Health
Nepean Blue Mountains
Local Health District

phn
NEPEAN
BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Nepean Blue Mountains

Local Health District and Primary Health Network

Joint regional Mental Health and Suicide Prevention

Foundation Plan

(V 1.0)

Foreword

Achieving better mental health outcomes for people so that they receive the right care, at the right time and in the right place is fundamental to the way mental health services will be delivered within the Nepean Blue Mountains region. Realising a seamless integration of care will require a collaborative approach in the way we develop and deliver services to transform the local mental health system.

The 'Fifth National Mental Health and Suicide Prevention Plan' places new significance and primacy on local leadership and local solutions to achieve regional integration in planning and service delivery for mental health and suicide prevention services. This work has to occur in an environment of unprecedented growth and infrastructure development across the Nepean Blue Mountains region

As strong regional partners in the provision of health care and commissioning, we welcome the opportunity under this Foundation Plan to further deepen our cooperation and with other stakeholders who can contribute to the reform process. Our new integrated regional mental health care system, starts with a Foundation Plan that provides a context for how this can be progressed.

We acknowledge we will not succeed alone, but in partnership with those with the lived experience of mental illness and suicide in a process of co-design, to ensure we deliver care that meets the real needs of our community. The workforce within the region is critical to attaining this goal so we must ensure their experience as clinicians and service providers supports a good experience in delivering safe and quality care

We accept this welcome opportunity to launch a foundation plan which provides an exciting first step with the challenge of transforming the way mental health services can improve care in our region.

Kay Hyman
Chief Executive
Nepean Blue Mountains
Local Health District

Lizz Reay
Chief Executive Officer
Nepean Blue Mountains
Primary Health Network

Contents

Executive Summary

This Foundation Plan represents the start of an iterative approach in the development of comprehensive regional mental health and suicide prevention planning and service provision within the Nepean Blue Mountains region. It focuses on the key partners working together to identify service gaps, shared priorities and opportunities to better utilise existing resources and innovate service design to meet identified regional needs. Consumers and carers will be at the heart and centre in shaping the way in which the services are planned and delivered.

The aim of joint regional service planning is to improve the mental health, physical health and wellbeing of people with or at risk of mental illness and suicide. Regional planning will enable services to be delivered and or commissioned to provide patient centred care and to effectively align resources to the identified needs. In this context, there are two broad, complementary objectives associated with regional mental health and suicide prevention planning:

> ***Objective1**: **Embed a foundation of integration**. Facilitating a plan for action on the ground delivered for people with or at risk of mental illness or suicide, will be achieved through the integration of mental health and suicide prevention planning and service development.*
>
> *This objective takes a whole of systems approach to strengthen the foundation of existing working relationships and develops newer integrated ways of working together to improve the mental health outcomes and experiences for consumers and carers at different levels. The architecture and processes underpinning previous joint planning processes will be reinforced.*
>
> ***Objective 2**: **Drives evidence-based service development** that address identified gaps and delivers care against key regional priorities informed and developed in partnership with local services, local communities and most importantly local consumers and carers.*
>
> *This objective considers how service development is a continuous and iterative process, responsive to change and local needs of the region over the next five years.*

To these objectives, the Nepean Blue Mountains Local Health District (NBMLHD) and the Nepean Blue Mountains Primary Health Network (NBMPHN) have agreed to commence with a Foundation Plan and continue commitment to subsequently develop an implementation plan by June 2020.

1. Background and context

1.1 Introduction and purpose

This Foundation Plan and the future of mental health reform in the Nepean Blue Mountains region is underpinned by a productive cooperation between key stakeholders. The LHD is largely responsible for acute, community and ambulatory mental health services. The LHD's vision is to drive innovation and excellence in health service delivery and provide safe, equitable, high quality, accessible, timely and efficient services that are responsive to the needs of patients and the community. The PHN is responsible for commissioning services outside of the acute sector and for developing system integration with the goal that primary care services are well integrated. Wentworth Healthcare, the providers of the PHN, achieves this through its mission to empower general practice and other health care professionals to deliver high-quality, accessible and integrated primary healthcare that meets the needs of the local community. The region also relies on the range of private health service providers funded through Medicare, including psychiatrists, psychologists, social workers, mental health nurses and Aboriginal mental health workers. A range of other government and non-government organisations (NGOs) also play a pivotal role in providing mental health and psychosocial care across the Nepean region, including housing, community, police, justice and other services. A key element of the Foundation Plan is to promote improved coordination and integration of these services between key health provider organisations.

1.2 Goals of the Foundation Plan

This Foundation Plan outlines how the LHD and PHN will work together, to build and strengthen partnerships and effective governance. This plan establishes a framework to guide the development of the Regional Mental Health and Suicide Prevention Implementation plan.

The goals of this Foundation Plan are:

- To prepare the region for the broader planning exercise required to develop the regional implementation plan by June 2020.
- To utilise existing agreements for joint regional planning governance and development processes
- To facilitate a teamwork approach across the LHD and PHN mental health services directorates and programs for future planning processes
- To develop a shared mental health vision, values and guiding principles to underpin integrated planning processes.
- To identify specific areas of mutual service design and development to strengthen integrated responses to mental health care across the region.
- To build the capacity and capability of local planners, consumers, carers, health care professionals and providers with involvement in co-design for mental health services and programs.

1.3 How the plan was developed

1.3.1 Joint LHD and PHN Board commitment

The PHN and LHD boards jointly committed through a memorandum of understanding (2018), to support collective a vision to improve the health of the region through collaborative action. The joint Boards further confirmed mental health as a key integration priority, with the objective of developing of a Foundation Plan by June 2019 and a subsequent regional mental health and suicide prevention implementation plan by June 2020. A significant commitment of resources has supported the development of the Foundation Plan and will continue to support further development through the implementation planning phase. These resources include dedicated staff from respective health planning and mental health directorates and programs and the engagement of external consultants.

1.4 Governance

To guide the development of this foundation plan, *The Joint PHN and LHD Regional Mental Health and Suicide Prevention Plan Steering Committee* has acted as a governance body. The Steering Committee represents key stakeholders from the Local Health District (LHD), Primary Health Network (PHN), healthcare clinicians and consumers and carers from the NBM region.

1.5 Consultations

Consulting with key stakeholders is critical to the continued development of mental health and suicide prevention services across the region. This Foundation Plan has incorporated and builds upon previous consultation undertaken across the region. This consultation has included young people, CALD and refugee groups, LGBTQI people and Aboriginal communities in the region as well as consumers and carers acting in an advisory capacity to the PHN and LHD. Consultations have been conducted in a variety of ways and with guidance from the relevant peak bodies as how to best engage with each of the different community groups.

In addition to this previous consultation process, the project team undertook a number of targeted interviews and group meetings with consumers, carers, clinicians and planners from across the region.

In parallel, the process of developing HealthPathways has facilitated consultation between primary and secondary care clinicians specific to supporting mental health and suicide prevention and management, as a targeted and ongoing area of development over the next 12 months. Mental health and suicide pathways will provide regionally localised clinical guidelines and referral mechanisms to support clinicians at the point of care management with patients.

1.6 The Broader Policy and Planning Context

1.6.1 Commonwealth

This Foundation Plan is impacted by a broader local, state and national policy context.

The National Mental Health Commissions' review *Contributing Lives, Thriving Communities: Review of Mental Health Programmes and Services* (November 2014) highlighted an urgent need for significant change across mental health services in Australia. The key commentary indicated a lack of system, but instead a collection of often uncoordinated services, developed sporadically over time with people

with lived experience, families and support people having a poor experience of care. As a result the Commonwealth extended the role of PHNs in scope to provide a regional architecture for equitable planning and commissioning of mental health and suicide prevention programs, services and integrated care (Australian Government Department of Health, 2016).

Released in 2017, The Fifth National Mental Health and Suicide Prevention Plan (Australian Government Department of Health, 2017), significantly endorsed by the Council of Australian Governments (COAG) Health Council, committed all governments to work together to achieve regional integration in planning and service delivery for mental health and suicide prevention services. It is a principle guiding document to the planning process. The commitment to enable effective regional responses to mental health and suicide prevention, rather than centralised approaches to planning and service design, is a key component . This places joint responsibility on LHDs and PHNs to lead reform.

The Fifth plan was informed by a range of stakeholders including mental health and suicide prevention service providers, Aboriginal and Torres Strait Islander organisations, people with lived experience, state and territory governments and a range of community stakeholders. Eight key priority areas were identified to implement:

- *Achieving integrated regional planning and service delivery*
- *Effective suicide prevention*
- *Coordinating treatment and supports for people with severe and complex mental illness*
- *Improving Aboriginal and Torres Strait Islander mental health and suicide prevention*
- *Improving the physical health of people living with mental illness and reducing early mortality*
- *Reducing stigma and discrimination*
- *Making safety and quality central to mental health service delivery*
- *Ensuring that the enablers of effective system performance and system improvement are in place.*

The Fifth Plan places strong emphasis on consumer and carer participation, taking the principle "*nothing about us without us"* to the core of all planning activities. It also emphasises the concept of stepped care, allocating resources to best fit the needs of people with a mental illness, from wellness to illness. This concept is expressed across the whole population in each region. Tools including the National Mental Health Services Planning Framework and the regional needs analyses are further intended to make this regional stepped care approach useful.

1.6.2 State

At the NSW State level, the Mental Health Commission of NSW's 2014 plan, *Living Well: A Strategic Plan for Mental Health in NSW* (Living Well), aims to improve the wellbeing and mental health of all people living in NSW. It focuses in particular on keeping those living with moderate to severe mental illness well, living in our communities and working towards recovery. This plan also emphasises the importance of consumer and carer participation in care and respecting the autonomy and dignity of the individual.

The development of Living Well was informed by extensive consultation across multiple NSW community and government agencies including multiple Aboriginal, rural and remote, LGBTQI+ and culturally and linguistically diverse communities. Understanding these perspectives helps inform change, aiming to build a care system that promotes resilience and is recovery-oriented, trauma-informed and, most importantly, puts the person with lived experience at the centre of their own care.

NSW 2021, is the State Government 10-year plan to guide policy and decision making and deliver on community priorities. The plan is reflective of the State government's commitment to improving the quality of life and opportunities for people in regional, rural and metropolitan NSW. NSW 2021 steps out several goals that align directly with the strategic objectives of this Foundation Plan:

- *Keeping people healthy and out of hospital*
- *Providing world class clinical services with timely access and effective infrastructure*
- *Better protecting the most vulnerable members of our community and break the cycle of disadvantage*
- *Increasing opportunities for people with a disability by providing supports that meet their individual needs and realize their potential.*

1.6.3 Regional level

NBMPHN Strategic Plan 2019-2022

In addition to these Federal and State plans, there are also significant local planning activities and priorities.

The key strategic direction of Wentworth Healthcare , providers of the NBM Primary Health Network is identified as improving the health and well-being of people in the community. This is achieved through empowering general practice and other healthcare providers to deliver high quality, accessible and integrated primary healthcare that meets the needs of the community. The five key strategies include:

- *Increasing capacity and influence of primary care*
- *Creating a culture of quality improvement and outcome focus*
- *Coordinating services within and across sectors*
- *Ensuring consumers are engaged in all that we do*
- *Embedding organisational excellence and impact*

These strategies are being pursued in line with key principles: a continuing effective relationship between a patient and their preferred primary care provider and; a care model that ensures people receive the right care in the right place at the right time, underpinned by the measures of the quadruple aim.

NBMLHD Strategic Plan 2018 - 2023

This LHD plan sets out the role of the LHD, describing its key vision as being *Together Achieving Better Health.* The Plan sets out the key challenges and opportunities facing the LHD and states that the LHD will drive innovation and excellence in health service delivery and provide safe, equitable, high quality,

accessible, timely and efficient services that are responsive to the needs of patients and the community.

NBMLHD Healthcare Services Plan 2012-2022

This LHD goal is further articulated in relation to mental health under this Plan, which sets out a ten-year horizon across both hospital and community services.

1.6.4 External factors

Planning in mental health is an inclusive process involving a range of other agencies and organisations that address the social determinants of health.

A significant contributor outside of health, but affecting the welfare of people with lived experience of mental health, is the National Disability Insurance Scheme (NDIS) which aims to support a better life for people with significant and permanent disability, their families and carers. The rollout of the NDIS has occurred gradually, with the NBM region being a trial site for youth rollout. Significant changes are occurring to the way in which people with disability access the support they need, including the eligibility criteria for some supports previously accessible to people living with mental illness. In the NBM region, local area coordination of the NDIS is provided by Uniting. There are two key issues in relation to the NDIS; how best to ensure integration between NDIS and health services occurs and; how best to respond to the needs of the majority of people who have a mental illness requiring attention but will not be eligible for assistance under the NDIS. The introduction of new Commonwealth funding to implement the National Psychosocial Support (NPS) Services, including Continuity of Support, will provide an opportunity for some people to be supported who are either continuing to test for eligibility and or are found ineligible for transition to NDIS. This will not however address all people with such needs in the region. This continues to flag a gap in local psychosocial support.

The Commonwealth has recently announced a substantial investment in the Penrith region to establish an Adult Mental Health Hub. The development of the Hub will require a collaborative contribution from both the LHD and the PHN (Liberal Party of Australia-NSW Division, 2019).

1.6.5 Regional planning context

Planning for new regional mental health services will be impacted by unprecedented and substantial regional infrastructure development associated with the delivery of the new airport, roads, rail and hospitals over the next 10 years which will have further impact on population growth and health service demands within the region. From a health perspective, this is supported by the partnerships of eight regional city councils, two LHDs and two PHNs to form the Western Sydney City Deals Health Alliance, that aims to address key impacts over the next 20 years.

A significant impact to regional planning are the disparate funding models, mandates and service provision of the LHD, PHN and other agencies and organisations supporting the delivery of mental health services. These are compounded by the psychosocial determinants of health and the capacity and capability of organisations to address the related issues. Although systems are disparate, the clients remain the same population, creating a call for action in effective planning and prioritisation.

1.7 Roles and responsibilities

1.7.1 Mental Health Funding

In Australia in 2016-17, the total national recurrent expenditure on mental health-related services was estimated to be $9.1 billion (AIHW, 2019). This was equivalent to $375 per person and was an annual increase of 1.1% since 2012-13 after adjusting for inflation. Funding responsibility is shared between state and territory governments, the Commonwealth and private health insurance funds. In 2016-17, the respective contributions were:

- State and territory governments funded $5.7 billion (61.6%)
- The Commonwealth funded $3.0 billion (32.9%)
- Private health insurance contributed $508 million (5.6%)

1.7.2 Commonwealth and PHN

The Australian government expenditure in 2016-17 was primarily for Medicare Benefits Scheme (MBS) - subsidised mental health-specific services and Pharmaceutical Benefits Scheme (PBS) and Repatriation PBS (RPBS)-subsidised mental health-related medications. Together, these accounted for 55.8% of the total in 2016-17

In NSW in 2016-17, total MBS expenditure on mental health-specific items – including mental health-specific services provided by psychiatrists, general practitioners (GPs), clinical and other psychologists and other allied health professionals was $368.2 million. Total PBS and RBPS expenditure on mental health-related medications in 2016-17 was $156.9 million. Overall, this was equivalent to spending $123.00 per person.

