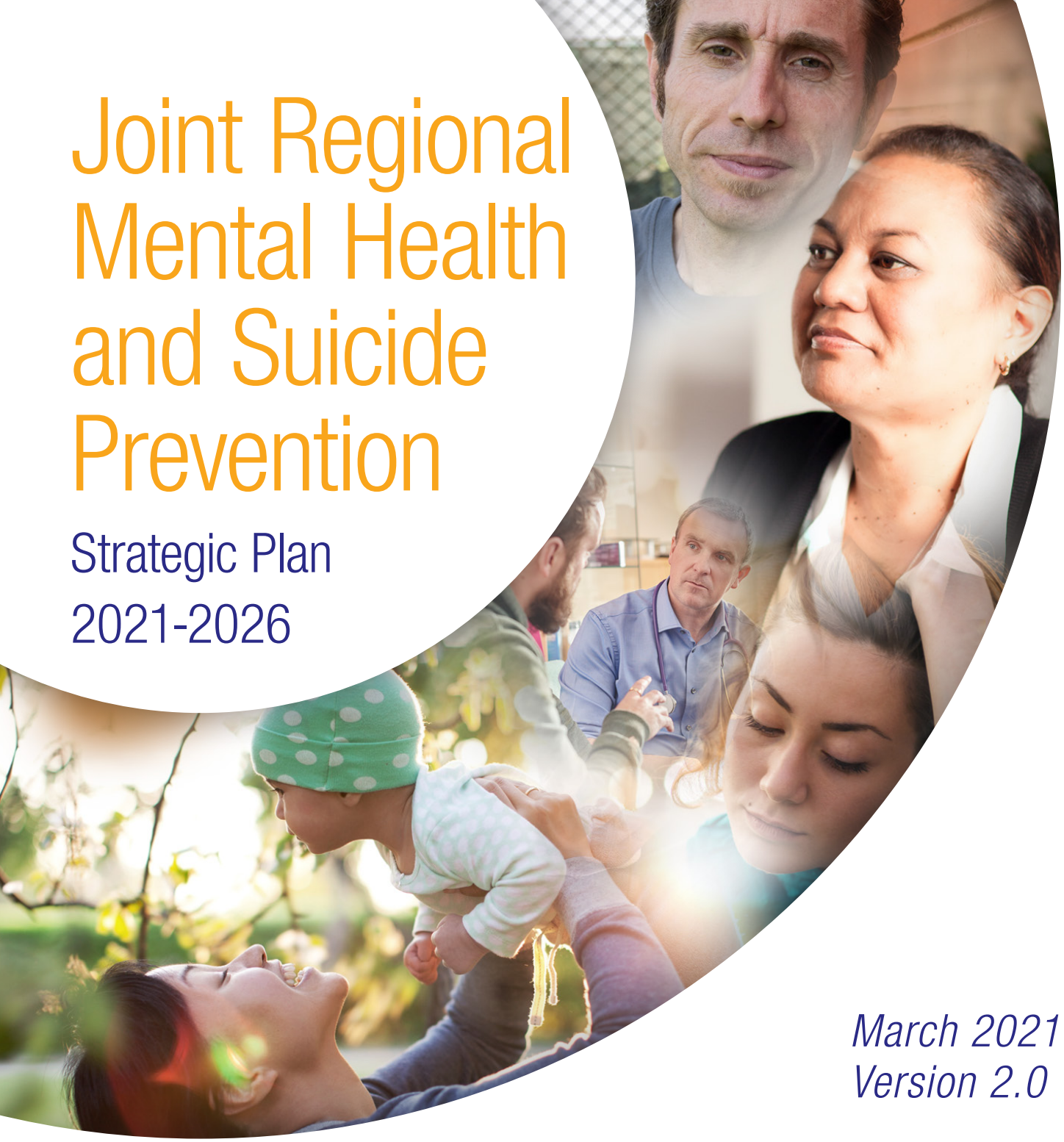
Joint Regional Mental Health and Suicide Prevention

Strategic Plan 2021-2026



March 2021
Version 2.0

NSW GOVERNMENT Health
Nepean Blue Mountains Local Health District

phn NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Acknowledgement of Country

We acknowledge the Darug, Gundungurra and Wiradjuri people as the traditional custodians of the land on which we live and work. We pay our respects to the Elders, past and present, as the holders of the memories, the traditions, the culture and the spiritual wellbeing of the Aboriginal and Torres Strait Islander peoples across the nation.

We are committed to working together with Aboriginal and Torres Strait Islander peoples to shape culturally appropriate and accessible health services that respond to, and address, the needs of the community.

Acknowledgement and Contributions

NBMLHD and NBMPHN would like to acknowledge and thank the following groups and people for giving their time and expertise to the development of this plan:

All the people with a lived experience of mental health, suicide and suicide bereavement who contributed to the consultation or review of this plan

All the consumers, clinicians and service providers who contributed to consultations

Members of the Steering Committee

Members of the Joint Consumer Advisory Committee

Members of the NBMLHD Consumer and Carers Committee

Members of the NBMLHD Lived Experience Advisory Group

Leanne Craze, Craze Consulting

Eliza Pross, Ochre and Salt Consulting

Foreword

The Nepean Blue Mountains Local Health District (NBMLHD) and Wentworth Healthcare, the providers of the Nepean Blue Mountains Primary Health Network (NBMPHN), celebrate the release of this Joint Regional Mental Health and Suicide Prevention Strategic Plan. This plan is the culmination of a number of years of work, multiple consultations and many contributions from the lived experience community, service providers and healthcare practitioners. We thank everyone who gave their time, expertise and experience.

These consultations and contributions helped to identify the priority areas for service development that you will see in this plan. They also identified a mental healthcare system that is complex, disjointed and, at times, difficult to access and navigate.

This plan represents a commitment by our two organisations to address these issues and create an environment where mental health and suicide prevention services are connected, safe and equitable; where the voices of people with lived experience are not only heard but are valued and prioritised; where a person living with a mental health condition or experiencing suicidal thoughts is supported, feels safe and can move between services easily, regardless of who is providing them. This plan also represents a commitment to improve the capacity and capabilities of the workforce providing mental health services and to ensuring that they, too, feel safe and supported.

The ongoing partnerships and collaborations with people with lived experience and providers of mental health and suicide prevention services in the community will be key to the successful implementation of the actions in this plan, ensuring transparency and accountability to the people we serve.

We again thank all those who have contributed to the development of this plan and who continue to work with us to transform mental health and suicide prevention services 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

Mental wellbeing and the factors that contribute to the development of mental health conditions or suicidal thinking are increasingly becoming areas for concern and focus across the country. The Nepean Blue Mountains (NBM) region is no different, with rates of psychological distress[45], mental health hospitalisations[46] and deaths by suicide[25] higher than the NSW average. The Joint Regional Mental Health and Suicide Prevention Strategic Plan (the Strategic Plan) sets out a five-year strategy to address these concerns and achieve the vision of mental health and suicide prevention services that deliver integrated and seamless care effectively and efficiently, tailored to meet the needs of people in the Nepean Blue Mountains region.

The actions included in this document will guide the development and redesign of services delivered or commissioned by the Nepean Blue Mountains Local Health District (NBMLHD) and the Nepean Blue Mountains Primary Health Network (NBMPHN). These actions have been developed to achieve the following six objectives:

- Improve outcomes and experiences
- Improve access
- Co-design services
- Integrate care
- Strengthen the health workforce
- Cooperate and collaborate across systems and services

Development of this Strategic Plan was informed by key national and state mental health and suicide prevention plans and policies and by extensive consultation with people with lived experience of mental health conditions; people with a lived experience of suicide; families; carers; local Aboriginal and Torres Strait Islander services; healthcare practitioners; and the broader community. These consultations helped to inform the service planning priorities that this plan focuses on. These areas are:

- General service priorities
- Suicide prevention
- Child and youth services
- People with lived experience
- Aboriginal and Torres Strait Islander Mental Health
- Priority population groups
- People with physical health comorbidities
- Preparing for and responding to the impact of disasters

The actions that have been included against each of these priority areas have been left deliberately broad. This will allow for the flexibility of prioritisation and operationalisation that will be necessary to take account of the changing needs of the region's population and of the different funding and resourcing models that become available.

True collaboration with people with lived experience will be key to prioritising and putting these actions into practice, including development of appropriate outcome measures and timeframes. Joint governance structures will oversee the implementation of this Strategic Plan, ensuring transparency around these decision making processes.

Our region looks forward to a supported and resilient workforce providing high quality, equitable, responsive and appropriate services that improve the outcomes and experiences of people with, or at risk of, mental health conditions, mental distress or people experiencing suicidal thinking.

1. Background and Context

1.1 Introduction and purpose

This plan sets out a five-year strategy to improve clinical outcomes and experiences for people in our region living with a mental health condition and their caring, family or kinship groups.

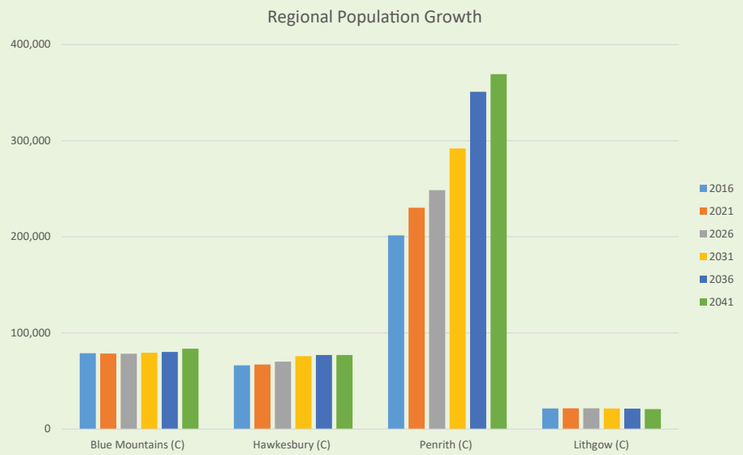
The high-level actions laid out in this plan aim to meet the needs of the communities in our region. They will support the development of seamlessly integrated, coordinated mental healthcare across the health system. The plan also supports the development of services that are based on evidence and that meet key regional priorities. These priorities will be informed and developed in partnership with local services, local communities and, most importantly, local consumers and carers.

The purpose of this plan is not to set out the specific activities that will be undertaken and when. Instead, the purpose of this plan is to provide high level, overarching guidance for activities within the NBMLHD and the NBMPHN over the next five years. Joint governance structures will oversee the prioritisation and operationalisation of the activities outlined in this Strategic Plan. In this way, the prioritisation and development of services can be flexible and responsive to the diverse and changing needs of people across the region and take advantage of new funding models as they become available.

Population snapshots

OUR REGION [11, 28, 39]

An estimated 380,996 people live in our region. The greatest growth is predicted in Penrith (74%) and Hawkesbury (16%) LGAs. The most rapid increases are projected for the population aged **65 years and over**.



The region's population is predicted to increase by 44% by 2036 to **529,457**

In 2016, **24%** of residents were **born overseas** and **11.9%** spoke a **language other than English** at home.

1.2 Scope

Actions in this plan are focussed on the development of new services and, where required, the assessment and redesign of current services. These services range from community mental health and suicide prevention services provided by the NBMLHD, or those commissioned by the NBMPHN, to the interface with primary care and community managed organisations. Community resilience activities undertaken by both organisations in partnership with others may also be developed or redesigned as part of this plan.

While not specifically addressed through this plan, it is acknowledged that issues such as dual diagnosis drug and alcohol-mental health and the interactions between mental health and social issues such as homelessness are common. The bi-directional relationship between drug and alcohol and mental health issues, in particular, is acknowledged. While this plan focuses on integrating and coordinating mental health care, the aim is to also develop services that take into account other supports that a person may need. This might include looking for opportunities to better integrate mental health services with drug and alcohol services, or education and accommodation services. The flexible nature of this Strategic Plan and the iterative process of its operationalisation means that service development or redesign in these areas can be prioritised as required.

