expansion of telepsychiatry is supported by its reliable diagnostic consistency, positive clinical results, and high consumer satisfaction.[15] Telehealth has the potential to significantly enhance psychiatric service accessibility for individuals residing in rural or isolated regions, as well as in situations where in-person consultations are not feasible.

Numerous studies have showcased telehealth's capacity to yield health improvements on par with traditional face-to-face consultations. The successful deployment of telepsychiatry demands a well-organised and synchronised strategy.

End

[13] https://journals.sagepub.com/doi/10.1177/1039856220943032
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8956990/

[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10063994/