Within the Nepean Blue Mountains region, total MBS expenditure on mental health-specific items in 2016-17 was $17.7 million, in terms of benefits paid by MBS (Australian Government Department of Health, 2018). The most commonly used mental health services were MBS funded GP services ($10.5 million), followed by MBS funded psychiatrist services ($9.7 million), then other allied health mental health services ($8.4 million) funded by the Better Access program. These services primarily support the majority of people in the community with less severe forms of mental illness and less intense needs.

PHNs are a key focus of the Australian Government for the implementation of mental health reforms encompassing prevention through to early intervention, treatment and recovery services. PHNs manage approximately 10% of the Australian Government expenditure on mental health. Approximately 60% of PHN funding is attributed to a flexible funding pool with the remainder tied to nationally prescribed commitments including Headspace, early psychosis youth services, Aboriginal and Torres Strait Islander mental health, suicide prevention and partners in recovery (Australian Government Department of Health, 2016). The Nepean Blue Mountains PHN currently commissions a range of primary mental health care and suicide prevention services in the local region. The Australian Government also funds programs delivered by NGOs, digital mental health and school based mental health programs.

Overall, Nepean Blue Mountains PHN has been funded to commission primary mental health care and suicide prevention services, support coordination, capacity building and service integration across the primary mental health care service sector. Commissioned services through the NBMPHN target evidenced based gaps across the stepped care framework including:

- Low intensity mental health services for people at risk, with undiagnosed or with mild forms of mental illness
- Psychological therapy services for underserviced and/or hard to reach groups
- Youth mental health services including early intervention
- Mental health nursing services for people with severe and complex illness
- Psychosocial support for people with a severe mental illness, not funded under the NDIS or existing community mental health programs
- Aboriginal and Torres Strait Islander mental health services with a focus on culturally appropriate services for those with or at risk of a dual diagnosis
- Assertive aftercare services for people discharged from hospital after a suicide attempt or serious self-harm
- Mental health support for people in Residential Aged Care Facilities
- Services for people affected by mental health and drug and alcohol needs including specific Aboriginal services
- Mental health support for people affected by regional declared drought through the empowering communities services

1.7.3 NSW State and LHD

The NSW Government through LHDs is responsible for funding specialised mental health services. In 2016-17, the greatest proportion of recurrent expenditure on these services in NSW was spent on public hospital services for admitted patients ($996.6 million), followed by community mental health care services ($560.7 million) and a smaller amount on residential mental health services ($11.5 million). Overall, this was equivalent to spending $230 per person.

Services provided by NBMLHD in the region include:

- Emergency and crisis services (including the Triage and Assessment Centre and Psychiatric Emergency Care Service at Nepean Hospital, Penrith)
- Specialised mental health care services provided in acute inpatient units at Nepean and Blue Mountains hospitals
- Mental Health Access teams – providing community assessment and liaison in Blue Mountains and Penrith
- Community mental health care teams, available at Katoomba, Springwood, Hawkesbury, Lithgow, Penrith and St Marys
- Child and Youth specific mental health services
- Whole of family mental health services

- Other community mental health care services, including Assertive Community Treatment teams and older persons community teams
- Suicide prevention (Peer-led) aftercare services
- Programs and services for particular specialised needs, e.g. perinatal mental health, older person's mental health unit, clozapine clinics, anxiety disorders clinic and the RESOLVE program.

NBMLHD also commissions or funds some NGO services, in particular psychosocial support services including the Community Living Supports (CLS) program and the Youth Community Living Supports Service (YCLSS). This includes psychosocial support provided in association with the state-wide Housing and Accommodation Support Initiative (HASI).

2. Foundations for Collaborative Action

2.1 The NBM Mental Health Collaborative Framework

To guide our development of *integrated mental health and suicide prevention planning and service delivery* for the NBM region, the foundations for action will be underpinned by a collaborative framework which defines our joint vision, values, guiding principles and key objectives, forming the basis of our working relationship into the future.

2.1.1 Vision

Our vision for Mental Health and Suicide Prevention supports a system that integrates planning to deliver seamless care effectively and efficiently, and is tailored to meet the needs of consumers and carers within the Nepean Blue Mountains Region.

2.1.2 Principles

We value equity, respond effectively to diversity and work towards social justice for the care of people in our region.

- Mental health services and planning will be recovery oriented, trauma informed and consumer-centred.
- People in the community will be at the centre of care included in shaping the way in which services are planned and delivered
- Partnerships, alliances and networks supporting effective mental health care will be promoted and resourced.
- A stepped care approach will underpin service planning and care delivery
- Early identification and intervention will potentially reduce progression to acute illness severity
- People are entitled to safe, high quality mental health care services and to wrap around care which recognises their broader needs.
- Effective communication and strong collaboration will strengthen all we do.
- The workforce is valued and supported
- Services are designed and delivered to address diverse needs of people within the region

2.1.3 Values

Our values are affiliated with the values identified with 'Living Well – a strategic plan for mental health in NSW. NSW Mental Health Commission (2014). They include:

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

2.2 Objectives

Our key objectives for integrated mental health and suicide prevention transformation are informed by the Fifth plan and the experience of other regional plans as follows:

- Co-design services - consumers are at the centre of care and will be included in shaping the way in which services are planned, delivered and evaluated.
- Enable better access – services are matched to need and equitably distributed through better use of resources
- Integrate care – consumers receive holistic, joined up services and experience smooth transitions of care
- Deliver better outcomes for consumers – care is available to address mental health issues early and reduce the overall impact of illness
- Strengthen - the capacity and capability of health care providers
- Promote - joint needs assessment, planning, health intelligence, digital health systems, performance management and accountability.

2.3 Enbalers and measures

The *underpinning enablers* that drive the priorities for action over the next 12 months to achieve the vision include:

- The intent to shift to a planning and implementation model of Integrated Care for Mental Health and Suicide Prevention
- To consistently adopt the philosophy and systems associated with Stepped Care, and
- To measure progress using the framework underpinned by applying the Quadruple Aim adapted for mental health outcomes.

The regional implementation plan will be grounded in these enablers and measured against the aspirations of the vision.

2.3.1 Integrated Care – an underpinning enabler

Integrated care is an approach to designing healthcare systems that focuses on creating a coordinated, connected and cohesive healthcare system, which allows the patient to have a seamless experience, easy navigation, better health outcomes and avoid repeat tests and unplanned hospitalisations.

At the simplest level Integrated Care involves coordination between providers. Those caring for any patient share information, keep each other informed and provide easier transfer of care between the different services. At the next level providers are co-located and/or connected through the use of technology, where transfers between services are 'warm handovers' involving one provider physically connecting the patient to the transfer, ensuring that the patient is never lost between services. At the most integrated level, services are not only co-located and/or connected through the use of technology but also use the same processes, documentation, funding and billing processes. They also operate under a common goal and set of objectives. Services seek to improve the health of a population by focusing on the underlying causes of illness and the wider determinants of health. Those involved in providing treatment services are connected with those who are providing

community care and to non-health services such as housing and budgeting services . The key principles that underpin Integrated Care (Ham and Walsh, 2013) include:

Governed through shared accountability*:*

- The service has a focus on prevention, and early intervention
- There is a willingness and ability to co-fund and therefore share accountability
- There is a governance structure for the service that goes beyond a single organisation.
- Decisions about prioritisation are made by this cross-organisation governance structure
- The responsibility for patients is understood and shared

Focuses on Building Resilience

- There is a focus in building resilience
- There is shared responsibility and roles in supporting the patient's journey to recovery and maintenance

Structured to be Equitable

- Care is culturally appropriate to the population being served
- Care is accessible to underserved communities, appropriately utilised and understood

Takes a Community Public Health Approach

- Individuals are not viewed in isolation and care is underpinned by a community public health approach
- The service takes into account other services that may be needed to support the patient such as, drug and alcohol services, education and accommodation services.
- Local people are able to input into the design and operation of the service.

Provides a Seamless Transition Between Services

- Emphasis is placed on "seamless transition" through services governed by different bodies.
- Seamless transition is achieved through good communication and shared understandings.
- There is understanding and agreed protocols for transfers

Ensures Resources are Co-ordinated

- The providers have the information and resources to co-ordinate the actions needed to deliver continuous care and seamless transitions

Application to mental health

Integrated care applied to mental health care should ensure that physical and mental health care needs are treated equally and together – *or integrated*.

An example of how integrated care could be applied in the NBM region effectively is demonstrated in a recent exploration of a HealthPathways clinical working group for eating disorders services:

Integrated Mental Health Care Case Example 1: Integrated Eating Disorders Services in the Nepean Blue Mountains Region (May 2019)

'Discussions indicated the establishment of an eating disorder clinic outside of, but near to, the Nepean Hospital would be part of a region-wide approach to eating disorders involving community, primary and secondary care. For it to contribute to an integrated care approach, collaborative planning needs to start early.

One of the first actions would be to establish a broad and encompassing governance structure inclusive of the LHD, the PHN and NGOs to help plan how services could work together effectively. While each organisation may have their own objectives for eating disorders, the core governance group would establish a set of overarching objectives that reflected a region-wide, population focus. A set of objectives would include a concept of 'care and cure', interacting with the patient in a way that reflected not just their immediate treatment needs but the broader context in which they lived. The clinic would be seen as one component of this service with other objectives that supported the region-wide integrated care approach. Without this governance and without the establishment of a set of jointly developed objectives that reflected this balance between 'care and cure' it is unlikely that substantial progress would be made with an integrated approach.

A second key step in the service integration would include the development of a process to share patient information and to manage patient transfers. Ensuring all providers interacting with the patient are using the same information and ensuring that the patient is not 'lost' in the transfer are two early steps in the process for integrating care.

The service should look to develop common protocols and process for service delivery, common documentation, potentially common facilities as well as common funding and billing processes. Aspects of co-location and improved use of technology would need to be further explored.

Commitment within joint partner planning and funding streams needs to be confirmed for progression to occur to pilot an implementation model.

Report from the HealthPathways Clinical Working Group May 2019

2.3.2 Stepped Care – an underpinning enabler

The Australian Government's response to the National Mental Health Commission's review of mental health services and programs commits the government to introducing a *stepped care* approach to the mental health system, including primary mental health care funding provided to PHNs.

Stepped care is an evidence-based, staged system, comprising a range of help and support options of varying intensity to match the level of need and complexity of the conditions being experienced by any given consumer.

A Stepped Care Model supports the delivery of integrated care where the consumer who uses the services and support is at the centre of their health care planning and has pathways to connect to and access the care that they need, when they need it. This includes refocusing primary mental health care

programmes and services to be redesigned within a stepped care model, moving from the 'one size fits all' approach to better matched services to individual need (Commonwealth of Australia, 2017).

A stepped care approach seeks to:

- Reduce the under-servicing and over-servicing of some consumers
- Emphasise early intervention and self-care
- Match the level of service to consumers' need and change services as their needs change,
- Shift focus to services that help prevent the need for acute and crisis intervention
- Offer the full continuum of services from low intensity through to high levels of care
- Ensure consumers have the choice of a broader range of services, better targeted to their needs
- Increase the use of digital mental health services
- Strengthen support for GPs in undertaking assessment to ensure people are referred to the right service

In a stepped care approach, a person seeking support accesses the service that meets their need, and as their needs change, the person continues to access the appropriate service to meet their changing need. Stepped care utilises a person- centred approach, so the person enters the type of service that is right for them at the time, there is no requirement to access a particular level, nor progressively move from one level to another (Commonwealth of Australia, 2017).

Stepped care has five core elements:

1. *Stratification of the population into different 'needs groups'*
2. *Defining distinct interventions for each group – this is necessary because not all needs require the same intervention*
3. *A comprehensive 'menu' of evidence based services to respond to the spectrum of need*
4. *Matching people to services, based on their needs*
5. *Providers delivering services at the level the person requires and adjusting as needs change*

Needs Groups

To help connect people to the service/s that are best for them, we need to understand their situation. Based on their needs, people can be stratified into one of the following eight needs groups.

- Keeping healthy (whole population) – all people can benefit from being physically and mentally healthy throughout their lives
- Community & Family – much support comes from family, friends and other natural supports in the community and they may have their own support needs as carers
- Early intervention/at risk – people with signs of distress, including from life events such as a relationship breakup or losing a job, may be at risk of developing mental illness if support isn't provided early (23% of population)
- Mild – people diagnosed with mental illness (including feeling depressed or anxious), that impacts on wellbeing and functioning to a level that is concerning but not overwhelming and is less than 12 months duration (9% of population)

- Moderate – people diagnosed with mental illness, which causes significant disruption to daily life, wellbeing and functioning and can be over 12 months duration (5% of population)
- Severe – people diagnosed with mental illness, which is very disruptive to daily life, wellbeing and functioning, may include risks to personal safety and is either persistent or episodic (3% of population)
- Severe & Complex – people with a diagnosed mental illness which is severe in its impact on wellbeing and functioning and where there are additional complexities such as difficulties with housing, employment and daily living (0.4% of population)
- Crisis – people with or without diagnosed mental illness who are in crisis, including self-destructive behaviour, suicidal behaviour, and harm to self or others and immediate action is required

The implementation of the a stepped care approach will inform the further development of the Regional Mental Health and Suicide prevention Implementation Plan, ensuring current services across the region and the development of future services meet the needs of the community (Commonwealth of Australia, 2017).