MENTAL HEALTH [28, 38-42]

There is wide variation in levels of **socioeconomic advantage** and **disadvantage** (areas with highest SEIFA scores: Glenbrook and Windsor Downs 1,101; areas with lowest SEIFA scores; Bowenfels 793 and North St Marys 833)

Almost **2 out of 5 households** (38.5%) in **Lithgow LGA** have an equivalised household income in the lowest income quartile compared to the state average (NSW, 25.0%)

Unemployment in Australia jumped from 5.2% in March 2020 to 6.2% in April 2020. A significant recent rise in unemployment across the region is expected to negatively impact upon the mental health and wellbeing of affected residents

Social isolation and **loneliness** are increasing problems impacting upon physical and mental health and use of health services. **More than 19%** of Australians aged 75+ years report being lonely

Early childhood education: Lower proportion of **children aged 4 years old enrolled in a preschool program** (NBM 79.0%) compared to NSW (81.3%) and Australia (86.3%)

Educational attainment: higher proportion of **residents left school at Year 10 or below or did not go to school** (NBM, 41.1%) compared to NSW (33.3%) in 2016

Higher rates of **domestic violence** assaults in Penrith LGA (581.4 per 100,000) compared to NSW (370 per 100,000)

Higher rates of **death by suicide** (13.6 per 100,000) compared to NSW average (10.8 per 100,000) in 2017

NBM rates for **mental health-related hospitalisations** the second highest in NSW in 2017-18

1.3 Summary of plan development

This Strategic Plan has been developed by the NBMLHD and NBMPHN, with governance oversight by the Joint Regional Mental Health and Suicide Prevention Plan Steering Committee. Membership of this was made up of representatives from NBMPHN, NBMLHD Planning and NBMLHD Mental Health. Additional representation was provided by a GP, a community clinical psychologist and two lived experience representatives. Regular reporting to the Joint PHN and LHD Boards was provided through the Joint Board Sub-Committee Integrating Care. Principles for the development of this plan were outlined in the Joint Regional Mental Health and Suicide Prevention Foundation Plan[1].

This Strategic Plan considers key national[2-6] and state[7-10] mental health and suicide prevention plans, policy and reform documents that outline strategies and actions requiring regional coordination. It also considers national and international evidence of best practice, key service gaps identified from Mental Health and Suicide Prevention HealthPathways clinical working groups underway in the region and analysis of information from the 2019 Nepean Blue Mountains PHN Needs Assessment[11]. More information on these key service gaps can be found throughout this plan and in Appendix F.

Most importantly, this plan is informed by consultation with people with a lived experience of mental health issues and/or suicide; their carers; families[54,55]; the broader community[53,54]; primary healthcare practitioners[56]; acute and community mental health practitioners[58]; local Aboriginal and Torres Strait Islander services[54]; and providers of community mental health services[53]. Our consultation process included a series of face-to-face community consultation forums held in each of our four government areas, online forums, and online and paper-based surveys.

The prevalence data included throughout this plan was extracted using the National Mental Health Service Planning Framework tool (NMHSPF).

The usage of the tool was approved by the Commonwealth and State. Interpretation of these estimates should consider that these numbers do not necessarily reflect actual demand because people do not always choose to access services or there may be other barriers to service access such as location and or cost.

1.4 NBM Collaborative Framework for Mental Health Service Design and Development

Objectives

Improve outcomes and experiences:
Care is available to improve resilience, address mental health issues early and reduce the overall impact of illness for people in our region.

Improve access:
Services are matched to need and equitably distributed through better use of resources. Duplication of, and barriers to, services are minimised where possible.

Co-design services:
Consumers are at the centre of care and are included in shaping the way services are planned, delivered and evaluated.

Integrate care:
Consumers receive holistic services that are well-connected and experience smooth transitions of care.

Strengthen the health workforce:
Increase resilience, capacity and capability of health care providers.

Cooperate and collaborate across systems and services:
Services provided by the LHD, PHN and Community Managed Organisations work together to ensure services remain agile and adaptable to the diverse and changing needs of people across the region.

COLLABORATIVE FRAMEWORK FOR MENTAL HEALTH SERVICE DESIGN AND DEVELOPMENT **2020-2025**

NEPEAN BLUE MOUNTAINS REGION

Vision

Mental health and suicide prevention services deliver integrated and seamless care effectively and efficiently, tailored to meet the needs of people within the Nepean Blue Mountains Region.

Principles

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

Our services are based on the principles of:

- Mental health planning and services 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 primary care 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.

Values

Our values are affiliated with the values identified with ‘Living Well – a strategic plan for mental health in NSW’. They include:

2. Consultation and Collaboration

Continuous engagement and collaboration with people with lived experience and service providers is identified as key to the effective operationalisation of the Strategic Plan.

Engaging people with lived experience

Ensuring mental health services in our region are truly person-centred, trauma-informed and recovery-oriented can only be achieved by engaging people with lived experience in authentic partnerships. These partnerships must not only value the knowledge and expertise of those with a lived experience of mental health issues but also acknowledge and proactively address the power imbalances inherent in the co-design partnership and the effect this can have[15].

The development of these partnerships aims to create a service environment where true co-design and collaboration can occur and where people with lived experience can participate in, influence and contribute to the planning, design, delivery and evaluation of all mental health services, activities and policies. Part of this process will be ensuring people with lived experience play a central role in the prioritisation and operationalisation of the actions set out in this plan, including the identification of appropriate timeframes and outcome measures.

Several mental health lived experience committees and groups are currently active in our region, assisting the journey towards achieving authentic partnerships and person-centred, trauma-informed, recovery-oriented services. Actions throughout this plan aim to build upon and strengthen this culture and approach. It aims to develop and improve the avenues available for productive engagment with, and participation by, people with lived experience[14], such as:

- As an individual, being involved in decisions about their own care or support;
- At a service or program level, being involved in the design or delivery of services being provided to themselves and others;
- At an organisation level, being involved in developing the policies, processes, referral pathways and service models being provided to, or made available to, themselves and others.

'*Nothing about us without us*' drives appropriate consultation and collaboration with people with lived experience, including carers and families. This approach helps to build relationships and collaboration rather than opportunistic encounters.

Specific service planning activities involving people with lived experience are further identified within section 7.4.

Engaging health professionals and other key stakeholders

Continuous engagement and consultation with health professionals and other key stakeholders is also identified as essential to the success of this plan. Clinical and non-clinical staff that work directly in the service impacted by actions identified in this plan, such as service co-design processes, provide unique subject matter expertise into the identification of issues and how these might be practically addressed[15]. The inclusion of the health workforce in the development of the implementation plans that flow from this Strategic Plan should demonstrate two-way, open engagement and communication that involves listening to health professionals and other identified key stakeholders, keeping them informed and being clear about how their contributions are being incorporated.

3. Joint Governance

Joint governance from the NBMLHD and NBMPHN for the delivery of this Plan will support dual commitment, accountability and investment of capability to manage and monitor the implementation of the plan over the next five years and will ensure the objectives of this plan are met.

The NBMLHD and NBMPHN Boards have jointly committed, through a memorandum of understanding (2017 and renewed in 2020), to support a collective vision to improve the health of the region through collaborative action and integrating care. In 2019, the Joint Boards further confirmed mental health as a key integration priority and supported the development of the Strategic Plan as a means to deliver integrated mental health services to 2025.

To support joint accountability, governance, monitoring and evaluation of the key priorities in this plan, the prioritisation and operationalisation of the Strategic Plan and its activities will be overseen by a new joint Governance Committee. The new committee will report regularly through the Executive Sponsors to the Joint Board Sub-Committee Integrating Care and, through this Sub-Committee, to both Boards.

Regular measurement of the progression of the Strategic Plan will ensure accountability to consumers and their support networks. It will also provide data and evidence to inform future design improvements of the services and systems developed over the five year period.

4. Integrated Care

Integrated care as an approach to designing healthcare systems focuses on creating a coordinated, connected and cohesive mental healthcare system. Once this integrated system is realised the navigation through and across services is seamless, resulting in better health outcomes and the avoidance of duplicated services and unplanned hospitalisations.

To ensure that mental healthcare is properly integrated, care should:

- Provide a seamless transition between services with resources that are coordinated
- Be governed through shared accountability
- Focus on builiding resilience
- Be equitable
- Take a holistic approach to supporting people with lived experience[12].

Regional consultations have identified several system issues that currently exist that prevent the mental health care provided in the NBM region from being truly integrated. These include communication and data sharing challenges between providers impacting safe and effective transfer of care between services, coordination of care and effective service planning[53,56,58].

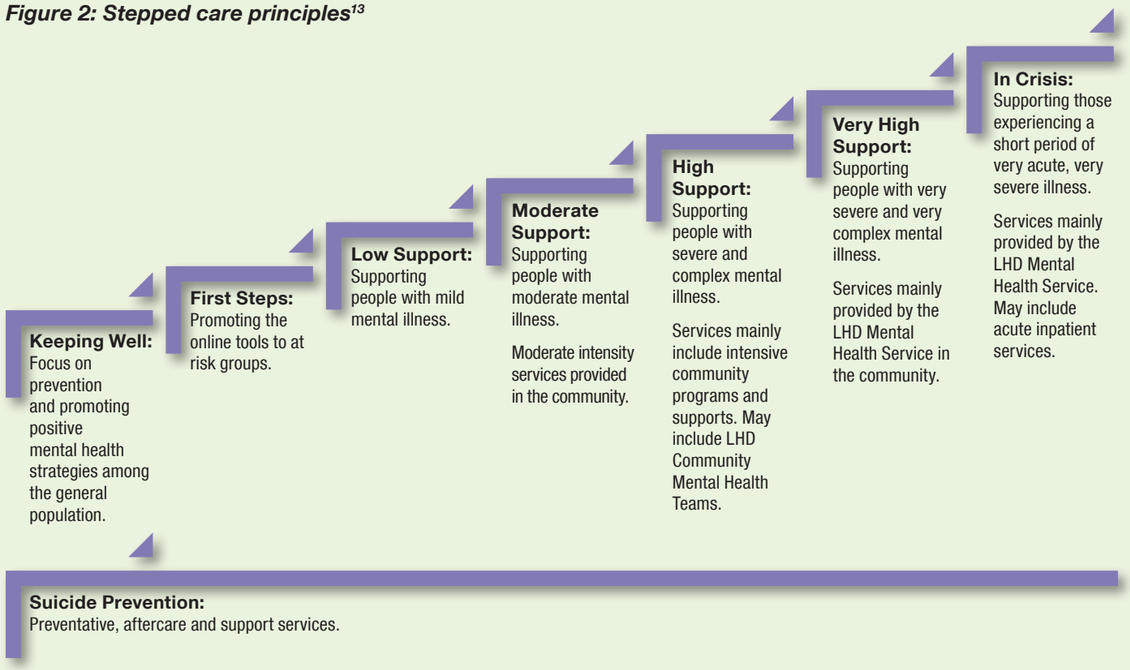
5. Stepped Care

A key underpinning framework for this Plan is a stepped care approach to service planning and delivery. Stepped care is an evidence-based, staged system comprising a range of interventions from the least intensive to the most intensive, which can be matched to the level of need and complexity of the conditions being experienced by any given consumer at a given time[13].

An important feature of this approach is the provision of person-centred care that targets the needs of the individual. This requires collaborative assessment and ongoing monitoring and two-way communication about an individual's desired recovery outcomes and progress towards their goals so the most appropriate level of care can be matched to the consumer's needs or care can be stepped-up or stepped-down through services as appropriate. A stepped care approach aims to ensure the right service at the right time is provided to the individual and supports people with mental health issues with the options and tools needed to reach their recovery goals.

The ten stepped care principles outlined in Figure 2 are central to the NBM stepped care approach. These principles will be central to the development of services as outlined in this plan. Appendix C outlines how the Stepped Care Framework will be applied in this region.

Figure 2: Stepped care principles[13]



6. Workforce

A strong, capable and compassionate workforce is essential to delivering services for, and together with, people with lived experience and their support people. Key areas of workforce shortage impact access to, and the quality of, care experienced by consumers. There is, therefore, an imperative for a shared mental health workforce strategy that works towards effective service planning and service delivery across the region.