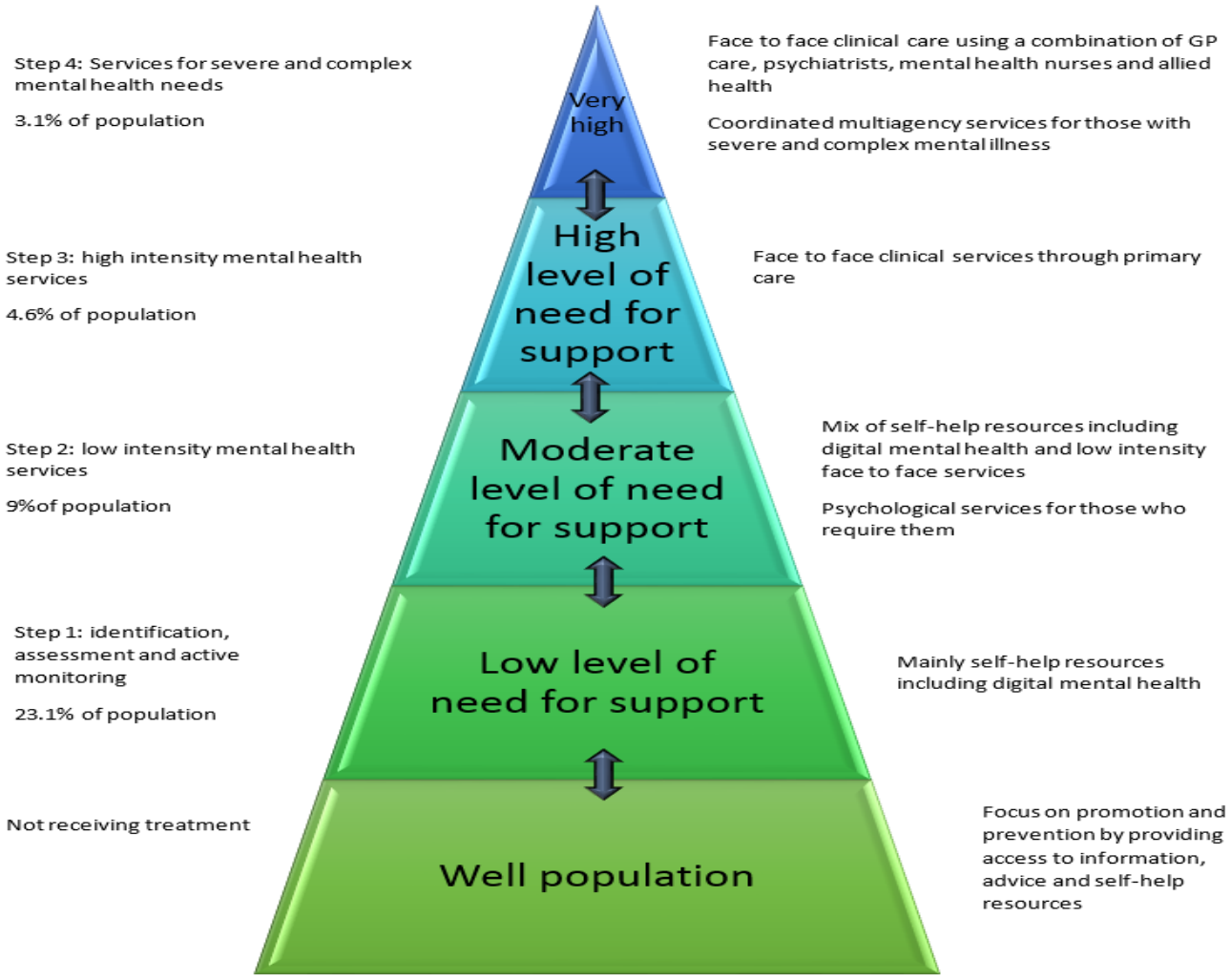


Figure 1: The Stepped Care Model

Integrated Mental Health Care Case Example 2: Decentralising the Clozapine Clinic (Mar 2019)

Currently Clozapine Clinics are delivered at designated times and locations throughout the region. There is little flexibility for the patient making it hard for some people to attend.

A shared-care arrangement with a GP would enable more flexible arrangements – which is especially useful for those people who work. Many of the patients attending the Clozapine Clinics also have physical health issues making a shared care arrangement with a GP a more holistic or 'whole person' approach to care.

To ensure this could work effectively, additional training for GPs and nursing staff is needed within the primary care setting. The training is targeted to improve clinical skills and increase confidence in managing this client group. Education and training is also required for the Mental Health team, including the psychiatrists, to enable greater support for GPs and the potential shared care arrangements

A Health Pathway would require development in order to promote the new referral mechansims to clinicans broadly.

Report from Consultant consultations, March 2019

2.3.3 Measures of Success and the Quadruple Aim

At a broader government level, the progress made though the joint planning process in developing a Regional Mental Health and Suicide Prevention Plan will be measured by the level of consumer and carer inclusion in service development and the implementation of evidence based stepped care mental health. Systems at broader government level will also be developed to ensure the LHD and PHN can better monitor local variation in health needs care and outcomes including health status, the quality of mental health care and the accessibility to care and integration of health care services (Commonwealth of Australia, 2017).

The Quadruple Aim (Bodenheimer and Sinsky, 2014) has also been adopted by the NSW Health Agency for Clinical Innovation (ACI) Mental Health Network and formulated to broadly apply to mental health as follows:

- *Improving the quality and experience of care for consumers and patients*
- *Improving the experience of staff*
- *Improving the mental health of the population*
- *Increasing the cost effectiveness of mental health care.*

At a local level, the application of the quadruple aim, with a lens of mental health & suicide prevention within the Nepean Blue Mountains could be further defined as follows to ensure the broader measures are met within the region:

- *Improving the quality and experience of care for consumers and carers.*
- *Enriching the wellbeing, capability and engagement of the health and social care workforce.*

- *Improving the mental health of the population through a focus on prevention and early intervention.*
- *Increasing the value obtained from expenditure in health and social care through continuous improvement, innovation, use of best practice, and the elimination of waste.*

Measuring Implementation Case Example 3: Quadruple Aim – adapted to mental health

Evaluating Better Access to Psychiatrists, Psychologists & GPs Programme: Case Example

An evaluation mirroring the quadruple aim principles applied to mental health followed the Commonwealths implementation of the Better Access to Psychiatrists, psychologist and GPs Program in 2006. An evaluation plan was developed that focused on four primary domains. Broadly, these were cost-effectiveness, consumer outcomes, workforce acceptability and uptake and population access to mental health care. These interlock. The success of the Better Access Program was contingent on improvement in all of these areas and has since guided further development of these services (Department of Health and Aging, 2010).

A similar application would apply to the local context through agreed KPIs against the regional implementation plan

3. Understanding the Nepean Blue Mountains region

3.1 Nepean Blue Mountains region

3.1.1 Geography

The Nepean Blue Mountains region is located in NSW approximately 50 kilometres West from the Sydney central business district to its Eastern boundary. Our region is comprised of urban, semi-rural and rural areas, covering almost 9,179 square kilometres and spans from St Marys in the East to Portland in the West. It is comprised of four Local Government Areas (LGAs): Blue Mountains, Hawkesbury, Lithgow and Penrith.

Nepean Blue Mountains is a diverse region with a mix of metropolitan, regional and rural areas. Penrith is the main regional city. Other major towns include Katoomba, Lithgow, Windsor and Richmond.

The NBMLHD is one of 15 NSW State Local Health Districts (LHD) and the NBM PHN is one of 10 Primary Health Networks in NSW, and provides primary, secondary and tertiary level healthcare for people living in each of the region's four LGAs, and tertiary care to residents of Greater Western Sydney Region. The Nepean Blue Mountains Local Health District (NBMLHD) and the Nepean Blue Mountains Primary Health Network (NBMPHN) share the same boundaries, helping to facilitate the setting of joint priorities and projects.

3.1.2 Population

Nepean Blue Mountains is geographically diverse with isolation, poor access to public transport and health services in some parts of the region. The current population of 372,199 people living in the region is expected to increase by 25%, or to 466,650 people, by 2036. Of the current population, 3.7% are Aboriginal and Torres Strait Islander which is higher than the NSW state average of 2.9%. People aged 65 years and older comprise 14.1% and this is expected to rise to 20.7% by 2036 (Nepean Blue Mountains PHN, 2018).

Our region also demonstrates significant cultural diversity, in particular the Penrith LGA. In 2016, 24% of the NBM population were born overseas and 11.9% spoke a language other than English at home.

Wide disparities in levels of socio-economic advantage and disadvantage are experienced within our region's LGAs with Lithgow having high levels of disadvantage and some areas of extreme disadvantage. Within Lithgow LGA, suburbs with extreme levels of socio-economic disadvantage include Bowenfels and Morts Estate-Oaky Park-Vale of Clwydd. Suburbs with the highest levels of socio-economic disadvantage in other LGAs in our region include: North St Marys and St Marys (Penrith); Katoomba Township and Katoomba-Medlow Bath (Blue Mountains); South Windsor and Richmond and district (Hawkesbury).

3.1.3 Infrastructure development

The development of the new Badgerys Creek Nancy Bird Walton Airport over the next 10 years is expected to have a bearing on the health and service needs of the greater Western Sydney region.

Major infrastructure development will have an impact on the environment, economy and the health, mental health and social needs of the local population which are yet to be fully determined.

3.2 Need for Mental Health and Suicide Prevention Services

3.2.1 Prevalence of mental illness within the region

The National Mental Health Service Planning Framework – Planning Support Tool (NMHSPF-PST) is a nationally-consistent tool to assist regional planning, coordination and resourcing of mental health services to the needs of a population. It provides population prevalence estimates for the number of persons with a mental health need by level of severity, based upon National prevalence surveys, research evidence and a stepped care model that tailors intensity of intervention to the level of need. Mental health need is defined as:

> *"A diagnosed mental illness or other indicator of need for mental health services such as sub-threshold symptoms of mental illness, distress, or a past diagnosis of mental illness, within an identified 12-month period."*

The NMHSPF provides the following estimates for the prevalence or number of persons of all ages with a mental illness within the NBMPHN region in 2019:

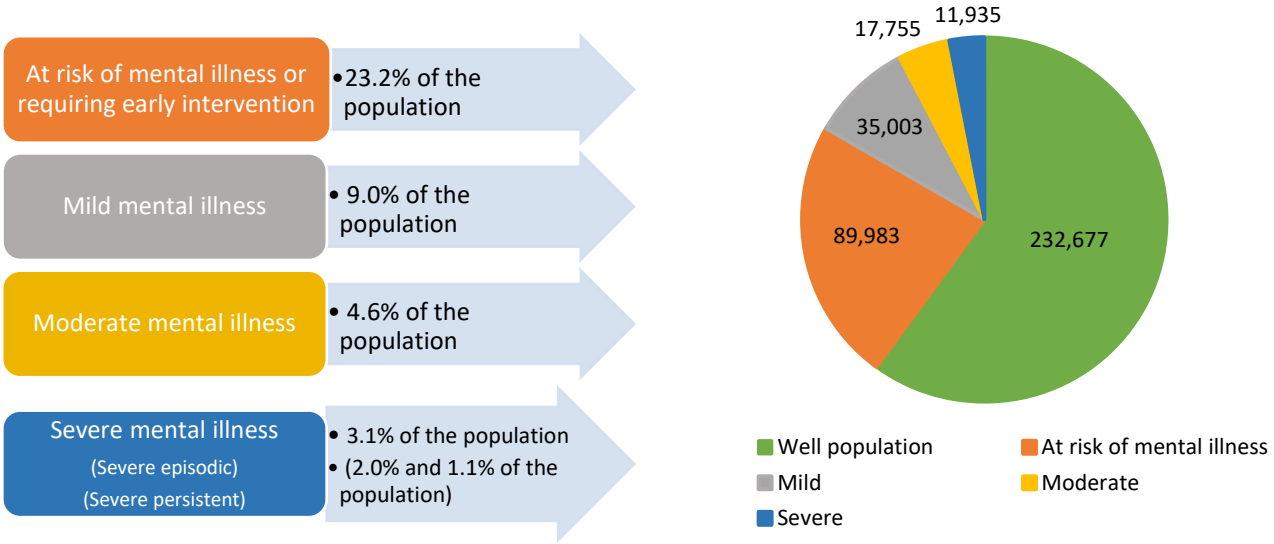


Figure 2: Estimates of number of persons with a mental illness by level of severity in the Nepean Blue Mountains population in 2019

In a population of 387,354 persons in the NBM region in 2019, it is estimated that approximately 64,693 people (16.7% of the total population) would be likely to have a mental illness in a 12 month period. A further 89,983 people (23.2% of the total population) are expected to be at risk of mental illness or may require some level of early intervention to prevent progression to a formal diagnosis and to manage distress. It is not expected that all of these individuals will seek or require services within a 12-month period.

3.3 Population mental health and suicide prevention indicators

Available population health data overall indicates the Nepean Blue Mountains region has a higher burden of mental illness and suicide compared to NSW.

These include:

- The region experiences relatively high levels of high or very high psychological distress. Overall, 17.2% of adults report high or very high psychological distress, with significant regional variability.
- Aboriginal and Torres Strait Islander people in the region are more likely to experience high or very high psychological distress, estimated to be 2.6 times greater than for non-Indigenous adults based upon national figures.
- The region experiences relatively high rates of hospitalisations for mental disorders – in 2016-17, the 9,390 hospitalisations in our region equated to the highest rate among LHD regions in NSW.
- The region experiences relatively high rates of suicide. The 46 deaths (12.5 per 100,000 persons) from suicide in the region in 2016 was the highest among metropolitan LHDs in NSW. The region experiences relatively high rates of self-harm, with hospitalisations for self-harm higher than the NSW state average. The burden related to self-harm within our region is highest for females, young people, Aboriginal and Torres Strait Islander people and residents of the Lithgow LGA.

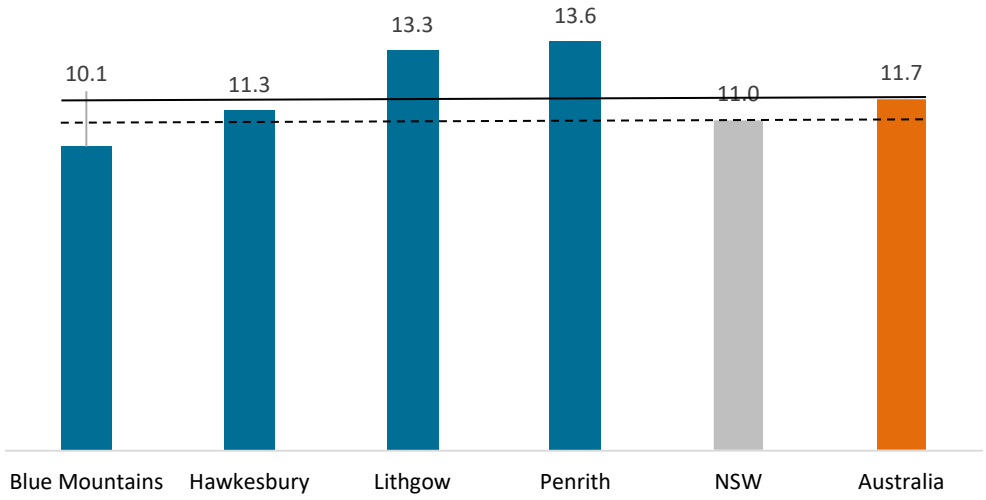


Figure 3: Modelled estimate prevalence (rate per 100) of high or very high psychological distress by LGA, 2014-15

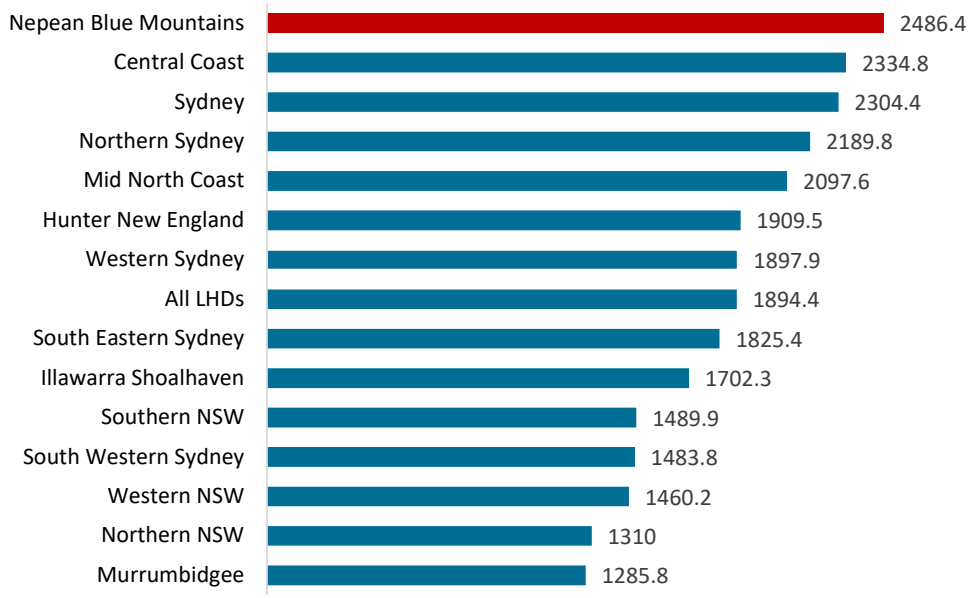


Figure 4: Comparison of age-standardised hospitalisations by category for mental disorders (rate per 100,000) among NSW LHDs, 2016-17

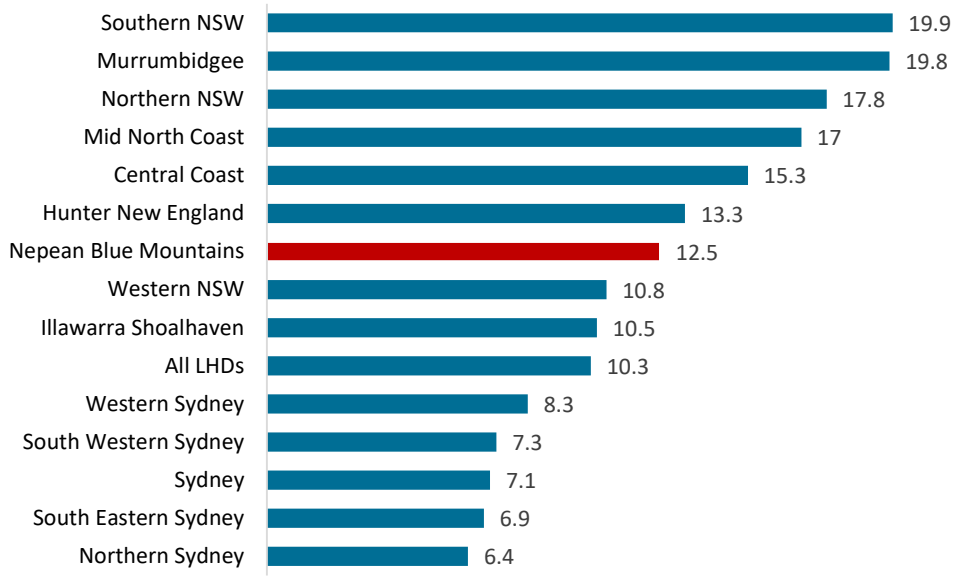


Figure 7: Comparison of age-standardised deaths by suicide (rate per 100,000) among NSW LHDs, 2016

3.4 Populations with special needs

Populations within the Nepean Blue Mountains region identified to be at greater risk of suicide, self-harm and/or who experience disproportionately greater mental ill health include:

- Aboriginal and Torres Strait Islander people
- Young People

- CALD Communities
- LGBTI Communities
- Homeless Populations

3.4.1 Aboriginal and Torres Strait Islander People

In 2014–15, nationally 29.3 per cent of Aboriginal and Torres Strait Islander people aged 15 years and over experienced a mental health condition. Almost one third also reported experiencing high and very high levels of psychological distress (31.4 per cent) while around one in six reported having lower levels of overall life satisfaction than others (Australian Bureau of Statistics, 2016).

Suicide has emerged in the past half century as a major cause of premature mortality and is a contributor to the overall health and life expectancy gap for Aboriginal and Torres Strait Islander peoples. In 2017 it was the fifth leading cause of death among Aboriginal and Torres Strait Islander peoples, and the age-standardised suicide rate was more than twice as high as the non-Aboriginal and Torres Strait Islander people's rate (Dudgeon et al, 2016). On average, over 100 Aboriginal and Torres Strait Islander persons end their lives through suicide each year, accounting for 1 in 20 Aboriginal and Torres Strait Islander deaths.

The evidence shows that the high suicide rates experienced by Aboriginal and Torres Strait Islander peoples, are due to multiple, complex and interrelated factors that heighten the risk for suicidal behaviours and self-harm.

Addressing the social determinants of suicide and mental health requires programs and services that support a multi-level approach to address dispossession, racism and the broader determinants of health, and the array of inequalities that impact on the physical and mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. Programs need to be culturally appropriate, and need to have community engagement and ownership from the outset.

The inclusion of Aboriginal and Torres Strait Islander services, Aboriginal and Torres Strait Islander representatives, Aboriginal and Torres Strait Islander with a lived experience of mental health across all development phases of the implementation plan will be critical.

3.5 Estimated demand rates for regional mental health services

The NMHSPF Framework also provides estimates of service demand rates for persons with an identified mental health need. The demand rate is defined as:

> *"The proportion of people with an identified mental health need who require an individually-tailored mental health service response."*

The estimated service demand rates and number of people with mental health needs who require an individually-tailored mental health service response for all age groups in the NBMPHN region in 2019, by level of severity are illustrated in Figure 6.

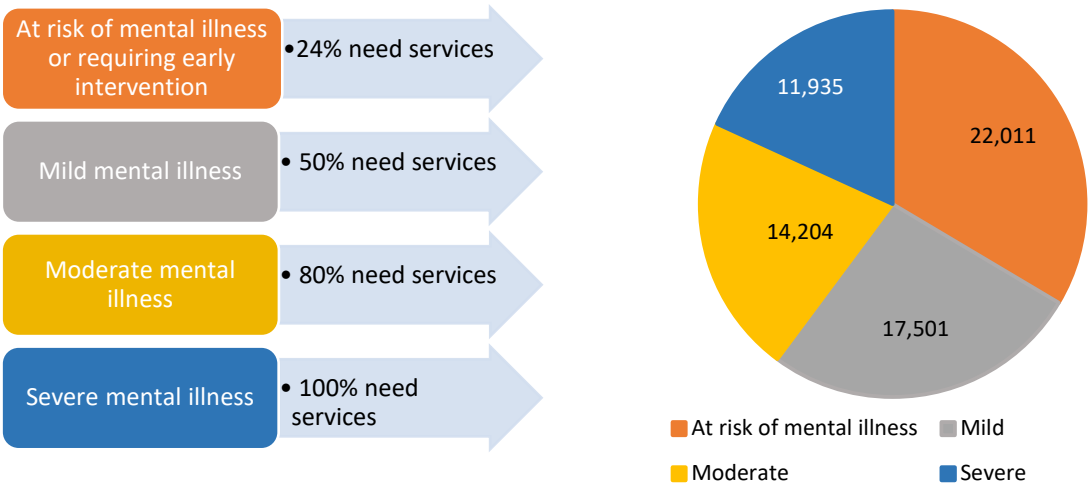


Figure 6: Estimates of service demand matched to illness severity for persons with a mental health need in the Nepean Blue Mountains Population in 2019.

Based on this approach, the estimated service demand rates or treatment population for each of the region's local government areas in 2019 were calculated and are set out in Table 1.

Table 1: Estimated number of persons with a mental illness by level of severity who require individually-tailored mental health services (treatment population), for the total Nepean Blue Mountains population and its LGAs in 2019.

Severity Level	Total NBM Population	Blue Mountains	Hawkesbury	Lithgow	Penrith
Severe	11,935	2,616	2,140	654	6,545
Moderate	14,204	3,076	2,551	762	7,843
Mild	17,501	3,785	3,143	936	9,670
At risk group	22,011	4,587	3,952	1,107	12,318
Total treatment population	**65,652**	**14,065**	**11,786**	**3,459**	**36,376**
Total population number including treatment population	387,354	84,506	69,645	20,991	213,587

3.6 Utilisation of regional mental health services

3.6.1 Utilisation of Commonwealth MBS funded primary mental health services

Analysis of Medicare Australia Medicare Benefits Schedule (MBS) data for mental health service items shows that 40,482 patients (10.9% of the NBMPHN population in 2017) residing in Nepean Blue Mountains accessed a Commonwealth funded MBS mental health service in 2016-17. Given NMHSPF estimates for the number of persons with or at risk of mental illness in the region in 2017 who required an individually-tailored mental health service response (63,877), it appears that less than two-thirds (63.3%) of these persons accessed some form of MBS service for their illness.

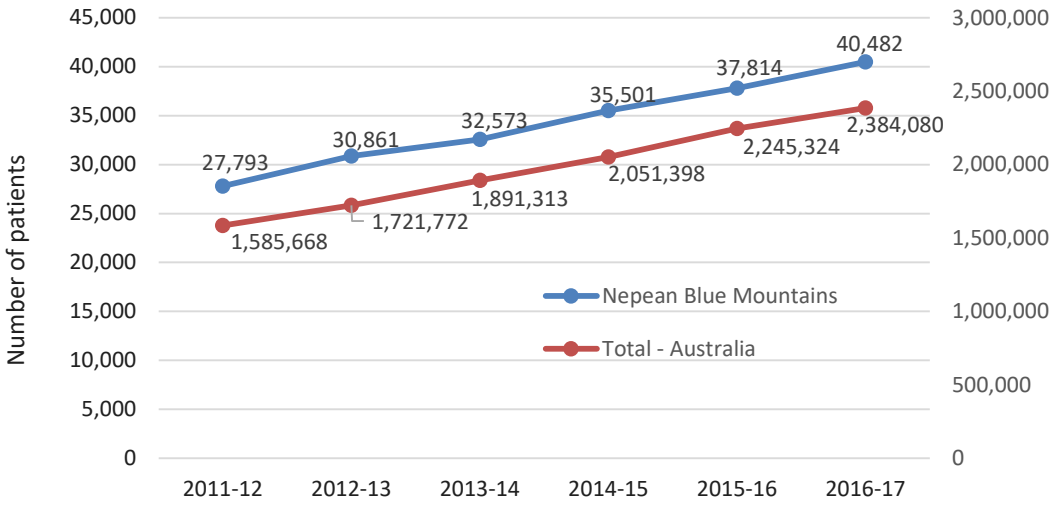


Figure 7: Total patient uptake of Commonwealth funded MBS Mental Health services by people residing in Nepean Blue Mountains vs. Australia, 2011-12 to 2016-17

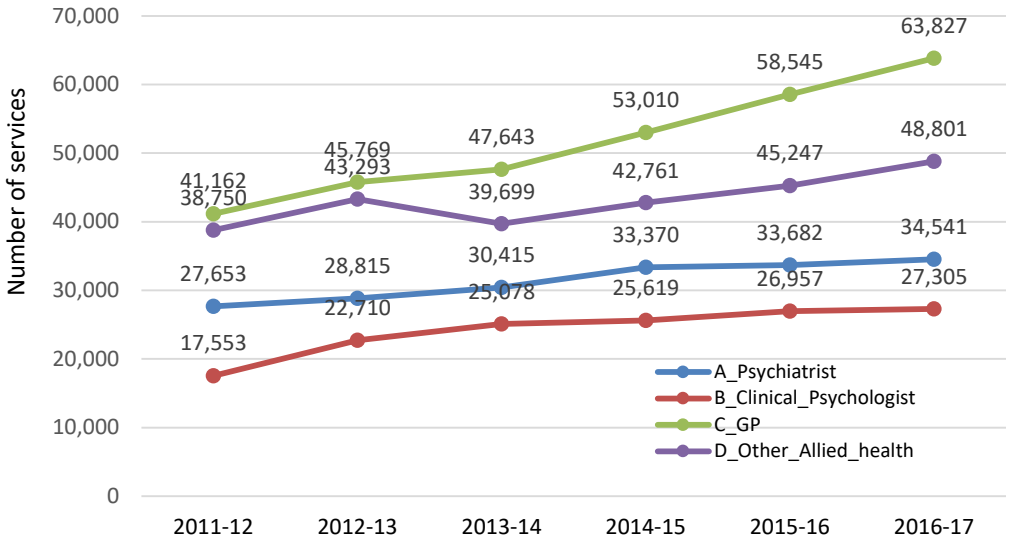


Figure 8: Service uptake of Commonwealth funded MBS Mental Health items by service type in Nepean Blue Mountains, 2011-12 to 2016-17

The highest number of Commonwealth funded MBS mental health services claimed by NBM residents in 2016-17 by service type was by: General Practitioners (36.6% of services), followed by "Other Allied Health" (Better Access items – 28.0%), psychiatrists (19.8%) and clinical psychologists (15.6%). Of the MBS mental health-specific services delivered by GPs in the region in 2016-17, more than one-third (26,511 or 41.5%) were for the preparation or review of a mental health treatment plan.

Table 2: Medicare Benefits Schedule services delivered under GP mental health treatment items in NBMPHN, FY 2016-17

MBS Reporting Group	MBS item(s)	No. of patients	Crude Rate (per 1,000 persons)	No. of services	Crude Rate (per 1,000 persons)
Preparation of a GP Mental Health Treatment Plan	2700, 2701, 2715, 2717	19,458	52.3	19,477	52.3
Review of a GP Mental Health Treatment Plan	2712	6,067	16.3	7,034	18.9
GP Mental Health Treatment Consultation	2713	17,816	47.9	33,332	89.6

Analysis of MBS data indicates that within the NBM region, Statistical Area 3 (SA3) locations with the *lowest* rate of services (crude rate per 1,000 persons) for GP mental health treatment items in 2016-17 were:

- **Preparation of a GP mental health treatment plan**: Lithgow-Mudgee (41.1), St Marys (47.1) and Penrith (55.5).
- **Review of a GP mental health treatment plan**: St Marys (16.5), Penrith (17.1) and Lithgow-Mudgee (18.1).
- **GP mental health treatment consultation** in order are: Lithgow-Mudgee (61.6), Blue Mountains (92.9) and Penrith (102.1).