Consumers consistently identify the need for greater investment in peer workers to help increase understanding of treatment and psycho-social support options and to provide support for people in acute care and in the community[11]. Consumers also identify the need for greater investment in a culturally competent workforce across the region[54]. There is a lack, and uneven distribution, of key mental health professionals across the region. This includes psychologists and other allied mental healthcare professionals[17-18]. There is also a clear shortage of psychiatry services[17, 19], in particular in Lithgow LGA. Access to paediatric psychologists and psychiatrists, credentialed mental health nurses, mental health nurse practitioners and mental health services available after hours and on weekends are all limited[17,20]. The identification of these workforce shortages has been based on analysis of the National Mental Health Service Planning Framework (NMHSPF), using the best available evidence and expert opinion, and assumptions about how services are organised and delivered.

To ensure the success of the objectives of this plan a collaborative approach to workforce planning and capacity development will be needed. The workforce needs to be appropriately skilled, experienced and supported to deliver equitably distributed, high-quality and sustainable mental health services that meet the needs of consumers, carers and family members.

7. Service Planning Priorities

7.1 General Service Priorities

Based on prevalence data, it is estimated that by 2025[17]:

- 38,774 people aged 18 and over in our region will be at risk of experiencing mental ill health in a 12 month period[17]. Of these, 9,136 will require early intervention services to address their situation and/or prevent progression to a formal diagnosis of a mild, moderate or severe mental health condition.
- 30,274 people aged 18 and over in our region will experience a mild mental health condition in a 12 month period. Of these, 15,137 will require an individually tailored mental health service response, such as one or more treatment services.
- 15,411 people aged 18 and over in our region will experience a moderate mental health condition in a 12 month period. Of these, 12,330 will potentially need or seek treatment.
- 11,180 people aged 18 and over will experience a severe mental health condition in a 12 month period. This includes severe disorders with high impact. All of these people will require acute or specialist interventions.

Consultations consistently identify gaps in the provision of services, regardless of support needs. These gaps are exacerbated by, among other factors, the workforce shortage issues identified in Section 6 of this plan. The actions outlined below aim to address these system issues and others identified in previous sections.

Improve outcomes and experiences

7.1.1 Establish accountability and reporting requirements for all new services to support service delivery and evaluation in line with community priorities.

7.1.2 Improve the flexibility and responsiveness of new and existing services to better meet the changing needs of people in the region.

7.1.3 Educate the community about common mental health issues, signs and symptoms of mental health conditions and/or mental distress, services available, referral pathways and information about counselling processes. Ensure:

- The co-design of education with the targeted population
- Education is designed and delivered in accessible and culturally sensitive ways.

7.1.4 Prioritise investment in peer-led services, including services that are exclusively peer-led such as support groups for people with lived experience of a particular issue (e.g. anxiety, hearing voices, suicidal ideation).

7.1.5 Support community-led strategies, approaches and activities that build community resilience, community empowerment, promote self-care and facilitate social engagement and connectedness.

Improve access

7.1.6 Ensure mental health services are available and expanded in their reach across the region using a stepped care approach to service planning and commissioning and include low intensity face-to-face psychological services, psychosocial services and psychiatric services.

7.1.7 Assess and reduce barriers to accessing services, including restrictive referral criteria and processes, cost barriers and complex referral pathways.

7.1.8 Support delivery and uptake of digitally-enabled mental health services among consumers and providers where appropriate.

7.1.9 To support personal decision making, improve health literacy through the development of services and programs that provide universally available information that is easy to understand, navigate and access.

7.1.10 Ensure national navigation services, such as the Department of Health's Head to Health website, are linked to local mental health, suicide prevention and psychosocial service access and provision.

Co-design services

7.1.11 Decisions about service models, procurement activities, referral pathways and availability of services are informed by service providers and lived experience representatives from diverse communities and peak bodies to ensure they are safe, appropriate and meet the needs of people from diverse community groups.

7.1.12 Advocate for the inclusion of capital support measures when seeking and applying for funding of new services in rural and remote areas.

7.1.13 Develop partnership arrangements with local services and peak bodies to support the needs of the community.

7.1.14 Leverage partnerships to advocate for services and models of care to be funded on 3-5 year contracts to improve continuity of service provision and planning.

Integrate care

7.1.15 Establish clear communication and coordination mechanisms across the sector to enhance continuity of care for all mental health consumers. These may include shared care planning, accessible electronic records, secure messaging and consistent and timely provision of the patient discharge summary to GPs and other providers in the consumer's care team.

7.1.16 Formalise partnerships between all service providers to articulate agreed ways of working together for referral pathways and smooth service transitions.

7.1.17 Establish a process for the development of single multiagency care plans for people with high and very high support needs who receive care from both primary and specialist care and support from community managed organisations, with the aim of coordinating physical health, mental health and psychosocial support needs.

7.1.18 Establish data and information sharing protocols across primary and acute care mental health services to facilitate care continuity as well as the development of joint needs assessments, identify emerging trends and inform future service design.

7.1.19 Enhance shared care referral pathway platforms to support accessibility to services, clarification of service and consistent taxonomy.

Strengthen the health workforce

7.1.20 Provide cross-sector workforce training and skills development opportunities for GPs, primary mental health professionals, acute care clinicians and community sector professionals in areas informed by workforce priorities and development needs.

7.1.21 Improve the identification of early signs of mental distress in patients in a primary care setting.

7.1.22 Support and enhance peer-led workforce activities across the region.

7.1.23 Build the capacity and capability of primary care, acute and community mental health professionals to assess, navigate, refer and provide services in a stepped care approach.

7.1.24 Ensure appropriate levels of supervision, mentoring, coaching, professional development opportunities and other supports are available to all mental health staff as required for their role.

7.1.25 Support opportunities to expand the scope of practice for mental health service delivery within the general practice setting.

7.1.26 Partner effectively with community managed organisations and build capacity with a view to introducing shared care planning for people who engage with both these organisations and with mental health services.

7.1.27 Leverage broader partnerships (e.g. Western Sydney Health Alliance) to attract and retain undergraduate and postgraduate students and skilled professionals, targeting identified areas of workforce shortage within the region.

7.1.28 Develop regional HealthPathways covering assessment, management and referral that focus on the critical transition points between mental health and other key services for:

- youth to adult services
- out-of-home care settings to family of origin or independent living
- hospital to community/primary care
- between public, private and community managed mental health services
- throughout the perinatal stages for parents
- between mental health services and Aboriginal Community Controlled Organisations.

7.1.29 Support GPs to use online programs to help their patients e.g. 'eMHprac', a resource guide for practitioners that provides an overview of Australian online and tele-web programs.

Cooperate and collaborate across systems and services

7.1.30 Ensure best practice in transfer of care across the sector, including post-discharge community care, is encompassed within models of care.

7.1.31 Embed service linker, care navigation and case coordination and management for health and social services into the models of care to support people with high or very high support needs.

7.1.32 Establish a joint operational level agreement to provide guidance to both PHN and LHD for working collaboratively on major new projects that have region and/or sector-wide implications, such as the Adult Mental Health Hub[21] and Towards Zero Suicides initiative[22].

7.2 Suicide Prevention

An estimated 16 lives are lost to suicide each week in NSW. Research estimates that, for each death by suicide, up to 125 other people are adversely affected through the grief, loss and trauma that these sudden and tragic deaths invoke[25].

In 2017, 50 people died by suicide in the NBM region at a rate of 13.6 per 100,000 persons – the highest among metropolitan PHNs in NSW and higher than the state average[26]. The NBM region recorded the highest rate of hospitalisations for self-harm in metropolitan Sydney in 2017-18 (241.6 per 100,000)[27]. Suicide is the leading cause of death for people aged between 15 – 44 years with the largest number of suicides in the 24 – 35 year age group[8].

The causes of suicide and suicide attempts are complex. A combination of individual, social, cultural, environmental and contextual factors influence suicide or suicide attempts[27]. These factors may include, but are not limited to, having a history of self-harm or suicidality; being bereaved by suicide; drug and alcohol misuse; living outside metropolitan areas or having a history of mental ill health or distress[59]. While these factors result in some people or groups being more vulnerable to suicide, suicide occurs across all demographics[59]. Understanding and addressing the complexity around the causes of suicide and suicide attempts is hampered by the difficulties in accessing accurate and timely data relating to suicide[59]. Adding to this difficulty is fact that approximately 40% of people who die by suicide have had no recent contact with the health system[27], although many may have had contact with several other government or community agencies[59].

Regional consultations have identified a number of specific suicide prevention system issues. These include limited awareness of services available in our region and how they can be accessed, including aftercare services and postvention services for those who have been bereaved by suicide[55,56,58]. Particular concerns exist around a lack of alternatives to the Emergency Department for people experiencing suicidality and around poor continuity and transfers of care for people who have made an attempt on their life[55,58].

Based on population projections by the ABS, a 'current trajectory' scenario would see suicides

continue to rise towards 2036. Significant investment by all levels of government seeks to halt this growing trend across the community with extensive investment in the National Suicide Prevention Strategy and NSW Towards Zero Suicides initiatives translating into the establishment of targeted and coordinated approaches to suicide prevention, aftercare, community education and responsive crisis service delivery in the NBM region. The NSW Towards Zero Suicides initiatives[27] aim to reduce this rate by 20 per cent by 2023 and many of these initiatives, supported by the actions below, will address the identified system issues outlined above and in Appendix F of this plan. Importantly, the Towards Zero Suicide initiatives and actions within this plan not only target people who are in contact, or who have previously had contact, with the health system but also aim to increase suicide prevention and postvention capacity and capability across the community.

Improve outcomes and experiences

7.2.1 Establish processes to ensure support and educational resources are available to assist patients, carers, families and communities following a suicide attempt or completed suicide.

7.2.2 Ensure that service planning encompasses a suicide bereavement service developed and delivered with people with a lived experience of suicide bereavement that provides support, assistance and a coordinated response for people bereaved or impacted by suicide.

7.2.3 Prioritise and make available applicable evidence-based gatekeeper training for identified gatekeepers, such as community (schools, workplaces, government and community agencies and communities at risk) and service providers (acute, primary care and community health).

Improve access

7.2.4 Develop alternatives to the Emergency Department for people experiencing suicidality or emotional crisis, with consideration given to:

- provision of multidisciplinary support, including peer workers
- safe places in community settings
- the importance of addressing situational and environmental stressors
- the availability of clear pathways and protocols that provide linkages to other supports required.

Co-design services

7.2.5 Expand the Lived Experience of Suicide Advisory Group to ensure the diversity of the lived experience voices supporting suicide prevention services planning is aligned to the diversity of the population of the region.

7.2.6 Establish a Suicide Prevention Collaborative to embed and drive regional approaches in line with the Strategic Framework for Suicide Prevention in NSW 2018-2023.[8] This will include regional approaches to capacity building and knowledge sharing with other government and community agencies.

Integrate care

7.2.7 In collaboration with people who have a lived experience of suicidal crisis, establish a robust suicide care pathway to ensure effective and timely communication and continuity of care across the sector.

Strengthen the health workforce

7.2.8 Support GPs and community care providers to be able to identify and provide care and support to people experiencing suicidality, who are in crisis, who have self-harmed or who have been bereaved by suicide.

Cooperate and collaborate across systems and services

7.2.9 Develop and implement a collaborative data strategy for capturing, sharing and optimising the use of regional suicide, self-harm and follow-up care services data to inform ongoing service planning and delivery. Importantly, the data strategy, where possible, will capture:

- local hospital data for patients who present to hospital with indications of self-harm
- linked data that illuminates the provision of follow-up care for people following a suicide attempt/self-harm by all providers, including community mental health teams, GPs and private mental health clinicians.

7.3 Child and Youth Services

Supporting and enhancing the mental health of infants, children, young people and families is linked to positive long term mental health outcomes. Three quarters of all mental health conditions manifest in people under the age of 25 and the onset of mental ill health peaks at the ages of 12-24 years.