3.7 Mental Health and Suicide Prevention Services available in the NBM Region

The service maps presented in Appendix C present a high level view of mental health and suicide prevention services available for each LGA in the region, by levels of severity within a stepped care service delivery model and by age or target population group. Services identified include those available through primary care, tertiary level services, the NGO sector, those commissioned or delivered by NBMPHN and NBMLHD, and services funded at a national or state level which are available locally.

A high level summary of the available services is described below. Services that require a referral by the LHD Access team are denoted by a # symbol and highlighted.

Penrith LGA

- Acute inpatient, high dependency and older persons units and psychiatric emergency care service
- Specialised Mental Health Triage and Assessment Centre.
- Community mental health teams available to provide adult and older persons services#
- Psychological services available through MBS, PHN funded psychological therapy services and private providers.

- Acute Child and Youth Mental Health Services[#], Headspace services and Youth Early Severe Service (YESS) available
- Peer-led Aftercare for people at risk of suicide or with complex needs upon discharge from hospital
- NGO services provide psychosocial and community support
- High availability of services physically located in the LGA

Blue Mountains LGA

- Acute inpatient unit at Blue Mountains Hospital
- Community mental health teams available to provide adult and older persons services[#]
- Psychological services available through MBS, PHN funded psychological therapy services and private providers.
- Acute Child and Youth Mental Health[#] (1x day per week only), travel required to Headspace services located in Penrith, Youth Early Severe Service (YESS) available via outreach
- Peer-led Aftercare for people at risk of suicide or with complex needs upon discharge from hospital
- NGO services provide psychosocial and community support
- Moderate availability of services physically located in the LGA

Hawkesbury LGA

- Community mental health team available to provide adult services[#], older persons services available by outreach only
- Psychological services available through MBS. PHN funded psychological therapy service providers and private providers available within town centres Richmond or Windsor only.
- Travel required to access acute Child and Youth Mental Health[#], Headspace services located in Penrith, Youth Early Severe Service (YESS) available via outreach
- Peer-led Aftercare for people at risk of suicide or with complex needs upon discharge from hospital
- NGO services provide psychosocial and community support
- Low to moderate availability of services physically located in the LGA

Lithgow LGA

- Community mental health team available to provide adult services[#], older persons services available via Blue Mountains team by outreach only
- Psychological services available through MBS. Limited number of PHN funded psychological therapy service providers and private providers, located in the Lithgow town centre only.
- Headspace service and Youth plus services (for young people at risk of or with a non-psychotic severe mental illness) available at the newly established Lithgow Headspace
- Peer-led Aftercare for people at risk of suicide or with complex needs upon discharge from hospital
- NGO services provide psychosocial and community support
- Limited availability of services physically located in the LGA

4. Identified Service Gaps, Issues and Challenges in the NBM Region's Mental Health Services

4.1 Systems problems and poorly integrated services

Evidence of systems problems, poorly integrated services and opportunities for system improvement have been identified by previous consultations with service users and service providers, service mapping, data analysis and NBMPHN needs assessments. The following key 'systems' themes have emerged:

4.1.1 Suicide prevention

- In recent years a number of key strategic suicide prevention plans have been released at a national, state and targeted population level including the National Suicide Prevention Strategy, the National Strategic framework for Aboriginal and Torres strait Islander peoples' mental health and social and emotional wellbeing, the Strategic Framework for Suicide Prevention in NSW 2018–2023, and the Living Is For Everyone (LIFE) Framework.
- All of these documents clearly articulate the devastating impact of suicide across the lives of friends, families and communities and the need for an integrated, cohesive response from health and community services to provide wrap around care for persons affected by suicide and self-harm.
- Initial consultation with consumers and carers in the Nepean Blue Mountains indicate that fragmented service delivery impacts greatly on the consistency of care provided to the person at risk of suicide. Our clinicians, NGOs and community services note the unfamiliarity with services and rapidly changing services affect their ability to make affective, timely referrals.
- Previous findings also highlight that community awareness of suicide, suicide risk and opportunities to support people who may be at risk are perceived to be inadequate. People who have attempted or are at risk of suicide, their families and friends experience difficulties navigating referral and care pathways. This includes accessing appropriate services and timely referral to a full range of supports. Concerns exist around the continuity and transfer of care for people who have made an attempt on their life following discharge from hospital or a reduction in treatment post discharge, and support available for family members. Such concerns highlight a heightened need for care coordination for these persons.
- Through a broad consultation process, an integrated approach to suicide prevention will be developed and articulated in the implementation plan that encompasses the needs of the local community, is culturally tailored to target groups, promotes early intervention and ensures support for those affected by suicide.

4.1.2 Mental health

Previous findings highlight inadequate access to psychiatric services among some communities in the NBM region.

- Service coordination, continuity and transfer of care between sectors for persons with mental illness are ongoing concerns. People transferring to primary care and/or community service

providers after discharge from acute mental health services are of particular concern. Challenges exist around effective care coordination, referral pathway coordination, case management and follow up between acute and primary mental health services, and between clinical and non-clinical services. This impacts the ability to support consumer-centred care and the seamless stepping up or down in the levels/type of care received.

- The community describes a need for better connections for young people in and out of Home Care, Juvenile Justice, FACS, Health and NGOs, through sharing data, information and communication feedback loops so as to support integrated care with clinical in-reach.
- Service providers need to ensure as a priority, that all people with severe, persistent and complex mental illness are connected to a regular GP.
- Collaboration, communication and an agreed functional framework for responsible providers / commissioners is required to enable consumers and carers to have a clear understanding of pathways and related service information. This will enable greater understanding and visibility of service provision across the treatment 'system', and help to reduce barriers to access.
- Further work is required to increase the provision of, and active participation in, culturally safe mental health services for Aboriginal people. This must be done collectively, and in collaboration with the community it intends to service. Developing the cultural competence of mainstream mental health services is recommended as a good starting point from which to improve and promoting positive mental health among Aboriginal people.

4.2 What service users have told us

Over the last 18 months consultation has been undertaken with a large number of *service users*. These have included:

- Young people
- Aboriginal and Torres Strait Islander people
- CALD Communities

Key themes emerging from these consultations included:

Knowledge

- A common theme that emerged in consultation with both consumers and providers was the lack of knowledge people had about the services available. Many young people, for example, were not aware of services such as Headspace.
- Poor health literacy among communities within the region is a major factor, adding to the lack of knowledge about service availability, access, ability to make appropriate healthcare decisions and recognition of need.

Barriers to service access

- The consultation revealed a number of barriers to service access including cost, transport, language and cultural appropriateness. Some people, for example, can't afford the gap charges for Medicare consultations with private psychologists.

- Transport to appropriate services is a major issue across the four LGAs. This is consistent with findings from other consultations held within the District, which covers approximately 9,200 spare kilometres.
- Cost is also an important barrier to accessing services. Many areas of the region are in lowest two deciles of the SEIFA indices, with inter-generational unemployment and high levels of social housing. A lack of practitioners who bulk bill and high numbers of sessional general practitioners within large corporate medical practices add to the difficulties in accessing appropriate and consistent medical care. Low levels of psychological distress may be missed in these conditions.

Social Context

- Levels of stigma and discrimination associated with mental illness and co-morbidities such as alcohol and other drug use often deter people from seeking appropriate healthcare services or even discussing their fears and thoughts in relation to their mental health. Non-disclosure can frequently exacerbate mental illness, and fear of discrimination can lead to increased feelings of isolation and distress. This may also lead to people not accessing the services which could assist in the management of their condition.

Cultural Appropriateness of Services

- Consumers also identified significant gaps in knowledge, or provision, of culturally appropriate and safe mental health services for targeted populations, including Aboriginal and Torres Strait Islander people, the CALD and refugee community and young people and the means to access them, where available.

Lack of Services

- In some key areas it was noted that the service simply did not exist within the region at this time. Services included dedicated acute paediatric and adolescent mental health beds, a wider range of support services for carers, and community based post-natal depression specific services.

4.3 What service providers and other stakeholders have told us

Over the last 18 months consultation has also been undertaken with a large number of *service providers.* These have included:

- LHD mental health clinicians (acute and community)
- General Practitioners
- Allied Health professionals
- Non-government Organisations (NGOs)
- Local Councils

Key themes central to integrated care emerging from these consultations include:

Communication and transfer of care between Services

- An ongoing issue noted by service providers in the community and acute services alike is the lack of agreed, tested and sustainable communication pathways, including transfer of care

between services. Consumers leaving the acute setting may not be provided with a discharge summary in real time; GPs are not made aware of discharge or changes in medication regimes. Psychosocial services who support the consumer are a rarely informed or included in discharge planning, and not kept informed about changes to risk management plans. GPs noted that they are often not kept 'in the loop' about treatment options for their patients and discharge details when they are transferred out of acute care. GPs and Allied Health Professionals also noted that multiple entry points to some services, including 'no wrong door' meant that, at times, they were unaware that their patients were accessing multiple services with a subsequent lack of co-ordination between service providers.

- Consumers may be receiving a number of psychosocial services, yet this often remains unclear to other service providers resulting in a lack of co-ordination in the provision of services, over utilisation of services or gaps appearing.
- Robust communication protocols, particularly when transferring across services, are crucial in assisting consumers to stay well and avoid readmission.

Access to Appropriate Services

- The single point of access through the Access Team to community mental health services is sometimes challenging for consumers to reach appropriate services. Once the consumer is referred to the Access team, outcomes of assessment, referrals or treatment plans are not always shared with the referrer. This single point of access to appropriate services, through the Community Access Team, was identified as a barrier by GPs and other primary care mental health professionals. Lack of clarity concerning the seniority of staff and criteria used to make decisions regarding patient access to public mental health services was reported as a cause of frustration.
- GPs and other primary care mental health professionals felt that there was no differentiation between referrals made by family members, self-referral by patients and GPs, undercutting their expertise and knowledge of the patient.
- Lack of knowledge available services, correct referral pathways and the continually changing service provision landscape - influenced by the roll out of the NDIS - creates difficulty for service providers navigating the system on behalf of consumers
- The dearth of dedicated specialist youth mental health services across the region was also mentioned frequently during the consultation process.
- In some instances appropriate services at an accessible location are not available. Service providers noted the concentration of services available in Penrith was ineffective for consumers who live outside the area who struggle with access to and cost of transport. In some instances services simply do not exist within the region or existing services may be at capacity with long wait lists. In some instances of critical need, GPs indicated they had referred patients directly to ED to support access to publicly delivered mental health services.

Access to Specialist Support

- GPs reported difficulty in referring patients to psychiatrists, in what they felt was a timely manner. Similarly they reported there could also be difficulty in accessing psychiatrist support and advice to guide community and GP management of mental health patients within their

practices. The development of HealthPathways for Mental Health Conditions should assist with this matter in the future.

Service Silos

- GPs and primary care mental health professionals described the lack of collaboration amongst primary and acute mental health professionals to coordinate discharge plans or develop a jointly agreed care plan. Service silos also contributed to the issue of poor communication between services described above and the difficulty of getting specialist support that would enable a patient to continue being cared for in the community.

5. Implementing the Foundation plan into action

Implementing the foundation plan aligns to the stated objectives of embedding a foundation of integration and driving evidenced based service planning and development, fleshing out priority area one of the fifth National Mental Health and Suicide Prevention Plan (2017), *Achieving integrated regional planning and service delivery*. The following key initiatives articulate the actions required to support the development of the implementation plan over the next 12 months.

The Mental Health and Suicide Prevention Foundation Plan			
Key initiative		Objectives	Timeframe
Process Actions			
1. Transformation to integrated care planning and service design			
1.1	Joint Boards endorsement of the Foundation plan. This includes the adoption of a shared vision, values and guiding principles for integrating mental health service planning and delivery.	Joint organisational agreement is reached between the NBM LHD and NBMPHN to initiate the next phase of developing the implementation plan.	July 2019
1.2	Joint LHD and PHN resources continue to be committed to support the development of the regional implementation plan. This includes the respective planning directorate/program development lead and mental health directorate/program expert clinical direction and contribution	Joint organisational resources continue to be committed over the next 12 months to enable the next phase of developing the implementation plan	July 2019 to 30 June 2020
1.3	Joint LHD and PHN Mental Health and Suicide Prevention Plan Steering Committee is re-established and meets regularly to guide the implementation plan development	Joint operational governance and leadership continues to guide the development of the implementation plan over the next 12 months	July 2019
1.4	Mental health and suicide prevention services and commissioning options are defined and prioritised against	The developed regional implementation plan is inclusive of	30 June 2020

	local need and incorporate features of integrated care	clearly defined approaches to facilitating integrated care	
1.5	Integrated care development with the LHD and PHN is inclusive of Mental health and suicide prevention service planning as a key priority	Mental health and suicide prevention planning is embedded into the LHD and PHNs broader integrated care strategy implementation	ongoing
2. Consumers and Carers are front and centre of the planning process			
2.1	Consumer and carer consultation processes are clearly defined to ensure meaningful contribution of consumers and carers in all phases of the implementation plan development over the next 12 months	Consumers are carers shape the way mental health and suicide prevention services are planned and delivered in the region	July 2019 to 30 June 2020
3. Regional service providers contribute to planning development			
3.1	A Regional service provider consultation processes is clearly defined to ensure contribution into defined phases of the planning process over the next 12 months	External regional service providers including primary care, government and non-government organisations and agencies contribute to the development of the implementation plan	01 July 2019 to 30 June 2020
4. Aboriginal people contribute to service planning			
4.1	A consultation processes is defined to ensure contribution of Aboriginal people into all phases of the planning process over the next 12 months	The needs of Aboriginal people are voiced by Aboriginal people in contributing to the development of the plan	01 July 2019 to 30 June 2020
5. Co-morbidities of mental health including physical health and drug and alcohol contribute to service planning			
5.1	A consultation processes is defined to ensure consideration and inclusion of comorbidities including physical health and drug and alcohol within defined phases of the planning process over the next 12 months	Comorbidities are a key consideration in the development of the implementation plan	01 July 2019 to 30 June 2020

6. Psychosocial determinants of health are considered and contribute to service planning			
6.1	A consultation processes is defined to ensure consideration and inclusion of the psychosocial determinants of health within defined phases of the planning process over the next 12 months	Psychosocial determinants are a key consideration in the development of the implementation plan	01 July 2019 to 30 June 2020
7. Health intelligence supports evidenced based planning			
7.1	Joint health intelligence contributes to the development of the implementation plan i.e. shared data and analysis of information	Shared health intelligence supports joint service planning, development and commissioning	July 2019 to 30 June 2020
8. Stepped care model defines local service provision			
8.1	Development of agreed stepped care model across primary, secondary and acute service systems for mental health and suicide prevention services	Shared taxonomy provides consistent joint service development and delivery	July 2019 to 30 June 2020
9. Developing measures of success			
9.1	Adopt and adapt the quadruple aim within the implementation plan to support how planned services could be aligned to clearly defined measures of success for mental health outcomes, consumer and carer experience, provider experience and value for money.	The quadruple aim, adapted to mental health and suicide prevention, demonstrates how success will be measured through service delivery	30 Jun 2020
9.2	Reports regularly to the joint Boards on the progression of the implementation plan	The joint Boards are informed by the appropriate evidence of the progression of the implementation plan development	July 2019 to 30 June 2020

Clinical Services Actions			
10. Care Pathways clearly articulate a smooth transition of care across the provision of services			
10.1	HealthPathways continue to develop mental health and suicide prevention pathways over the next 12 months – clearly defining access to mental health services	Health pathways specific to mental health and suicide prevention clearly define care and referral at a local regional level	July 2019 to 30 June 2020
11. Development of clinical service initiatives			
11.1	Develop a 'portfolio' of prioritised clinical service implementation initiatives that deliver comprehensive and integrated mental health and suicide preventative care in the region. Examples include: a) Eating disorders outreach clinic b) Clozapine outreach clinic c) ADHD outreach clinic	A range of evidence based services are developed and prioritised as funding becomes available to support implementation	July 2019 to 30 June 2020
11.2	Consult and confirm best practice models of care to be incorporated within planning processes across primary, secondary and acute service systems for mental health and suicide prevention services	Provides consistency across service model development and delivery that supports sustainability and ensures quality of care	July 2019 to 30 June 2020

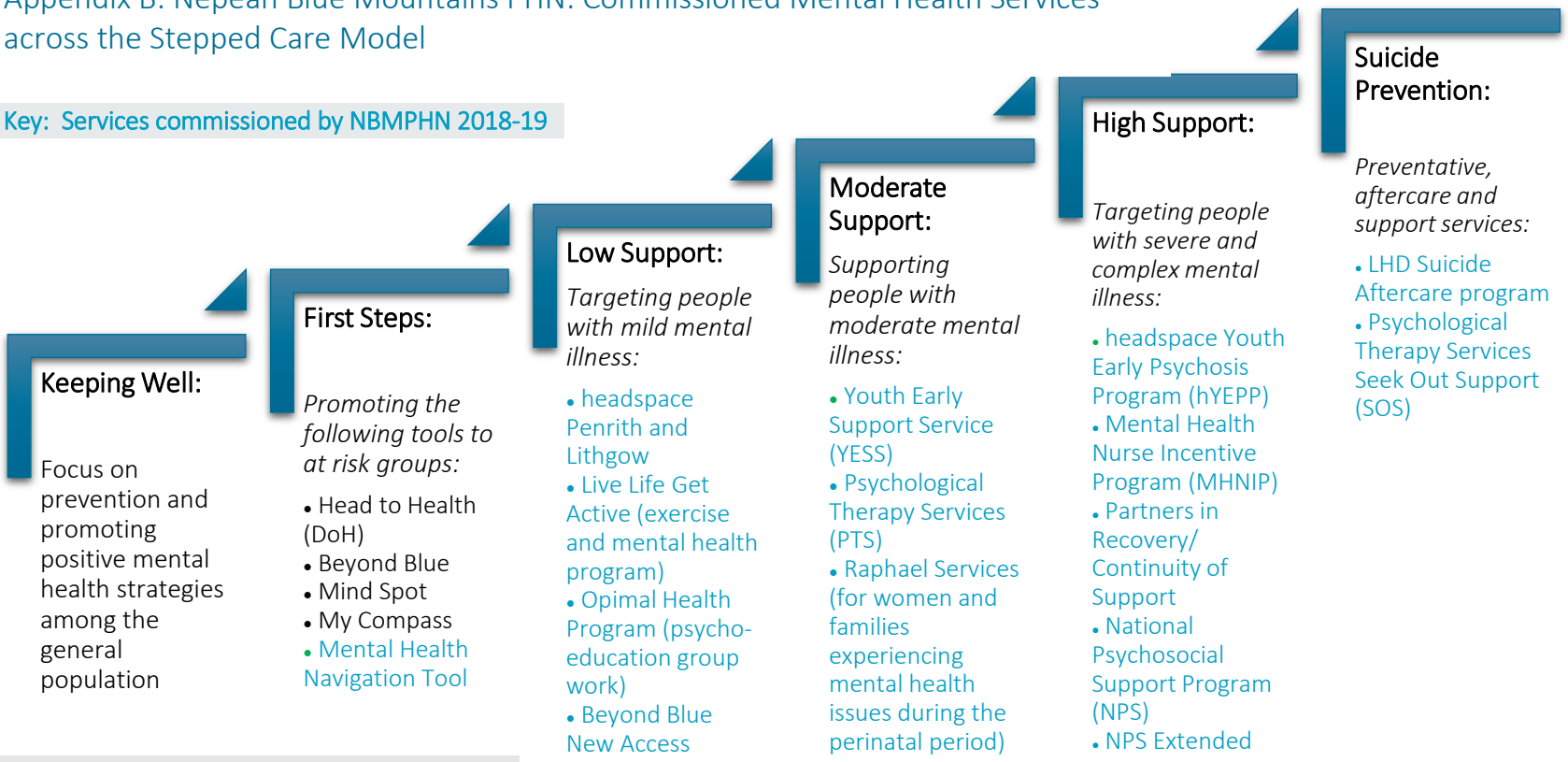
Appendices

Appendix A: Acronyms

ACI	Agency for Clinical Innovation
CBT	Cognitive Behaviour Therapy
CLS	Community Living Supports
HASI	Housing and Accommodation Support Initiative
IHI	Institute for Healthcare Improvement
KPIs	Key Performance Indicators
LGBTQI+	Lesbian, Gay, Bi-sexual, Transgender, Queer, Intersex
LHD	Local Health District
MBS	Medicare Benefits Scheme
NBMPHN	Nepean Blue Mountains Primary Health Network
NDIS	National Disability Insurance Scheme
NGO	Non-Governmental Organisation
NBM	Nepean Blue Mountains
NSW	New South Wales
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
RPBS	Repatriation Pharmaceutical Benefits Scheme
YCLSS	Youth Community Living Supports Service

Appendix B: Nepean Blue Mountains PHN: Commissioned Mental Health Services across the Stepped Care Model

Key: Services commissioned by NBMPHN 2018-19



Community-based supports

Encouraging strong linkages between PHN commissioned services and psychosocial support services, community mental health, neighbourhood centres, community managed organisations, clubs and other government agencies

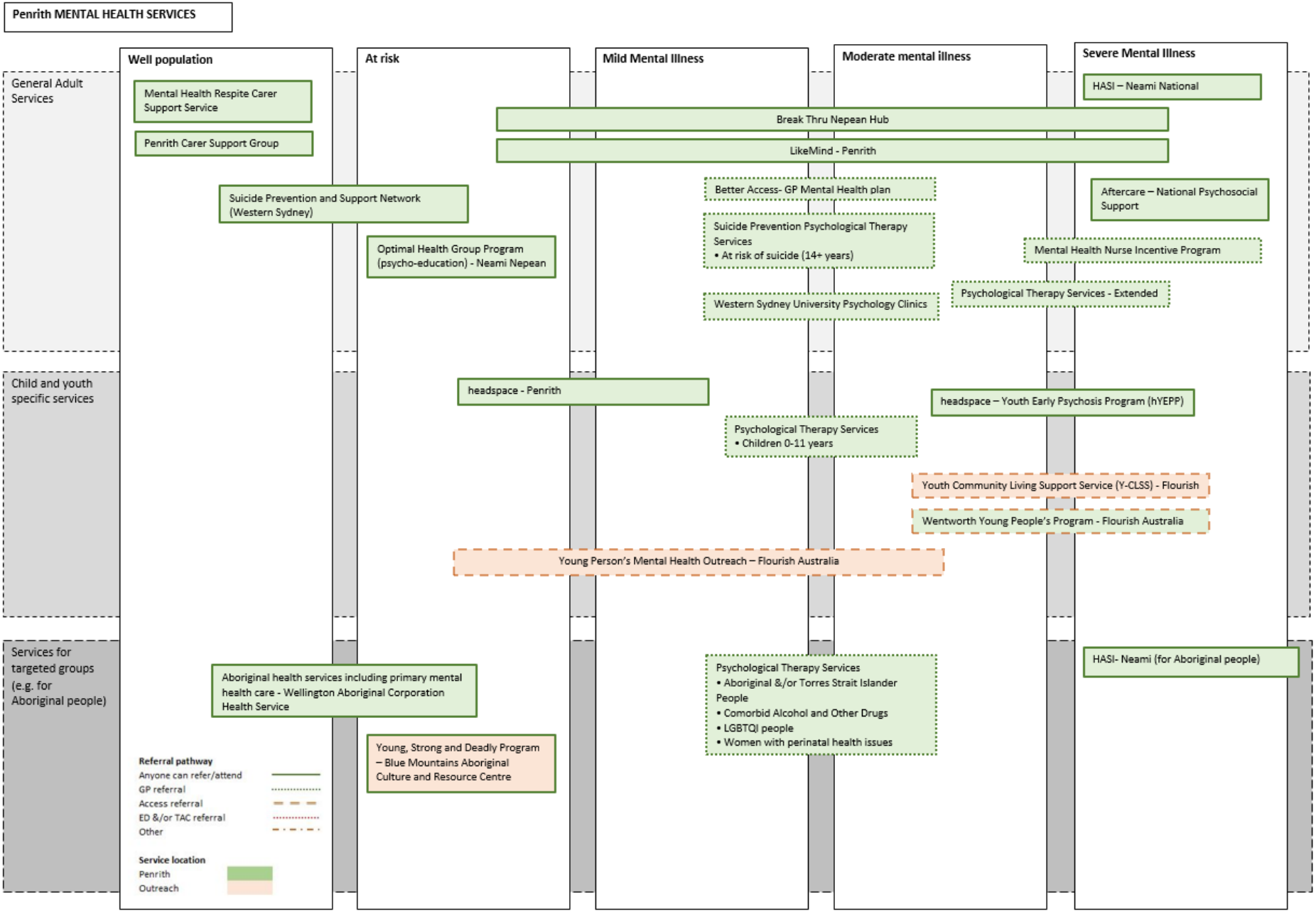
Acute Care: NSW government funded services

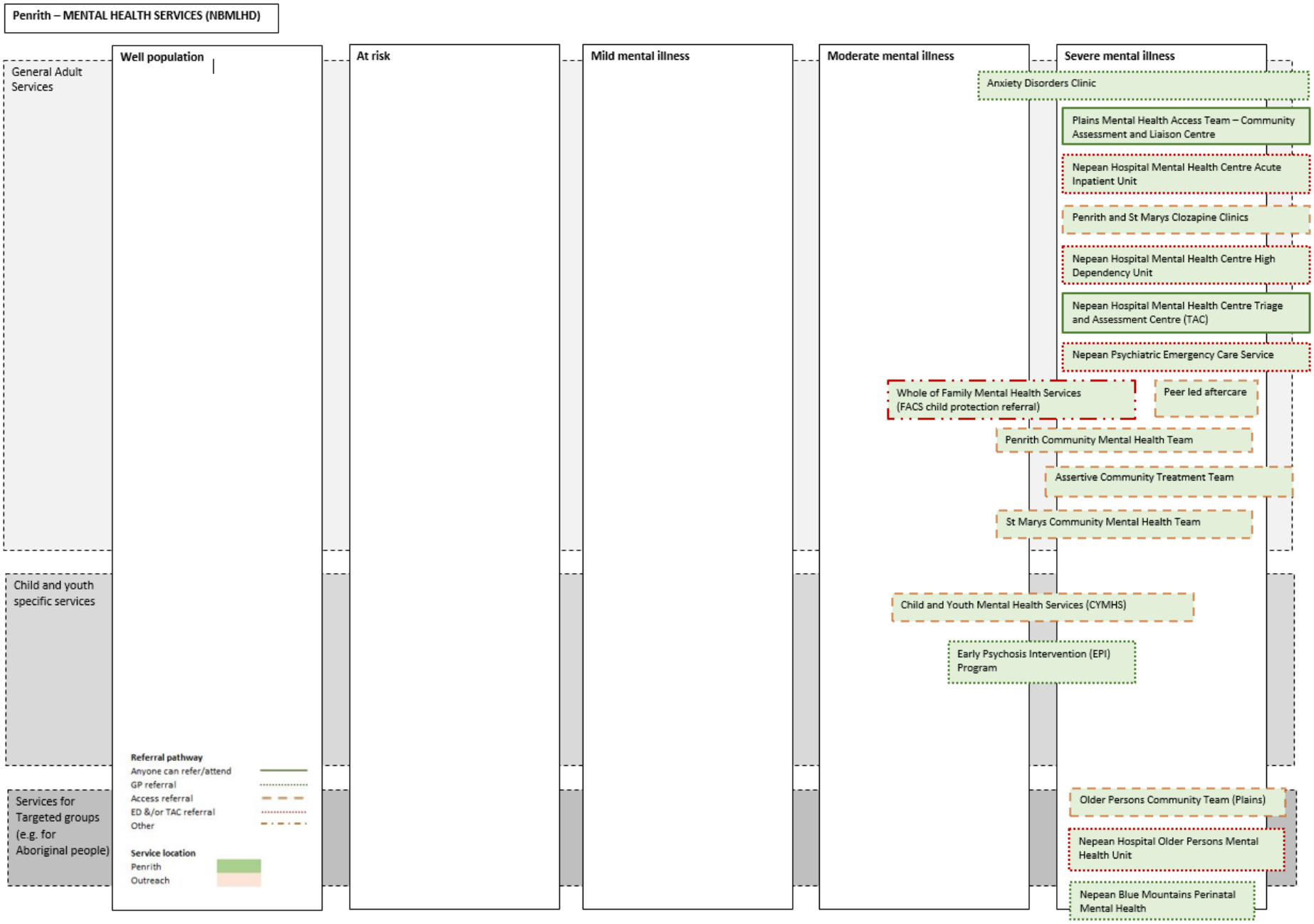
Creating strong linkages between PHN commissioned services and state-based services