Almost 1 in 4 young people aged 15-19 years report experiencing psychological distress and this has been increasing over the last 7 years[22]. The Nepean Blue Mountains region also has a high prevalence of problematic substance abuse among young people[11].

Based on the predicted prevalence data for the year 2025 for young people (YP) aged 5-17 years in our region[17]:

- 3,871 YP will require early intervention services to address their mental health and/or prevent progression to a formal diagnosis of a mild, moderate or severe mental health condition.
- 3,307 YP will require services for a mild mental health condition in any 12 month period.
- 2,672 YP will need a service for a moderate mental health condition in any 12 month period.
- 1,729 YP will need a service for a severe mental health condition in any 12 month period.

Early intervention should underpin strategies to meet the mental health needs of young people. The above prevalence data supports the need for more of these early intervention strategies in our region. In addition, identifying young people who are at risk of a mental health condition and connecting them with services early is crucial to addressing and preventing progression to more severe health conditions or levels of distress.

Improve outcomes and experiences

7.3.1 Improve the flexibility and responsiveness of new and existing service models to better meet the specific needs of children and young people across the region.

7.3.2 Ensure programs and services are developed to empower parents of young people to address their own mental health concerns, thereby maximising the potential for healthy childhood development.

Improve access

7.3.3 In collaboration with young people, design youth services to specifically improve the health literacy of young people and ensure they and their families are well-informed with reliable and credible information about services, including those in the digital sphere.

7.3.4 In collaboration with young people, develop youth-specific suicide prevention services to address the increasing prevalence of suicidality and self-harm.

7.3.5 Increase awareness of targeted parenting support services that support the perinatal and early childhood period, particularly in the first 2000 days of life.

Co-design services

7.3.6 Embed a youth-specific reference group in the commissioning and development of youth-specific services across the region.

7.3.7 Develop a Youth and Young People Activity Work Plan to clearly identify the objectives of the youth reference group and milestones against agreed activities.

Integrate care

7.3.8 Integrate family-based services within mental health service provision.

7.4 People with Lived Experience

There has been a shift in recent years to more formally acknowledge and value the unique expertise that people with lived experience of mental health conditions and/or suicide have. Genuinely and productively engaging with people with lived experience when developing or redesigning services results in greater empowerment of people with lived experience and ownership of mental health programs, effective advocacy and, most importantly, better quality services.

Both the LHD and PHN support committees for people with lived experience who provide input into key decisions. These committees provide:

- Advocacy regarding service issues and quality improvement
- Meaningful and genuine consumer and carer participation across the mental health service
- A lived experience perspective regarding new initiatives, projects, policies and procedures.

Additionally, both organisations seek broader input from people with lived experience through public consultations, forums and surveys, such as the mental health consumer and community consultations conducted in November-December 2019[23,55]. However, while traction has been gained across consumer engagement activities, there remains significant work in broadening the number and diversity of people with lived experience participating and the types of activities open for collaboration with lived experience representatives. Additional work also needs to be done in developing mechanisms to more fully capture the lived experience voice and embedding and maturing the co-design process.

Improve outcomes and experiences

7.4.1 Support people with lived experience so they can know about, advocate for and act on their rights as users of the health system.

Co-design services

7.4.2 Establish a formalised process of co-design, ensuring all new services and programs are developed, implemented and evaluated in equal partnership with people with lived experience and include representatives from diverse communities and peak bodies.

7.4.3 Regularly evaluate engagement and participation activities and use the results to improve future activities.

7.4.4 Ensure all funding and commissioning processes for new services include a statement of the processes that will be followed for:

- engagement and co-design with people with lived experience from diverse backgrounds and reporting upon how changes were made as a result of feedback received.
- how the principles of recovery-oriented and trauma-informed care will be implemented.

7.4.5 Provide development and training opportunities that empower people with lived experience to have the confidence, knowledge and skills to advocate for the lived experience voice in formal planning and governance activities.

7.4.6 Develop a pool of people with lived experience who can be available for ongoing advice, consultation work or discrete projects, enabling access to lived experience experts based on areas of expertise and interest.

7.4.7 Develop a live mental health lived experience engagement map to illustrate regional opportunities and options for participation and collaboration activities.

7.4.8 Support people with lived experience to develop leadership capabilities.

Strengthen the health workforce

7.4.9 Create an inclusive organisational culture that strongly supports lived experience engagement within the LHD, PHN and the lived experience community.

7.4.10 Increase service provider expertise in engagement and co-design.

7.5 Aboriginal and Torres Strait Islander Mental Health

Aboriginal people comprise 3.7% of the total Nepean Blue Mountains population, with approximately 13,164 people identified as Aboriginal or Torres Strait Islander[28]. In Australia, Aboriginal and Torres Strait Islander people consistently experience high or very high psychological distress at more than 2.5 times the rate compared to the general population, they are more than twice as likely to be hospitalised for mental health related conditions. In NSW, Aboriginal and Torres Strait Islander people have more than 1.5 times the rate of suicide compared to non-Aboriginal people[10].

Multiple inter-related factors continue to impact the social and emotional wellbeing of Aboriginal and Torres Strait Islander communities, including inter-generational trauma, social and economic disadvantage, racism and the interruption of culture. Compounding this are multiple barriers faced by Aboriginal and Torres Strait Islander people when accessing appropriate services and support. Local Aboriginal communities have consistently identified the need for culturally safe mental health services for Aboriginal people in the region[29,30,54]. Significant work is underway to achieve this but it must continue to be strengthened through collaboration and partnership with local Aboriginal communities and the Aboriginal Community Controlled Health Service in our region.

Improve outcomes and experiences

7.5.1 Prioritise the development of services and models of care that consider Aboriginal and Torres Strait Islander perspectives on health, healing and wellbeing (as opposed to only approaches to illness). This is in line with the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023[3].

7.5.2 In collaboration with local Aboriginal and Torres Strait Islander communities, develop a transfer of care protocol for Aboriginal and Torres Strait Islander people who present to, are admitted to and are discharged from hospital. This transfer of care protocol will:

- include coordination strategies for discharge planning and post-discharge care and support
- have as its focus the needs of the individual as well as their extended family unit.

7.5.3 In collaboration with local Aboriginal and Torres Strait Islander community representatives, resource the informal care system (carers, families, communities) to support members of the community experiencing, or at risk of developing, mental health problems.

Improve access

7.5.4 Support capacity building within Aboriginal Community Controlled Organisations to deliver Aboriginal and Torres Strait Islander mental health services.

Co-design services

7.5.5 Develop local co-design protocols in partnership with Aboriginal Community Controlled Organisations that consider cultural communication methods. This should include transparency in reporting on activities and outcomes of initiatives.

7.5.6 Develop outcome measures in partnership with Aboriginal and Torres Strait Islander people to ensure measures of service effectiveness are in line with culturally accepted views of effectiveness, healing and health.

7.5.7 Incorporate Aboriginal and Torres Strait Islander governance and co-design into service planning activities and in the commissioning of services to Aboriginal and Torres Strait Islander communities.

7.5.8 Establish a regional consultation repository to minimise consultation duplication and enable sharing of community priorities within the service system.

Integrate care

7.5.9 In collaboration with local Aboriginal and Torres Strait Islander community representatives, design services that recognise and incorporate effective traditional and culturally-specific healing practices.

Strengthen the health workforce

7.5.10 Grow the Aboriginal mental health workforce.

7.5.11 Improve the cultural responsiveness of the mainstream system's workforce by investing in training by Aboriginal and Torres Strait Islander trainers.

Cooperate and collaborate across systems and services

7.5.12 Co-design data collection and outcome measurement strategies with Aboriginal and Torres Strait Islander service providers and communities. Ensure data collection tools are culturally validated.

7.5.13 Establish a regional funding and commissioning protocol that recognises community needs and cultural considerations for Aboriginal and Torres Strait Islander mental health service providers and defines the specific considerations for program funding (including tender, partnership, co-design and/or commissioning activities).

7.5.14 In collaboration with neighbouring regions, recognise and address the limitations of planning area boundaries in supporting individuals and families across traditional Country boundaries.

7.5.15 Establish an Aboriginal Health Impact Statement process to provide guidance for new policies, programs or service delivery or the redesign of services or models of care to assess the potential impact on Aboriginal and Torres Strait Islander peoples.

7.5.16 Cooperate with the broader LHD and PHN to advocate for services and systems that better meet the needs of Aboriginal and Torres Strait Islander people.

7.6 Priority Population Groups

The diversity of the population in our region is growing[28] and, as a result, our services need to grow and adapt accordingly to ensure the particular service needs of our diverse population groups are responded to in a collaborative and respectful way. Many of these diverse population groups are at higher risk of poor mental health, have lower levels of health literacy or experience greater disadvantage, such as discrimination, racism and stigma when seeking to access health services[52]. It should be noted that diversity includes LGBTQI populations, cultural and linguistic diversity and diversity in age and socio-economic status.

Improve outcomes and experiences

7.6.1 Develop or redesign mental health services to ensure they are culturally safe and responsive, including but not limited to, assisting health practitioners to overcome language and cultural barriers when caring for patients from culturally and linguistically diverse (CALD) backgrounds.

7.6.2 Ensure a CALD-specific service assessment is made for CALD clients at the initial intake or referral as a part of standard practice.

Improve access

7.6.3 Address social isolation among older people. This may include through expansion of the delivery of the Social Connectedness of Older Australians project (Compassionate Communities model) to all LGAs in the NBM region in partnership with GPs, practice nurses, local councils and other relevant bodies.

Integrate care

7.6.4 Promote linkages, such as referral pathways, between the Transcultural Mental Health Service (TMHC), the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), the NSW Refugee Health Service, local multicultural health agencies and local primary care, acute and community mental health services.

Strengthen the health workforce

7.6.5 Support an increase in the number of mental health professionals from diverse backgrounds (e.g. bi-lingual mental health professionals) delivering services within the region.

7.6.6 Ensure services that work with diverse population groups establish strategies for evaluating and improving their cultural capability and responsiveness, such as by using the Organisational Cultural Responsiveness Assessment scale (OCRAS) 6. The OCRAS is designed to support the development of culturally responsive practice at an organisation-wide level.

7.6.7 Support the improvement of cultural responsiveness of GPs and practice staff. This may involve cultural competency training, the appropriate use of interpreters, accountability measures to ensure a culturally competent practice, the employment of bi-lingual staff and building a knowledge base within the service regarding the migration and settlement experience.

7.6.8 Support professional development opportunities for GPs, other primary mental health professionals and mental health clinicians from the acute care and community sector that focus on the specific needs and risks of the region's diverse population groups.

7.7 People with Physical Health Comorbidity

People with mental health conditions, in particular those with higher and more complex support needs, have poorer physical health and higher rates of physical illness compared to other Australians[5,31]. 4 out of 5 people living with a mental health condition have a co-existing physical illness[5].

People with a mental health condition have a shorter life expectancy. They are twice as likely to have cardiovascular disease, respiratory disease, metabolic syndrome, diabetes and osteoporosis and they are 65% more likely to smoke and six times more likely to have dental problems[5]. People with co-existing mental and physical health conditions are twice as likely as people with only one physical or mental health condition, and eight times more likely than people with no physical or mental health condition, to struggle with activities of daily living.

As such, individual conditions cannot be viewed in isolation. To improve outcomes for people with co-existing mental and physical health conditions, care must be holistic and provided through coordinated service models and systems of support across physical health and mental health boundaries.

Improve outcomes and experiences

7.7.1 Promote routine physical health checks or screening and lifestyle interventions in primary care settings, for example as part of GP Mental Health Treatment and Review Plans AND in tertiary mental health care settings to people newly diagnosed with a mental health condition and those with more long-standing conditions.

7.7.2 Support people living with mental health conditions to achieve their physical health goals through the provision of recovery and wellbeing coaching.

7.7.3 Monitor consumers' experience of physical health care as a part of their mental health care.

7.7.4 Explore and address the underlying social and environment determinants and other contributing causes to comorbidity, including the effects of psychotropic medications.

Improve access

7.7.5 Expand commissioned and other local mental health service models to include provision of physical health interventions.

7.7.6 Investigate flexible funding for people with co-existing mental and physical health conditions to receive targeted, personalised lifestyle care packages and coordinated supports in the community.

Strengthen the health workforce

7.7.7 Provide GPs and other primary health providers with up-to-date information about local services, community activities and resources, including online resources, that promote physical and mental health and social and emotional wellbeing.

7.7.8 Promote increased GP referrals to allied physical health care providers such as exercise physiologists, dietitians and physiotherapists and to evidence-based healthy lifestyle programs (including exercise, smoking cessation, healthy diet and weight control) as part of the patient-GP mental health treatment plan.

7.8 Preparing For and Responding to the Impact of Disasters on Mental Health and Wellbeing

Disasters are part of the Australian landscape. Bushfires, floods, cyclones and drought occur across the country[32]. In our recent history, parts of our region have experienced significant drought, bushfires and flash flooding – all of which have had significant impacts upon the mental health and wellbeing of affected communities and the broader community more generally.

Most recently within our Nepean Blue Mountains region, the effects of local bushfires, floods and the global outbreak of Coronavirus (COVID-19), all occurring within a six month timeframe, has had additional significant impacts on our local population. The effects have been both acute and residual with little time for recovery between each event.

Available evidence shows that severe psychological distress is common following major natural disasters[33]. Most people recover from this distress within a number of months and are able to return to normal or near-normal functioning in their lives. However, a sizeable minority will continue to experience mental health problems in the months to years after the initial event and may require professional support[34-38]. Populations found to be at greater risk of poor mental health outcomes post-disaster and who may require additional levels of support or access to treatment include[39]:

- women and children
- people who had greater exposure to the disaster
- people with low or negative social support
- people with prior mental health conditions
- people experiencing major life stressors, such as change of income, change in accommodation or change in personal relationships.

Available evidence[40] also suggests that common consequences of large-scale disease outbreaks like COVID-19 include heightened anxiety and panic, depression, anger, confusion and uncertainty and financial stress. The pandemic is anticipated to significantly decrease protective factors and increase risk factors for mental ill health and suicide in the short and long-term[41].

Populations who are at risk of experiencing higher levels of anxiety and who may require additional levels of support or access to mental health treatment during and following the COVID-19 outbreak include:

- people with pre-existing anxiety disorders and existing health anxiety
- people with other mental health disorders
- health care workers (including doctors, nurses and auxiliary staff)
- those who have been placed in quarantine
- hospitalised patients who survived COVID-19
- people who are unemployed, casual workers or who face high job insecurity.

Improve access

7.8.1 Ensure the ability to enhance or scale-up existing mental health and suicide prevention services and supports as needed and where possible, in particular low-intensity therapies and those supporting service navigation/initial assessment and referral.

7.8.2 Adapt and plan for the expansion of services commissioned by NBMPHN that have a role in the pandemic response and which are likely to face increased demand.

Integrate care

7.8.3 Establish a regional system to identify and follow up residents affected by local or regional disasters to screen for common mental health problems and provide appropriate psychological supports.

Strengthen the health workforce

7.8.4 Ensure the availability of adequate mental health supports that take account of the particular impacts of disasters on the health workforce.

7.8.5 Ensure that GPs, primary mental health professionals, acute care clinicians and community sector professionals are aware of coordinated disaster response systems and processes.

7.8.6 Build capacity of GPs, primary mental health professionals, acute care clinicians and community sector professionals to respond to emerging needs at times of disasters or crisis.

7.8.7 Support opportunities for training and upskilling community connectors, gatekeepers and community leaders who are likely to come into contact with distressed individuals at times of disasters or crisis so that they can identify signs of distress and refer appropriately.

8. Joint Regional Mental Health and Suicide Prevention Action Summary Table

This table summarises the actions outlined throughout this Strategic Plan. These actions will be operationalised over the next five years.

Service Planning Priority	Objective	Action	
General Service Priorities	**Improve outcomes and experiences**	7.1.1	Establish accountability and reporting requirements for all new services to support service delivery and evaluation in line with community priorities.
		7.1.2	Improve the flexibility and responsiveness of new and existing services to better meet the changing needs of people in the region.
		7.1.3	Educate the community about common mental health issues, signs and symptoms of mental health conditions and/or mental distress, services available, referral pathways and information about counselling processes. Ensure: • The co-design of education with the targeted population • Education is designed and delivered in accessible and culturally sensitive ways.
		7.1.4	Prioritise investment in peer-led services, including services that are exclusively peer-led such as support groups for people with lived experience of a particular issue (e.g. anxiety, hearing voices, suicidal ideation).
		7.1.5	Support community-led strategies, approaches and activities that build community resilience, community empowerment, promote self-care and facilitate social engagement and connectedness.
	Improve access	7.1.6	Ensure mental health services are available and expanded in their reach across the region using a stepped care approach to service planning and commissioning and include low intensity face-to-face psychological services, psychosocial services and psychiatric services.
		7.1.7	Assess and reduce barriers to accessing services, including restrictive referral criteria and processes, cost barriers and complex referral pathways.
		7.1.8	Support delivery and uptake of digitally-enabled mental health services among consumers and providers where appropriate.
		7.1.9	Improve health literacy through the development of services and programs that provide universally available information that is easy to understand, navigate and access to support personal decision-making.
		7.1.10	To support personal decision making, improve health literacy through the development of services and programs that provide universally available information that is easy to understand, navigate and access.

	Co-design services	7.1.11	Decisions about service models, procurement activities, referral pathways and availability of services are informed by service providers and lived experience representatives from diverse communities and peak bodies to ensure they are safe, appropriate and meet the needs of people from diverse community groups.
		7.1.12	Advocate for the inclusion of capital support measures when seeking and applying for funding of new services in rural and remote areas.
		7.1.13	Develop partnership arrangements with local services and peak bodies to support the needs of the community.
		7.1.14	Leverage partnerships to advocate for services and models of care to be funded on 3-5 year contracts to improve continuity of service provision and planning.
	Integrate care	7.1.15	Establish clear communication and coordination mechanisms across the sector to enhance continuity of care for all mental health consumers. These may include shared care planning, accessible electronic records, secure messaging and consistent and timely provision of the patient discharge summary to GPs and other providers in the consumer's care team.
		7.1.16	Formalise partnerships between all service providers to articulate agreed ways of working together for referral pathways and smooth service transitions.
		7.1.17	Establish a process for the development of single multiagency care plans for people with high and very high support needs who receive care from both primary and specialist care and support from community managed organisations, with the aim of coordinating physical health, mental health and psychosocial support needs.
		7.1.18	Establish data and information sharing protocols across primary and acute care mental health services to facilitate care continuity as well as the development of joint needs assessments, identify emerging trends and inform future service design.
		7.1.19	Enhance shared care referral pathway platforms to support accessibility to services, clarification of service and consistent taxonomy.
	Strengthen the health workforce	7.1.20	Provide cross-sector workforce training and skills development opportunities for GPs, primary mental health professionals, acute care clinicians and community sector professionals in areas informed by workforce priorities and development needs.
		7.1.21	Improve the identification of early signs of mental distress in patients in a primary care setting.
		7.1.22	Support and enhance peer-led workforce activities across the region.
		7.1.23	Build the capacity and capability of primary care, acute and community mental health professionals to assess, navigate, refer and provide services in a stepped care approach.
		7.1.24	Ensure appropriate levels of supervision, mentoring, coaching, professional development opportunities and other supports are available to all mental health staff as required for their role.
		7.1.25	Support opportunities to expand the scope of practice for mental health service delivery within the general practice setting.

		7.1.26	Partner effectively with community managed organisations and build capacity with a view to introducing shared care planning for people who engage with both these organisations and with mental health services.
		7.1.27	Leverage broader partnerships (e.g. Western Sydney Health Alliance) to attract and retain undergraduate and postgraduate students and skilled professionals, targeting identified areas of workforce shortage within the region.
		7.1.28	Develop regional HealthPathways covering assessment, management and referral that focus on the critical transition points between mental health and other key services for: • youth to adult services • out-of-home care settings to family of origin or independent living • hospital to community/primary care • between public, private and community managed mental health services • throughout the perinatal stages for parents • between mental health services and Aboriginal Community Controlled Organisations
		7.1.29	Support GPs to use online programs to help their patients e.g. 'eMHprac' a resource guide for practitioners that provides an overview of Australian online and tele-web programs.
	Cooperate and collaborate across systems and services	7.1.30	Ensure best practice in transfer of care across the sector, including post-discharge community care, is encompassed within models of care.
		7.1.31	Embed service linker, care navigation and case coordination and management for health and social services into the models of care to support people with high or very high support needs.
		7.1.32	Establish a joint operational level agreement to provide guidance to both PHN and LHD for working collaboratively on major new projects that have region and/or sector-wide implications, such as the Adult Mental Health Hub21 and Towards Zero Suicides initiative.
Suicide Prevention	**Improve outcomes and experiences**	7.2.1	Establish processes to ensure support and educational resources are available to assist patients, carers, families and communities following a suicide attempt or completed suicide.
		7.2.2	Ensure that service planning encompasses a suicide bereavement service developed and delivered with people with a lived experience of suicide bereavement that provides support, assistance and a coordinated response for people bereaved or impacted by suicide.
		7.2.3	Prioritise and make available applicable evidence-based gatekeeper training for identified gatekeepers, such as community (schools, workplaces, government and community agencies and communities at risk) and service providers (acute, primary care and community health).

	Improve access	7.2.4	Develop alternatives to the Emergency Department for people experiencing suicidality or emotional crisis, with consideration given to: • provision of multidisciplinary support, including peer workers • safe places in community settings • the importance of addressing situational and environmental stressors • the availability of clear pathways and protocols that provide linkages to other supports required.
	Co-design services	7.2.5	Expand the Lived Experience of Suicide Advisory Group to ensure the diversity of the lived experience voices supporting suicide prevention services planning is aligned to the diversity of the population of the region.
		7.2.6	Establish a Suicide Prevention Collaborative to embed and drive regional approaches in line with the Strategic Framework for Suicide Prevention in NSW 2018-2023. This will include regional approaches to capacity building and knowledge sharing with other government and community agencies.
	Integrate care	7.2.7	In collaboration with people who have a lived experience of suicidal crisis, establish a robust suicide care pathway to ensure effective and timely communication and continuity of care across the sector.
	Strengthen the health workforce	7.2.8	Support GPs and community care providers to be able to identify and provide care and support to people experiencing suicidality, who are in crisis, who have self-harmed or who have been bereaved by suicide.
	Cooperate and collaborate across systems	7.2.9	Develop and implement a collaborative data strategy for capturing, sharing and optimising the use of regional suicide, self-harm and follow-up care services data to inform ongoing service planning and delivery. Importantly, the data strategy, where possible, will capture: • local hospital data for patients who present to hospital with self-harm • linked data that illuminates the provision of follow-up care for people following a suicide attempt/self-harm by all providers, including community mental health teams, GPs and private mental health clinicians.
Child and Youth Services	**Improve outcomes and experiences**	7.3.1	Improve the flexibility and responsiveness of new and existing service models to better meet the specific needs of children and young people across the region.
		7.3.2	Ensure programs and services are developed to empower parents of young people to address their own mental health concerns, thereby maximising the potential for healthy childhood development.
	Improve access	7.3.3	In collaboration with young people, design youth services to specifically improve the health literacy of young people and ensure they and their families are well-informed with reliable and credible information about services, including those in the digital sphere.
		7.3.4	In collaboration with young people, develop youth-specific suicide prevention services to address the increasing prevalence of suicidality and self-harm.