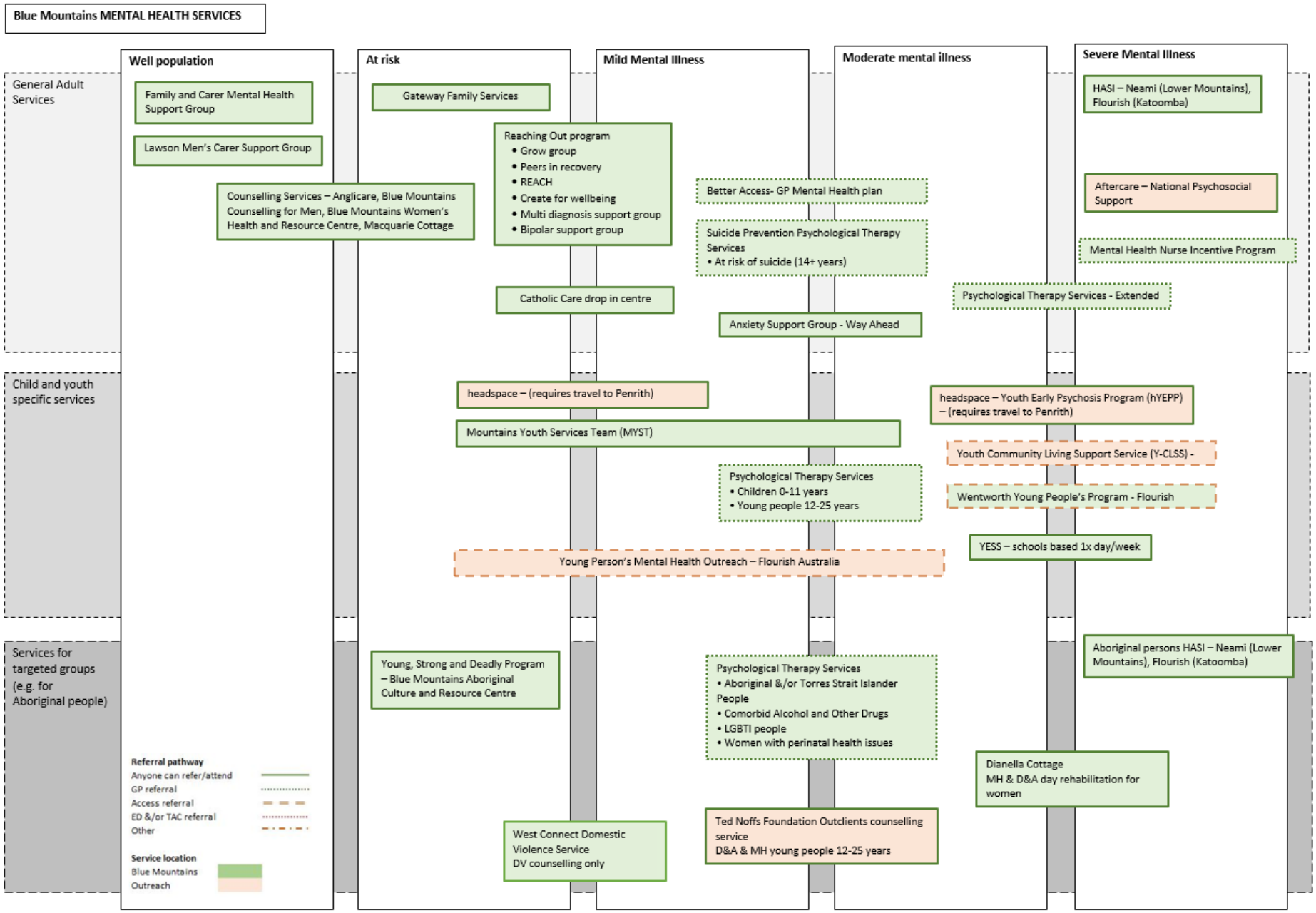
Appendix C: LGA mental health and suicide prevention service maps

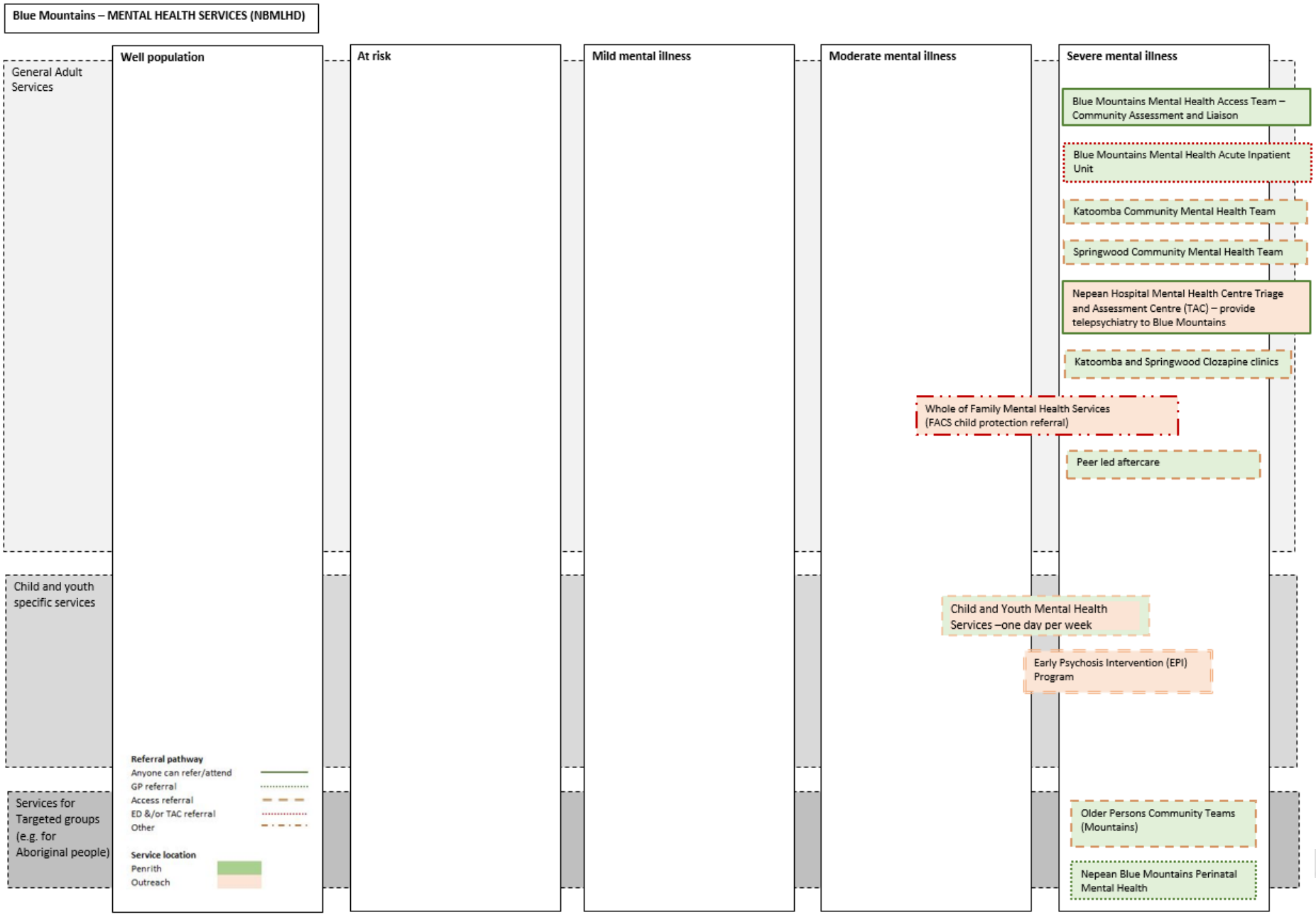
The service maps presented in the following pages are those discussed in section 3.7. They provide an analysis of regional mental health and suicide prevention services currently available by levels of severity within a stepped care service delivery model and by age or target population group.

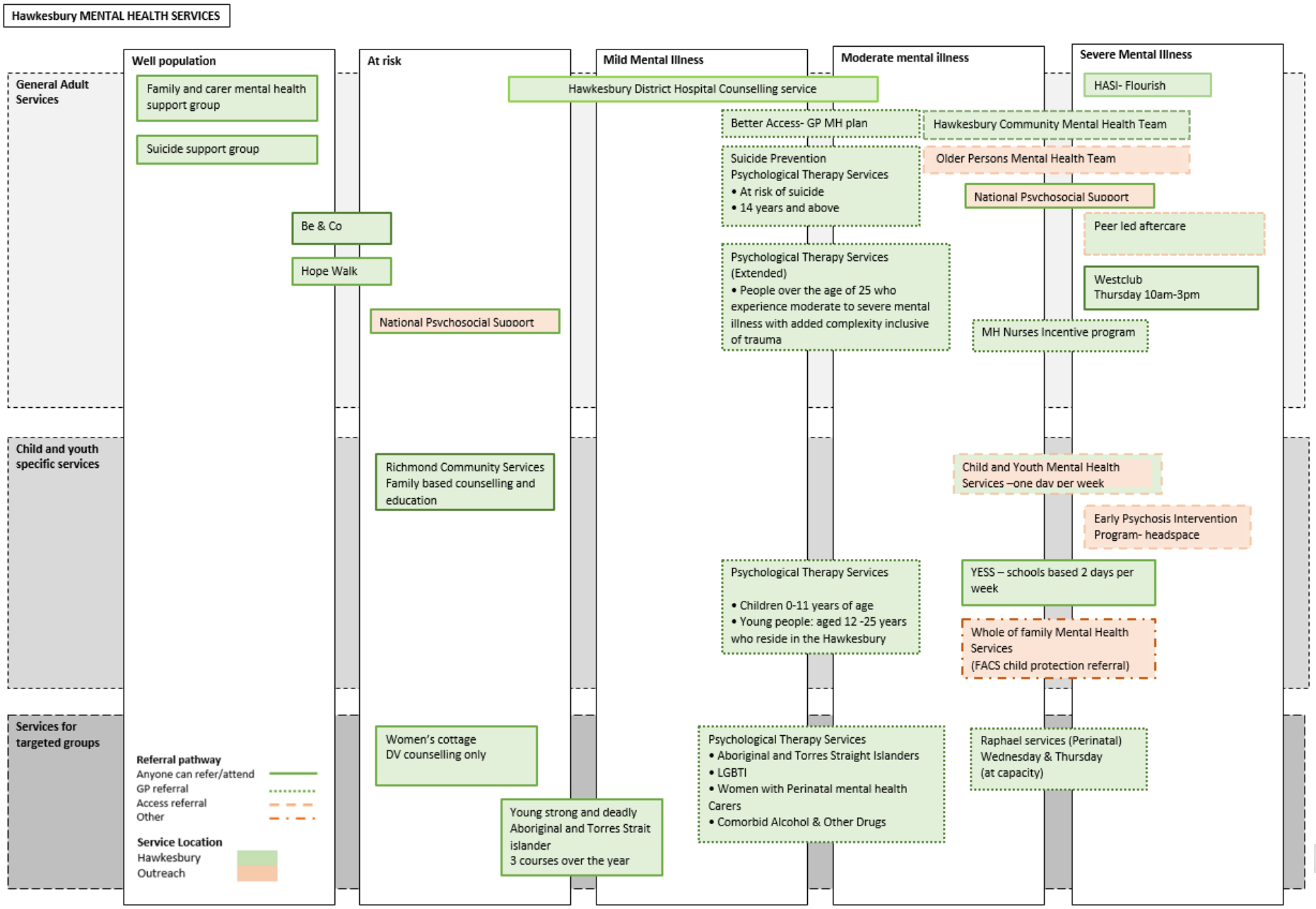
The service maps for Penrith and Blue Mountains LGAs are split across two maps due to the number of services available.

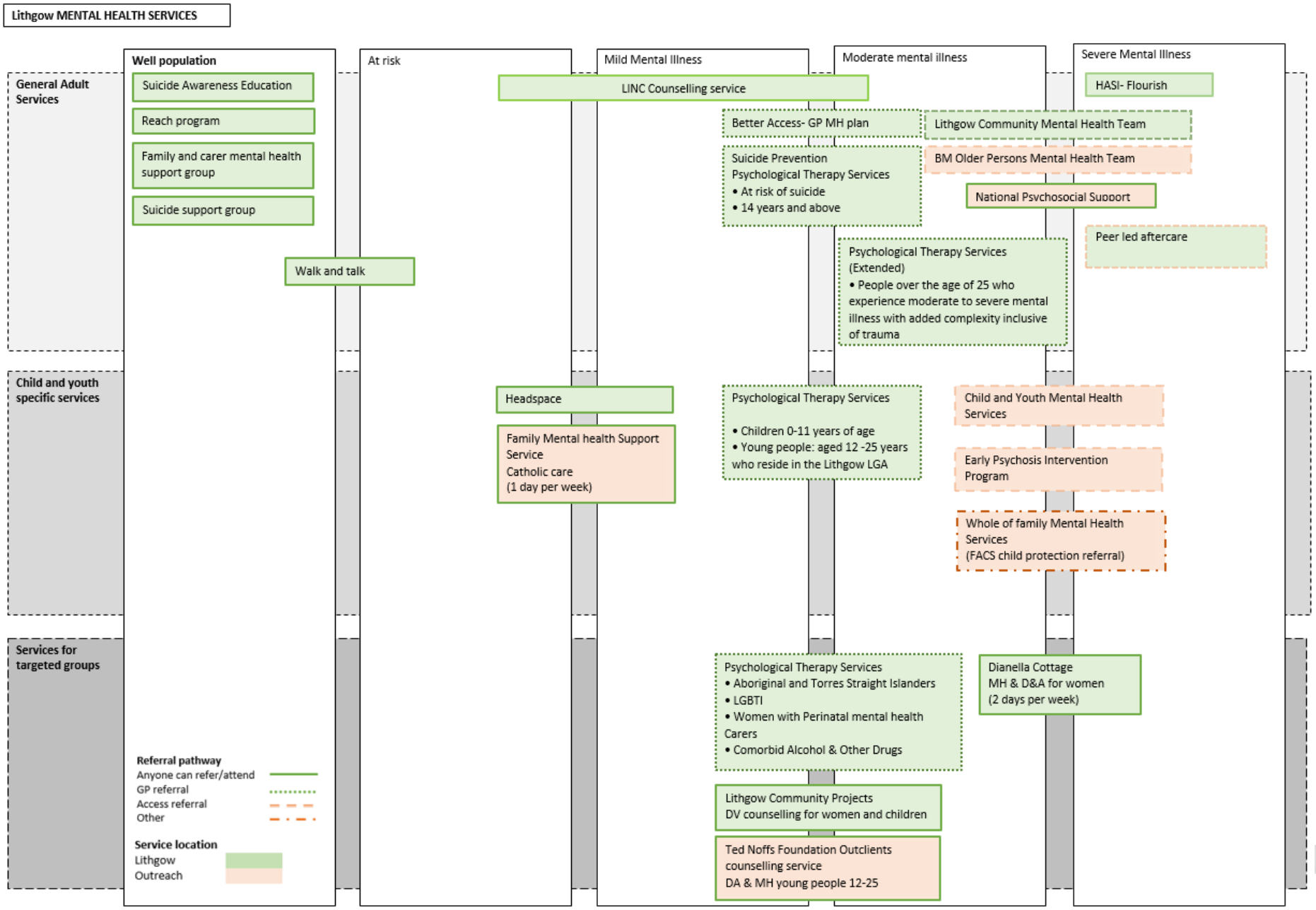

Penrith MENTAL HEALTH SERVICES
Well population
At risk
Mild Mental Illness
Moderate mental illness
Severe Mental Illness
General Adult Services
Child and youth specific services
Services for targeted groups (e.g. for Aboriginal people)
Mental Health Respite Carer Support Service
Penrith Carer Support Group
Suicide Prevention and Support Network (Western Sydney)
Optimal Health Group Program (psycho-education) - Neami Nepean
Break Thru Nepean Hub
LikeMind - Penrith
Better Access- GP Mental Health plan
Suicide Prevention Psychological Therapy Services
• At risk of suicide (14+ years)
Western Sydney University Psychology Clinics
HASI – Neami National
Aftercare – National Psychosocial Support
Mental Health Nurse Incentive Program
Psychological Therapy Services - Extended
headspace - Penrith
Psychological Therapy Services
• Children 0-11 years
headspace – Youth Early Psychosis Program (hYEPP)
Youth Community Living Support Service (Y-CLSS) - Flourish
Wentworth Young People's Program - Flourish Australia
Young Person's Mental Health Outreach – Flourish Australia
Aboriginal health services including primary mental health care - Wellington Aboriginal Corporation Health Service
Young, Strong and Deadly Program – Blue Mountains Aboriginal Culture and Resource Centre
Psychological Therapy Services
• Aboriginal &/or Torres Strait Islander People
• Comorbid Alcohol and Other Drugs
• LGBTQI people
• Women with perinatal health issues
HASI- Neami (for Aboriginal people)
Referral pathway
Anyone can refer/attend
GP referral
Access referral
ED &/or TAC referral
Other
Service location
Penrith
Outreach