		7.3.5	Increase awareness of targeted parenting support services that support the perinatal and early childhood period, particularly in the first 2000 days of life.
	Co-design services	7.3.6	Embed a youth-specific reference group in the commissioning and development of youth-specific services across the region.
		7.3.7	Develop a Youth and Young People Activity Work Plan to clearly identify the objectives of the youth reference group and milestones against agreed activities.
	Integrate care	7.3.8	Integrate family-based services in mental health service provision.
People with Lived Experience	**Improve outcomes and experiences**	7.4.1	Support people with lived experience so they can know about, advocate for and act on their rights as users of the health system.
	Co-design services	7.4.2	Establish a formalised process of co-design, ensuring all new services and programs are developed, implemented and evaluated in equal partnership with people with lived experience and include representatives from diverse communities and peak bodies.
		7.4.3	Regularly evaluate engagement and participation activities and use the results to improve future activities.
		7.4.4	Ensure all funding and commissioning processes for new services include a statement of the processes that will be followed for: • engagement and co-design with people with lived experience from diverse backgrounds and reporting upon how changes were made as a result of feedback received. • how the principles of recovery-oriented and trauma-informed care will be implemented.
		7.4.5	Provide development and training opportunities that empower people with lived experience to have the confidence, knowledge and skills to advocate for the lived experience voice in formal planning and governance activities.
		7.4.6	Develop a pool of people with lived experience who can be available for ongoing advice, consultation work or discrete projects, enabling access to lived experience experts based on areas of expertise and interest.
		7.4.7	Develop a live mental health lived experience engagement map to illustrate regional opportunities and options for participation and collaboration activities.
		7.4.8	Support people with lived experience to develop leadership capabilities.
	Strengthen the health workforce	7.4.9	Create an inclusive organisational culture that strongly supports lived experience engagement within the LHD, PHN and the lived experience community.
		7.4.10	Increase service provider expertise in engagement and co-design.
Aboriginal and Torres Strait Islander Mental Health	**Improve outcomes and experiences**	7.5.1	Prioritise the development of services and models of care that consider Aboriginal and Torres Strait Islander perspectives on health, healing and wellbeing (as opposed to only approaches to illness). This is in line with the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023[3].

		7.5.2	In collaboration with local Aboriginal and Torres Strait Islander communities, develop a transfer of care protocol for Aboriginal and Torres Strait Islander people who present to, are admitted to and are discharged from hospital. This transfer of care protocol will: • include coordination strategies for discharge planning and post-discharge care and support • have as its focus the needs of the individual as well as their extended family unit.
		7.5.3	In collaboration with local Aboriginal and Torres Strait Islander community representatives, resource the informal care system (carers, families, communities) to support members of the community experiencing, or at risk of developing, mental health problems.
	Improve access	7.5.4	Support capacity building within Aboriginal Community Controlled Organisations to deliver Aboriginal and Torres Strait Islander mental health services.
	Co-design services	7.5.5	Develop local co-design protocols in partnership with Aboriginal Community Controlled Organisations that consider cultural communication methods. This should include transparency in reporting on activities and outcomes of initiatives.
		7.5.6	Develop outcome measures in partnership with Aboriginal and Torres Strait Islander people to ensure measures of service effectiveness are in line with culturally accepted views of effectiveness, healing and health.
		7.5.7	Incorporate Aboriginal and Torres Strait Islander governance and co-design into service planning activities and in the commissioning of services to Aboriginal and Torres Strait Islander communities.
		7.5.8	Establish a regional consultation repository to minimise consultation duplication and enable sharing of community priorities within the service system.
	Integrate care	7.5.9	In collaboration with local Aboriginal and Torres Strait Islander community representatives, design services that recognise and incorporate effective traditional and culturally-specific healing practices.
	Strengthen the health workforce	7.5.10	Grow the Aboriginal mental health workforce.
		7.5.11	Improve the cultural responsiveness of the mainstream system's workforce by investing in training by Aboriginal and Torres Strait Islander trainers.
	Cooperate and collaborate across systems and services	7.5.12	Co-design data collection and outcome measurement strategies with Aboriginal and Torres Strait Islander service providers and communities. Ensure data collection tools are culturally validated.
		7.5.13	Establish a regional funding and commissioning protocol that recognises community needs and cultural considerations for Aboriginal and Torres Strait Islander mental health service providers and defines the specific considerations for program funding (including tender, partnership, co-design and/or commissioning activities).
		7.5.14	In collaboration with neighbouring regions, recognise and address the limitations of planning area boundaries in supporting individuals and families across traditional Country boundaries.
		7.5.15	Establish an Aboriginal Health Impact Statement process to provide guidance for new policies, programs or service delivery or the redesign of services or models of care to assess the potential impact on Aboriginal and Torres Strait Islander peoples.
		7.5.16	Cooperate with the broader LHD and PHN to advocate for services and systems that better meet the needs of Aboriginal and Torres Strait Islander people.
Priority Population Groups	**Improve outcomes and experiences**	7.6.1	Develop or redesign mental health services to ensure they are culturally safe and responsive, including but not limited to, assisting health practitioners to overcome language and cultural barriers when caring for patients from culturally and linguistically diverse (CALD) backgrounds.
		7.6.2	Ensure a CALD-specific service assessment is made for CALD clients at the initial intake or referral as a part of standard practice. This practice may effectively reduce the duration of treatment.
	Improve access	7.6.3	Address social isolation among older people. This may include through expansion of the delivery of the Social Connectedness of Older Australians project (Compassionate Communities model) to all LGAs in the NBM region in partnership with GPs, practice nurses, local councils and other relevant bodies.
	Integrate care	7.6.4	Promote linkages, such as referral pathways, between the Transcultural Mental Health Service (TMHC), the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), the NSW Refugee Health Service, local multicultural health agencies and local primary care, acute and community mental health services.
	Strengthen the health workforce	7.6.5	Support an increase in the number of mental health professionals from diverse backgrounds (e.g. bi-lingual mental health professionals) delivering services within the region.
		7.6.6	Ensure services that work with diverse population groups establish strategies for evaluating and improving their cultural capability and responsiveness, such as by using the Organisational Cultural Responsiveness Assessment scale (OCRAS)6. The OCRAS is designed to support the development of culturally responsive practice at an organisation-wide level.
		7.6.7	Support the improvement of cultural responsiveness of GPs and practice staff. This may involve cultural competency training, the appropriate use of interpreters, accountability measures to ensure a culturally competent practice, the employment of bi-lingual staff and building a knowledge base within the service regarding the migration and settlement experience.
		7.6.8	Support professional development opportunities for GPs, other primary mental health professionals and mental health clinicians from the acute care and community sector that focus on the specific needs and risks of the region's diverse population groups.

People with Physical Health Comorbidity	**Improve outcomes and experiences**	7.7.1	Promote routine physical health checks or screening and lifestyle interventions in primary care settings, for example as part of GP Mental Health Treatment and Review Plans AND in tertiary mental health care settings to people newly diagnosed with a mental health condition and those with more long-standing conditions..
		7.7.2	Support people living with mental health conditions to achieve their physical health goals through the provision of recovery and wellbeing coaching.
		7.7.3	Monitor consumers' experience of physical health care as a part of their mental health care.
		7.7.4	Explore and address the underlying social and environment determinants and other contributing causes to comorbidity, including the effects of psychotropic medications.
	Improve access	7.7.5	Expand commissioned and other local mental health service models to include provision of physical health interventions.
		7.7.6	Investigate flexible funding for people with co-existing mental and physical health conditions to receive targeted, personalised lifestyle care packages and coordinated supports in the community.
	Strengthen the health workforce	7.7.7	Provide GPs and other primary health providers with up-to-date information about local services, community activities and resources, including online resources, that promote physical and mental health and social and emotional wellbeing.
		7.7.8	Promote increased GP referrals to allied physical health care providers such as exercise physiologists, dietitians and physiotherapists and to evidence-based healthy lifestyle programs (including exercise, smoking cessation, healthy diet and weight control) as part of the patient-GP mental health treatment plan.
Preparing For and Responding to the Impact of Disasters on Mental Health and Wellbeing	**Improve access**	7.8.1	Ensure the ability to enhance or scale-up existing mental health and suicide prevention services and supports as needed and where possible, in particular low-intensity therapies and those supporting service navigation/initial assessment and referral.
		7.8.2	Adapt and plan for the expansion of services commissioned by NBMPHN that have a role in the pandemic response and which are likely to face increased demand.
	Integrate care	7.8.3	Establish a regional system to identify and follow up residents affected by local or regional disasters to screen for common mental health problems and provide appropriate psychological supports.
	Strengthen the health workforce	7.8.4	Ensure the availability of adequate mental health supports that take account of the particular impacts of disasters on the health workforce.
		7.8.5	Ensure that GPs, primary mental health professionals, acute care clinicians and community sector professionals are aware of coordinated disaster response systems and processes.
		7.8.6	Build capacity of GPs, primary mental health professionals, acute care clinicians and community sector professionals to respond to emerging needs at times of disasters or crisis.
		7.8.7	Support opportunities for training and upskilling community connectors, gatekeepers and community leaders who are likely to come into contact with distressed individuals at times of disasters or crisis so that they can identify signs of distress and refer appropriately.

9. References

1. Nepean Blue Mountains Local Health District and Primary Health Network. *Joint regional Mental Health and Suicide Prevention Foundation Plan*; 2019.
2. COAC Health Council. *The Fifth National Mental Health and Suicide Prevention Plan (2017-2022).* Canberra: Commonwealth of Australia; 2017.
3. Commonwealth of Australia. *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*. Canberra: Department of the Prime Minister and Cabinet; 2017.
4. National Aboriginal and Torres Strait Islander Leadership in Mental Health Ltd. *Gayaa Dhuwi (Proud Spirit) Declaration.* Sydney: NATSILMH Ltd.; 2016.
5. National Mental Health Commission. *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia*. Sydney NMHC; 2016
6. Mental Health in Multicultural Australia (MHiMA). *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery.* Macgregor, QLD: National Coordination Unit; 2014.
7. NSW Mental Health Commission. *Living Well: A Strategic Plan for Mental Health in NSW*. Sydney, NSW; 2014.
8. Mental Health Commission of NSW. *Strategic Framework for Suicide Prevention in NSW 2018-2023*; 2018.
9. NSW Ministry of Health. *NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022*. North Sydney, NSW; 2018.
10. Mental Health Commission of NSW. *Lived Experience Framework for NSW.* Sydney, NSW; 2018.
11. Wentworth Healthcare Limited. *Nepean Blue Mountains Primary Health Network Needs Assessment.* Kingswood, NSW; 2019.
12. Ham C, Walsh N. *Lessons from experience: Making integrated care happen at scale and pace.* The Kings Fund [Internet]. 2013; [cited 2019 June]. Available from: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-integrated-care-happen-kingsfund-mar13.pdf
13. Australian Government Department of Health. *PHN Mental Health Flexible Funding Pool Programme Guidance: Stepped Care.* Canberra, ACT; 2019.
14. Australian Government, National Mental Health Commission. *Engage and Participate in Mental Health: Summary Report.* Canberra, ACT; 2018.
15. Agency for Clinical Innovation. *A Guide to Build Co-design Capability.* Chatswood, NSW; 2019.
16. NSW Health. *Collaborative Commissioning Part 1: Summary Guidance to Establishing Collaborative Commissioning;* 2019.
17. The University of Queensland. The National Mental Health Services Planning Framework. Commissioned by the Australian Government Department of Health. Version 1.2 Tableau. Brisbane: The University of Queensland. Extracted December 2020.
18. Commonwealth Department of Health. National Health Workforce Dataset Data Tool [Internet]. 2020 [cited 2020 February]. Available from: https://hwd.health.gov.au/datatool.html. (Restricted Access).
19. Healthshare Directory. *Find a Health Practitioner by Specialty* [Internet]. 2020 [cited 2020 February). Available from: https://www.healthshare.com.au/directory/find-a-health-professional/
20. Wentworth Healthcare Limited. *Internal analysis from consultations with local GPs, paediatricians and the Wentworth Healthcare Limited mental health team*; 2020.
21. Liberal Party NSW. *$19.5 million in Western Sydney Community Health and Wellbeing Package* [Internet]. 2019 [cited 2020 May). Available from: https://nsw.liberal.org.au/Shared-Content/News/2019/$19-5-million-Western-Sydney-Community-Health
22. Hall S, Fildes J, Perrens B, Plummer J, Carlisle E, Cockayne N, Werner-Seidler, A. *Can we Talk? Seven Year Youth Mental Health Report - 2012-2018*. Mission Australia: Sydney, NSW; 2019.
23. Craze Lateral Solutions. *Community Forums, Wentworth Healthcare: Mental Health Consumer and Carer Consultations;* Kingswood, NSW; 2019.
24. Suicide Prevention Australia. *Submission to Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health.* Canberra: Australian Government Productivity Commission; 2019.

25. Centre for Epidemiology and Evidence. Health Statistics New South Wales: *Suicide by Local Health District, NSW 2017* [Internet]. 2020 [cited 2020 February]. Available from: http://www.healthstats.nsw.gov.au/
26. Centre for Epidemiology and Evidence. Health Statistics New South Wales: *Intentional self-harm: hospitalisations by Local Health District persons of all ages and 15-24 years, 2017-18* [Internet]. 2020 [cited 2020 March]. Available from: http://www.healthstats.nsw.gov.au/
27. NSW Government. *Towards Zero Suicides initiatives.* North Sydney: NSW Ministry of Health [Internet]. 2020 [cited 2020 March]. Available from: https://www.health.nsw.gov.au/mentalhealth/resources/Pages/Towards-Zero-Suicides-initiatives-Factsheet.aspx
28 .id community profile Nepean Blue Mountains Primary Health Network [Internet]. 2020 [cited 2020 April]. Available from: https://profile.id.com.au/nbmphn
29. Nepean Blue Mountains Medicare Local and Nepean Blue Mountains Local Health District. *Blue Mountains, Penrith, Hawkesbury Aboriginal Sharing and Learning Circle Reports*; 2015.
30. Shared Path Aboriginal and Torres Strait Islander Corporation Report. *Community Forums: Co-design of Aboriginal Specific Mental Health and Drug and Alcohol Services*; 2016.
31. Royal Australian and New Zealand College of Psychiatrists (RANZCP). *Keeping Body and Mind Together: Improving the physical health and life expectancy of people with serious mental illness*; 2015.
32. Wentworth Healthcare Limited. *Planning for Disaster Management: An emergency preparedness guide for Primary Health Networks and others supporting the local General Practitioner response during emergencies;* 2018.
33. Black Dog Institute. *Mental Health Ramifications of COVID-19: The Australian context* [Internet]. 2020 [cited 2020 May]. Available from: https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/20200319_covid19-evidence-and-reccomendations.pdf
34. Australian Government, National Mental Health Commission. *National Mental Health and Wellbeing Pandemic Response Plan.* Canberra, ACT; 2020.
35. PHN Cooperative (MHAOD working group). *Mental Health Pandemic Response Plan: Submission from Primary Health Networks (PHNs); 2020.*
36. Australian Health Ministers' Advisory Council. *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. Canberra: Commonwealth of Australia; 2013.
37. Kezelman CA and Stavropoulos PA. *Practice Guidelines for Clinical Treatment of Complex Trauma.* Blue Knot Foundation [Internet]. 2020 [cited 2020 April]. Available from: https://www.blueknot.org.au/Resources/Publications/Practice-Guidelines/Practice-Guidelines-2019
38. Wentworth Healthcare Limited. Customer relationship management database extract as at 17th March 2020. Restricted Access; 2020
39. NSW Government Planning, Industry and Environment. New South Wales State and Local Government Area Population Projections [Internet]. 2016 [cited April 2020]. Available from: http://www.planning.nsw.gov.au/Research-and-Demography/Demography/Population-projections.
40. World Health Organization and Calouste Gulbenkian Foundation. *Social determinants of mental health*. Geneva, World Health Organization; 2014.
41. Australian Bureau of Statistics. *Socio-Economic Indexes for Australia (SEIFA), 2016*. Cat no. 2033.0.55.001; 2018
42. Australian Bureau of Statistics. *Labour Force, Australia: April 2020* [Internet]. 2020 [cited 2020 May]. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/mf/6202.0
43. Relationships Australia. *Is Australia experiencing an epidemic of loneliness? Findings from 16 waves of the Household Income and Labour Dynamics of Australia Survey*. Canberra: Relationships Australia; 2018.
44. Nepean Blue Mountains PHN. *Addressing the Psychosocial needs of people with severe mental illness in the Nepean Blue Mountains, community consultation report*; 2018.
45. Centre for Epidemiology and Evidence. Health Statistics New South Wales: High or very high psychological distress in adults by Local Health District, persons aged 16 years and over, NSW 2017. [Internet]. 2020 [cited 2020 March]. Available from: http://www.healthstats.nsw.gov.au/
46. Centre for Epidemiology and Evidence. Health Statistics New South Wales: *Hospitalisations by category of cause and Local Health District, 2018-19* [Internet]. 2020 [cited 2020 March]. Available from: http://www.healthstats.nsw.gov.au/
47. Mental Health Commission of NSW. *Suicide in NSW by age and gender – interactive* [Internet]. 2019 [cited 2020 February]. Available from: https://nswmentalhealthcommission.com.au/resources/suicide-in-nsw-by-age
48. Australian Institute of Health and Welfare. *Medicare-subsidised GP, allied health and specialist health care across local areas: 2013-14 to 2017-18* [Internet]. 2019 [cited 2019 November]. Available from: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-gp-allied-health-and-specialis/contents/introduction
49. Australian Government Department of Health. *Pharmaceutical Benefits Scheme Data: Mental Health Related PBS Data for 2016-17* [Internet]. 2019 [cited 2019 November]. Available from: PHN Secure Data Area, Restricted access
50. headspace National, 2020. *PHN headspace centre reporting suite* [Internet]. 2020 [cited 2020 March]. Restricted access.
51. Nepean Blue Mountains Local Health District. *Internal data for selected mental health services and mental health service activity*; 2019. Restricted access.
52. Nepean Migrant Access Inc. *Breaking Barriers Bringing Understanding (3BU) Project: a study of CALD communities' perceptions, attitudes and awareness of mental health and service provision in Penrith, Hawkesbury, Blue Mountains and Lithgow LGAs;* 2016. Available from: http://nma.org.au/wp-content/uploads/2016/12/3BU-FINAL-REPORT.pdf
53. Nepean Blue Mountains PHN. *Regional mental health system issues – analysis of evidence and consultation findings;* 2020
54. Nepean Blue Mountains PHN. *Aboriginal and Torres Strait Islander consultation outcomes and recommended planning strategies*; November 2019
55. Nepean Blue Mountains PHN. *Mental Health Consumer and Carer Community Consultations*; 2020
56. Nepean Blue Mountains PHN. *Primary Care Provider Consultations*; 2020
57. Life in Mind. *Gatekeeper training*; https://lifeinmind.org.au/gatekeeper-courses#:~:text=Training%20that%20teaches%20individuals%20who,those%20who%20have%20lived%20experience. Accessed November 2020
58. Nepean Blue Mountains LHD. *LHD Mental Health Clinician Consultation Report*; 2020
59. Department of Health. *A report detailing key themes and early findings to support initial advice of the National Suicide Prevention Adviser;* November 2019. Available from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/CBD1A157EC292D9FCA2584700028CC75/$File/Report%20detailing%20key%20themes%20and%20early%20findings%20-%20for%20discussion.pdf
60. Australian Institute of Health and Welfare. *Suicide by local areas* [Internet]. Available from: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/geography/suicide-by-local-areas Accessed February 2021
61. Australian Bureau of Statistics. *Australian Statistical Geography Standard* [Internet]. Available from: https://www.abs.gov.au/websitedbs/d3310114.nsf/home/australian+statistical+geography+standard+(asgs)#:~:text=Statistical%20Areas%20Level%203%20(SA3s,the%20output%20of%20regional%20data.&text=They%20are%20often%20the%20functional,within%20the%20major%20urban%20areas. Accessed February 2021

Note:

Prevalence data has been included throughout the plan, giving estimates of predicted illness throughout the NBM region. These estimates have been derived from analysis of data from the National Mental Health Service Planning Framework (NMHSPF)17. Interpretation of these estimates should consider that these numbers do not necessarily reflect actual demand because people do not always choose to access services or there may be other barriers to service access such as location or cost.

The National Mental Health Service Planning Framework (NMHSPF) is a standardised national model which was developed based on best available evidence and expert opinion. It relies on a set of assumptions about expected levels of demand and efficient operation of service components within a comprehensive, integrated and interdependent mental health service system. The NMHSPF outputs do not reflect local context, such as sociodemographic factors impacting on demand or differences in how local services are arranged and delivered. These factors must be taken into consideration when applying the NMHSPF outputs. The NMHSPF outputs should be tailored to the designated population of focus and details of local modelling refinements or variations should be documented to guide interpretation.

The NMHSPF provides a standardised cost model which can be used for comparing potential costs across the NMHSPF modelled services. These costs do not fully reflect the complexity of existing costing and funding arrangements, and should not be relied upon to cost local services. Importantly, the NMHSPF is a planning tool, not a funding allocation model.

The NMHSPF is periodically updated and refined as new evidence becomes available. Published outputs are only relevant for the NMHSPF version from which they were derived. These outputs quoted in this document were produced by licensed users at the NSW Ministry of Health using the version 1.2 of the Tableau version of the NMHSPF. Further information on the NMHSPF can be found at www.nmhspf.org.au

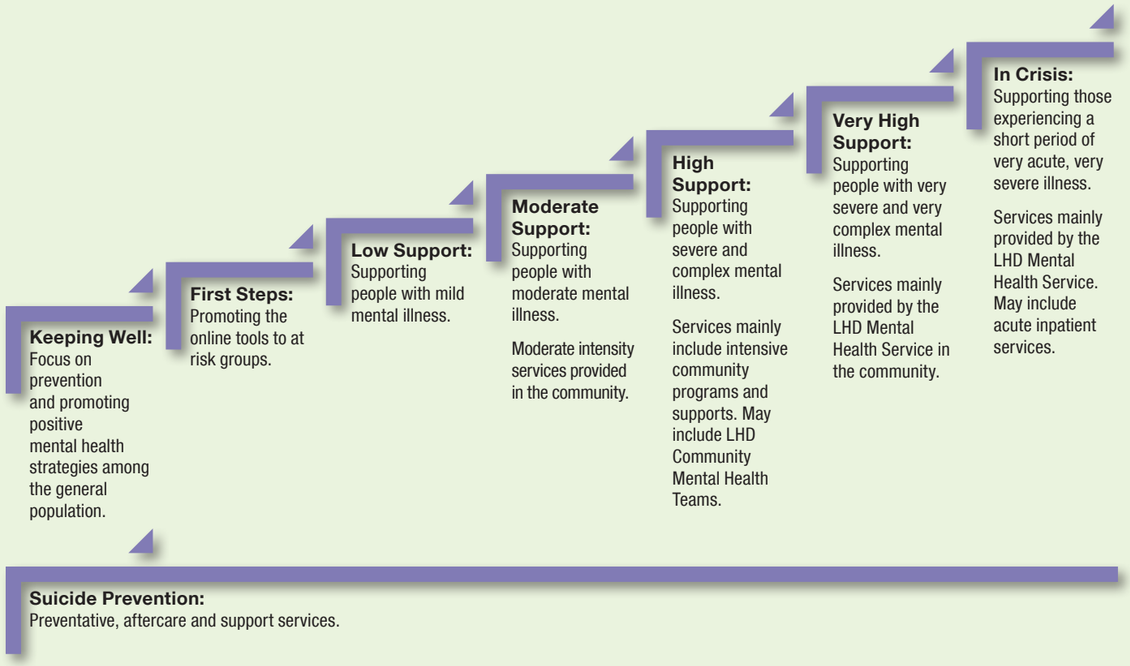
Appendix A: Acronyms

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACI	Agency for Clinical Innovation
AOD	Alcohol and Other Drugs
CALD	Culturally and Linguistically Diverse
CMHT	Community Mental Health Team
ED	Emergency Department
GP	General Practitioner
ICD-10	International Classification of Diseases 10th Revision
LGA	Local Government Area
LGBTQI+	Lesbian, Gay, Bi-sexual, Transgender, Queer, Intersex
LHD	Local Health District
NBM	Nepean Blue Mountains
NBMLHD	Nepean Blue Mountains Local Health District
NBMPHN	Nepean Blue Mountains Primary Health Network
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NMHSPF	National Mental Health Services Planning Framework
NSW	New South Wales
PHN	Primary Health Network
WHL	Wentworth Healthcare Limited
YP	Young People