Penrith – MENTAL HEALTH SERVICES (NBMLHD)
Well population
At risk
Mild mental illness
Moderate mental illness
Severe mental illness
General Adult Services
Child and youth specific services
Services for Targeted groups (e.g. for Aboriginal people)
Anxiety Disorders Clinic
Plains Mental Health Access Team – Community Assessment and Liaison Centre
Nepean Hospital Mental Health Centre Acute Inpatient Unit
Penrith and St Marys Clozapine Clinics
Nepean Hospital Mental Health Centre High Dependency Unit
Nepean Hospital Mental Health Centre Triage and Assessment Centre (TAC)
Nepean Psychiatric Emergency Care Service
Whole of Family Mental Health Services (FACS child protection referral)
Peer led aftercare
Penrith Community Mental Health Team
Assertive Community Treatment Team
St Marys Community Mental Health Team
Child and Youth Mental Health Services (CYMHS)
Early Psychosis Intervention (EPI) Program
Older Persons Community Team (Plains)
Nepean Hospital Older Persons Mental Health Unit
Nepean Blue Mountains Perinatal Mental Health
Referral pathway
Anyone can refer/attend
GP referral
Access referral
ED &/or TAC referral
Other
Service location
Penrith
Outreach


Blue Mountains MENTAL HEALTH SERVICES
Well population
At risk
Mild Mental Illness
Moderate mental illness
Severe Mental Illness
General Adult Services
Child and youth specific services
Services for targeted groups (e.g. for Aboriginal people)
Family and Carer Mental Health Support Group
Lawson Men's Carer Support Group
Counselling Services – Anglicare, Blue Mountains Counselling for Men, Blue Mountains Women's Health and Resource Centre, Macquarie Cottage
Gateway Family Services
Reaching Out program
• Grow group
• Peers in recovery
• REACH
• Create for wellbeing
• Multi diagnosis support group
• Bipolar support group
Catholic Care drop in centre
Better Access- GP Mental Health plan
Suicide Prevention Psychological Therapy Services
• At risk of suicide (14+ years)
Anxiety Support Group - Way Ahead
HASI – Neami (Lower Mountains), Flourish (Katoomba)
Aftercare – National Psychosocial Support
Mental Health Nurse Incentive Program
Psychological Therapy Services - Extended
headspace – (requires travel to Penrith)
Mountains Youth Services Team (MYST)
Psychological Therapy Services
• Children 0-11 years
• Young people 12-25 years
Young Person's Mental Health Outreach – Flourish Australia
headspace – Youth Early Psychosis Program (hYEPP) – (requires travel to Penrith)
Youth Community Living Support Service (Y-CLSS) -
Wentworth Young People's Program - Flourish
YESS – schools based 1x day/week
Young, Strong and Deadly Program – Blue Mountains Aboriginal Culture and Resource Centre
Psychological Therapy Services
• Aboriginal &/or Torres Strait Islander People
• Comorbid Alcohol and Other Drugs
• LGBTI people
• Women with perinatal health issues
Aboriginal persons HASI – Neami (Lower Mountains), Flourish (Katoomba)
Dianella Cottage
MH & D&A day rehabilitation for women
West Connect Domestic Violence Service
DV counselling only
Ted Noffs Foundation Outclients counselling service
D&A & MH young people 12-25 years
Referral pathway
Anyone can refer/attend
GP referral
Access referral
ED &/or TAC referral
Other
Service location
Blue Mountains
Outreach


Blue Mountains – MENTAL HEALTH SERVICES (NBMLHD)
Well population
At risk
Mild mental illness
Moderate mental illness
Severe mental illness
General Adult Services
Child and youth specific services
Services for Targeted groups (e.g. for Aboriginal people)
Blue Mountains Mental Health Access Team – Community Assessment and Liaison
Blue Mountains Mental Health Acute Inpatient Unit
Katoomba Community Mental Health Team
Springwood Community Mental Health Team
Nepean Hospital Mental Health Centre Triage and Assessment Centre (TAC) – provide telepsychiatry to Blue Mountains
Katoomba and Springwood Clozapine clinics
Whole of Family Mental Health Services (FACS child protection referral)
Peer led aftercare
Child and Youth Mental Health Services –one day per week
Early Psychosis Intervention (EPI) Program
Older Persons Community Teams (Mountains)
Nepean Blue Mountains Perinatal Mental Health
Referral pathway
Anyone can refer/attend
GP referral
Access referral
ED &/or TAC referral
Other
Service location
Penrith
Outreach


Hawkesbury MENTAL HEALTH SERVICES
Well population
At risk
Mild Mental Illness
Moderate mental illness
Severe Mental Illness
General Adult Services
Child and youth specific services
Services for targeted groups
Family and carer mental health support group
Suicide support group
Be & Co
Hope Walk
National Psychosocial Support
Richmond Community Services Family based counselling and education
Women's cottage DV counselling only
Young strong and deadly Aboriginal and Torres Strait islander 3 courses over the year
Hawkesbury District Hospital Counselling service
Better Access- GP MH plan
Suicide Prevention Psychological Therapy Services
• At risk of suicide
• 14 years and above
Psychological Therapy Services (Extended)
• People over the age of 25 who experience moderate to severe mental illness with added complexity inclusive of trauma
Psychological Therapy Services
• Children 0-11 years of age
• Young people: aged 12 -25 years who reside in the Hawkesbury
Psychological Therapy Services
• Aboriginal and Torres Straight Islanders
• LGBTI
• Women with Perinatal mental health Carers
• Comorbid Alcohol & Other Drugs
Hawkesbury Community Mental Health Team
Older Persons Mental Health Team
National Psychosocial Support
MH Nurses Incentive program
Child and Youth Mental Health Services –one day per week
YESS – schools based 2 days per week
Whole of family Mental Health Services (FACS child protection referral)
Raphael services (Perinatal) Wednesday & Thursday (at capacity)
HASI- Flourish
Peer led aftercare
Westclub Thursday 10am-3pm
Early Psychosis Intervention Program- headspace
Referral pathway
Anyone can refer/attend
GP referral
Access referral
Other
Service Location
Hawkesbury
Outreach


Lithgow MENTAL HEALTH SERVICES
Well population
At risk
Mild Mental Illness
Moderate mental illness
Severe Mental Illness
General Adult Services
Child and youth specific services
Services for targeted groups
Suicide Awareness Education
Reach program
Family and carer mental health support group
Suicide support group
Walk and talk
LINC Counselling service
Better Access- GP MH plan
Lithgow Community Mental Health Team
Suicide Prevention Psychological Therapy Services
• At risk of suicide
• 14 years and above
BM Older Persons Mental Health Team
National Psychosocial Support
HASI- Flourish
Peer led aftercare
Psychological Therapy Services (Extended)
• People over the age of 25 who experience moderate to severe mental illness with added complexity inclusive of trauma
Headspace
Family Mental health Support Service
Catholic care
(1 day per week)
Psychological Therapy Services
• Children 0-11 years of age
• Young people: aged 12 -25 years who reside in the Lithgow LGA
Child and Youth Mental Health Services
Early Psychosis Intervention Program
Whole of family Mental Health Services
(FACS child protection referral)
Psychological Therapy Services
• Aboriginal and Torres Straight Islanders
• LGBTI
• Women with Perinatal mental health Carers
• Comorbid Alcohol & Other Drugs
Dianella Cottage
MH & D&A for women
(2 days per week)
Lithgow Community Projects
DV counselling for women and children
Ted Noffs Foundation Outclients counselling service
DA & MH young people 12-25
Referral pathway
Anyone can refer/attend
GP referral
Access referral
Other
Service location
Lithgow
Outreach

References

Australian Bureau of Statistics (2016), *National Aboriginal and Torres Strait Islander Social Survey, Australia 2014- 15* [Online], Available at: www.abs.gov.au/ausstats/abs@.nsf/mf/4714.0 [Accessed May 2016]

Australian Government Department of Health, 2017. The Fifth National Mental Health and Suicide Prevention Plan [Online], Available at: http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf [Accessed June 2018]

Australian Government Department of Health, Integrated Regional Planning Working Group, 2018. Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs) [Online]. Available at: https://www.health.gov.au/internet/main/publishing.nsf/content/mental-health-intergrated-reg-planning [Accessed November 2018]

Australian Government Department of Health, Integrated Regional Planning Working Group, 2018. Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Compendium of Resources to assist Local Health Networks (LHNs) and Primary Health Networks (PHNs) [Online]. Available at: https://www.health.gov.au/internet/main/publishing.nsf/content/mental-health-intergrated-reg-planning [Accessed November 2018]

Australian Government Department of Health, 2018. *Mental Health Data: MBS Mental Health Data by PHN* [Online], Available at: https://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Health_Data [Accessed June 2019]

Australian Government Department of Health, 2018. *Mental Health PHN Circular 1 – 12 January 2016* [Online], Available at: https://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Circular1

Australian Institute of Health and Welfare, 2019. *Mental Health Services in Australia* [Online], Available at: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services. [Accessed June 2019]

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: care, health, and cost. Health Aff (Millwood), 27(3), 759-769.

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med, 12(6), 573-576.

Coordinare - South Eastern NSW PHN, Southern NSW Local Health District, Illawarra Shoalhaven Local Health District, 2019. South Eastern NSW Regional Mental Health and Suicide Prevention Plan: 2018-

2023 [Online', Available at: https://www.coordinare.org.au/for-health-professionals/health-priorities/mental-health-and-suicide-prevention/ [Accessed, June 2019].

Department of Health and Aging, 2010. Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) Initiative.

Dudgeon, P., Milroy, J., Calma, T., Luxford, Y., Ring, I.T., Walker, R., Cox, A., Georgatos, G., Holland, C (2016). Solutions that work: What the evidence and our people tell us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project report. University of Western Australia.

Freeman, Jan, S. (2015). Providing Whole-Person Care: Integrating Behavioral Health Into Primary Care. North Carolina Medical Journal, 76(1).

Ham, C., Walsh, N. (2013). Lessons from experience: Making integrated care happen at scale and pace. The Kings Fund [Online]. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-integrated-care-happen-kingsfund-mar13.pdf

Katon, W., Unützer, J., Fan, M. Y., Williams, J. W., Schoenbaum, M., Lin, E. H., & Hunkeler, E. M. (2006). Cost-effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression. Diabetes Care, 29(2), 265-270.

Katon, W., Russo, J., Lin, E. H., Schmittdiel, J., Ciechanowski, P., Ludman, E., Peterson, D., Young, B., Von Korff, M. (2012). Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. Arch Gen Psychiatry, 69(5), 506-514.

Liberal Party of Australia, NSW Division (2019). $19.5 miillion Western Sydney Community Health and Wellbeing Package [Online]. Available at: https://nsw.liberal.org.au/Shared-Content/News/2019/$19-5-million-Western-Sydney-Community-Health [Accessed May 2019]

Malek, Stephen., Norris, Douglas., Paulus, Jordan., Matthews, Katherine., Weaver, Alexander., & Davenport, Stoddard. (2018). Potential economic impact of integrated medicalbehavioral healthcare. Updated projections for 2017. American Psychiatric Association.

Moussavi S, Chatterji S, Verdes E, Tandon A, Patel V, et al. (2007) Depression, chronic diseases, and decrements in health: results from the World Health Surveys. Lancet 370:851–858.

Murray CJ, Vos T, Lozano R, Naghavi M, Flaxman AD, et al. (2013) Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 380:2197–2223.

National Mental Health Commission, Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services, 30 November 2014, Volume 1.

Nepean Blue Mountains PHN, 2017. *Mental Health & Suicide Prevention Needs Assessment 2018* [Online]. Available at: http://www.nbmphn.com.au/About/Plans-Reports.aspx

North Coast Primary Health Network, 2015. Northern NSW Mental Health Integration Plan: 2015-2018 [Online]. Available at: https://ncphn.org.au/key-documents [Accessed December 2018]

Thistlethwaite, P. (2011). Integrating health and social care in Torbay: Improving care for Mrs Smith. The King's Fund.

Unützer, J., Katon, W. J., Fan, M.-Y., Schoenbaum, M. C., Lin, E. H. B., Della Penna, R. D., & Powers, D. (2008). Long-term Cost Effects of Collaborative Care for Late-life Depression. American Journal of Managed Care, 14(2).

Wells, R., Kite, B., Breckenridge, E., & Sunbury, T. (2018). Community Mental Health Center Integrated Care Outcomes. Psychiatr Q, 89(4), 969-982

Western Queensland PHN, 2018. Mental Health, Suicide Prevention, Alcohol and Other Drugs Services: Regional Plan 2017-2020 [Online]. Available at: http://wqphn.com.au/resources/wqphn-publications [Accessed, February 2019]

Windle, Karen., Wagland, Richard., Forder, Julien., D'Amico, Francesco., Janssen, Dirk., & Wistow, Gerald. (2009). National Evaluation of Partnerships for Older People Projects. Final Report. PSSRU.