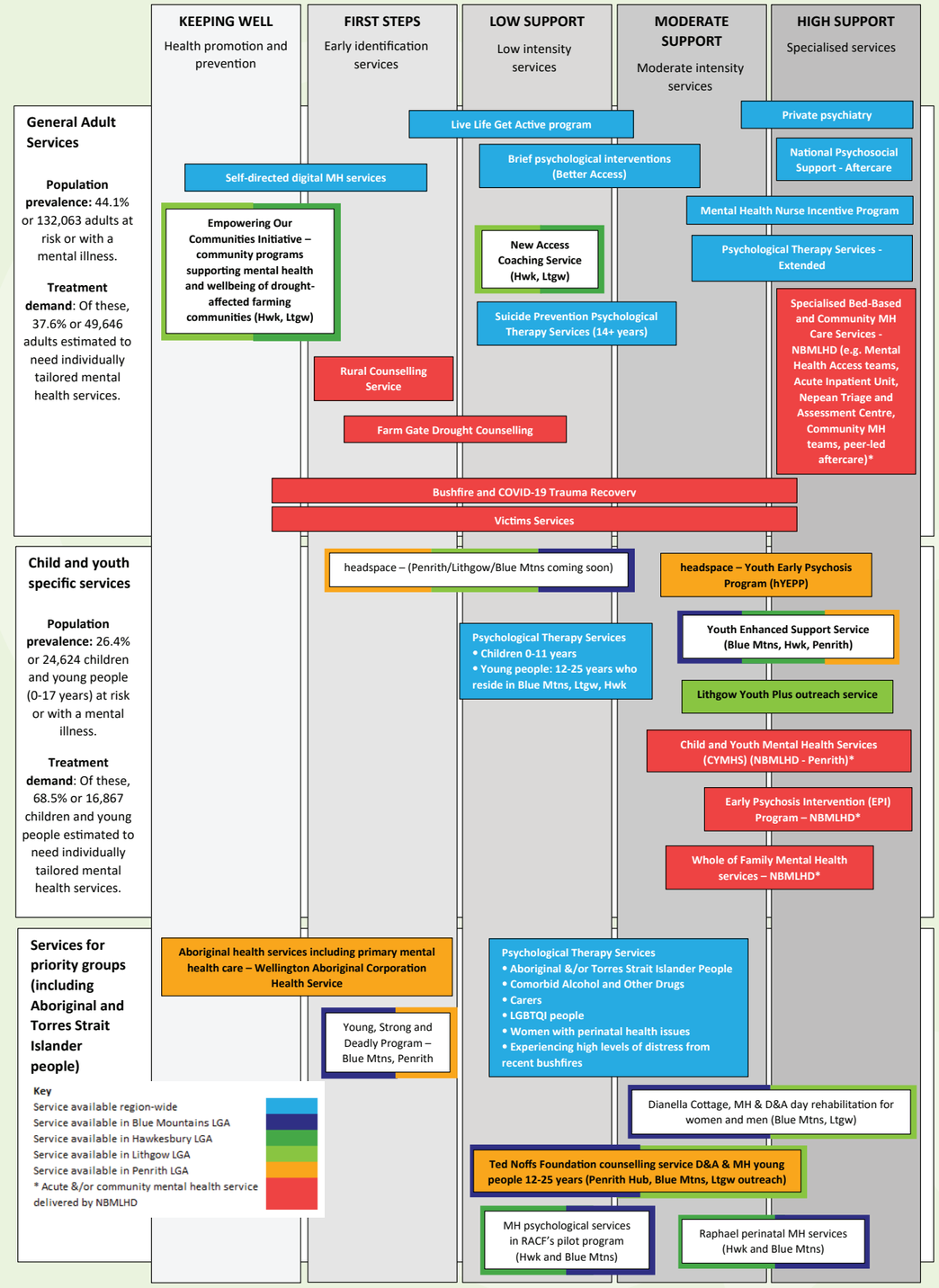
Appendix B: Terminology

Aftercare	The care received after a suicide attempt.
Carer	Carers are people who provide unpaid care and support to family members and friends who have a mental illness.
Chronic disease	Chronic diseases are long lasting conditions with persistent effects (Australian Institute of Health and Welfare).
Clinical governance	Clinical governance refers to the responsibilities set by a service to ensure good clinical outcomes. Clinical governance helps to ensure that systems are in place to deliver safe and high-quality care and continuously improve services.
Co-design	Co-design is the engagement of people with lived experience in the design process. This design may refer to the designing of physical buildings or spaces or to the design and development of models of care. Engagement of people with lived experience as partners in development and delivery of services is vital to get the best results and ensure that services genuinely promote person-centred care. Authentic co-design involves people with lived experience being engaged from the beginning of service design and must be appropriately resourced.
Commissioning	Commissioning is a term used to describe how services are purchased or funded. Commissioning includes needs assessment, priority setting, procurement through contracts, monitoring of service delivery and review and evaluation (Department of Health, 2016).
Consumer	A person who is currently using, or has previously used, a mental health service. This term is gradually being replaced by 'person with lived experience'.
Discrimination	Discrimination happens when a person or group of people are treated less favourably than another person or group of people because of their background or certain personal characteristics (e.g. age, gender, sexuality, health status) (Human Rights Commission of Australia) and includes homophobia and transphobia.
Gatekeepers	Those individuals within a community who have regular contact with others in that community. Often these individuals have a prominent role within that community e.g. school principal, community Elder, President of the local sports club, parish priest or church minister; however, they may also be service providers or someone who is simply active within many community groups.
Gatekeeper training	Training for gatekeepers to recognise and respond to people in their community who are at risk of suicide or to provide support to those with lived experience of suicide or who have been bereaved by suicide[57].
Integration	There are various definitions of integration and integrated care. In its simplest form, integration is how services work together, communicate and create an experience of care for the consumer that is seamless and connected.
Lived Experience	A person is considered to have a lived experience if they: • have a direct personal experience of mental illness • are a family member, carer or support person and have regularly provided unpaid care or support for a person living with a mental illness • have experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, or been bereaved by suicide.
Models of care	A model of care is a defined way of delivering a service. The model of care describes the tasks, activities and the way the service is delivered.
Multi-agency	Where a group of agencies work together and combine resources.
Multi-disciplinary care	Multi-disciplinary care occurs when professionals from a range of disciplines bring complementary skills, knowledge and experience to provide the best possible care for an individual.
National Mental Health Services Planning Framework	The NMHSPF is used by governments and service providers to estimate need and expected demand for mental health care and the level and mix of mental health services required for a given population.
No wrong door	The National Mental Health Commission describes a "no wrong door" approach as "every door in the service system should be the right door with a range of services being accessible to everyone from multiple points of entry. This commits all services to respond to the individual's needs through either providing direct services for both their mental health and drug and alcohol problems or linkage and case co-ordination, rather than sending a person from one agency to another."
Peer work	A mental health peer worker is someone employed on the basis of their personal lived experience of mental illness and recovery (consumer peer worker) or their experience of supporting family or friends with mental illness (carer peer worker) (Peer Work Hub, NSW Mental Health Commission).
Postvention services	Services that support individuals, families and communities that have been bereaved by suicide. Services may include counselling, support groups, education and information on how to discuss suicide, or practical support immediately following a suicide.
Primary mental healthcare	Primary mental healthcare has general practice at its core. Primary mental healthcare services are based in the community, are broad-ranging and include health promotion, prevention and screening, early intervention and treatment.
Referral pathways	A referral pathway helps consumers and referrers to understand their assessment and intervention options and provides information on how to refer to local services.
Statistical Area 3 areas	Statistical Areas Level 3 are part of a framework used by the Australian Bureau of Statistics to define regional areas with similar characteristics, administrative boundaries or labour markets. This allows for ease of data analysis. SA3s generally have a population of between 30,000 and 130,000[61].
Shared decision making	In partnership with their clinician, patients are encouraged to consider available screening, treatment, or management options and the likely benefits and harms of each, to communicate their preferences, and help select the course of action that best fits these (Australian Commission on Safety and Quality in Healthcare).
Stepped care	A stepped care approach promotes person-centred care that targets the needs of the individual. Rather than offering a one-size-fits-all approach to care, individuals will be more likely to receive a service that optimally matches their needs, does not under or over service them, and makes the best use of the available workforce and technology. A stepped care approach also presumes early intervention – providing the right service at the right time and having lower intensity steps available to support individuals before an illness develops or gets worse (Department of Health, 2019).
Stigma	Stigma against people with mental illness involves a variety of myths, prejudices and negative stereotypes about mental illness. Stigma includes inaccurate or harmful representations of people as violent, comical or incompetent (SANE Australia).
Systems approach to suicide prevention	A systems approach is a community-wide approach with strong collaborations needed across many sectors within a community. In addition to clinical services, a wide range of activities have been shown to assist in reducing suicide rates and these are outlined in section 3.4 of this Strategic Plan.
Trauma	Trauma can arise from a single or repeated event that threatens to overwhelm a person's ability to cope. When it is repeated and extreme, occurs over a long time, or is perpetrated in childhood by care-givers it is called complex trauma (Blue Knot Foundation).
Trauma-informed care	Trauma-informed care is where services and interventions are organised and responsive to the impact of trauma. It emphasises the physical, psychological and emotional safety for people who require support, their families, carers and service providers. (Blue Knot Foundation).
Wrap-around care	An individualised care plan that is developed through collaboration with the person, their family or carers and a range of services that are key to the person's wellbeing and health. The services involved go beyond health and may also include social support, accommodation or education services.

Appendix C: Application of the Stepped Care Framework in the NBM Region



Appendix D: Current state of primary care and/or NBMPHN-funded regional mental health services, 2020



Appendix E: Additional Information on the Regional Population Mental Health and Suicide Prevention Profile, 2020

AREA PROFILE [11, 19, 38]

9,179km^2

5 hospitals
9 community health centres

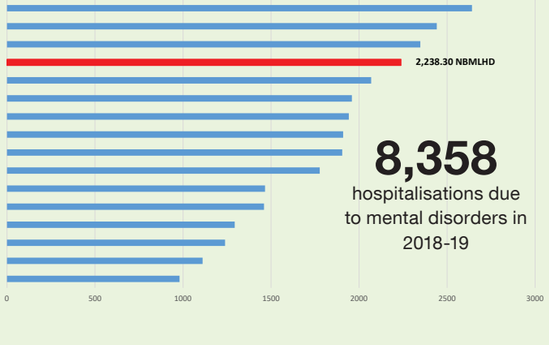
24 private psychiatrists / psychiatry services

548 GPs
8 credentialed Mental Health Nurses

139 General Practices
(including 1 Aboriginal Medical Services)

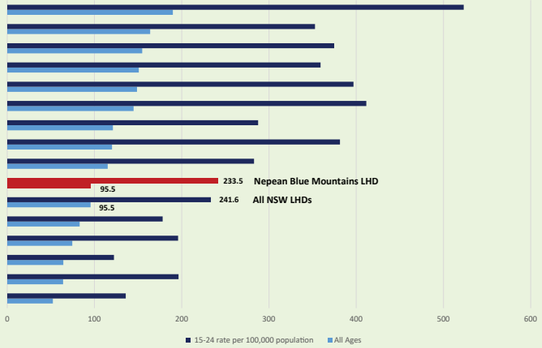
372 registered psychologists

Age standardised hospitalisations for mental health conditions among NSW LHDs, per 100,000 population, 2018-2019[45]



8,358 hospitalisations due to mental disorders in 2018-19

Intentional self-harm hospitalisations by LHD, persons of all ages and 15-24 years, 2017-18[26]

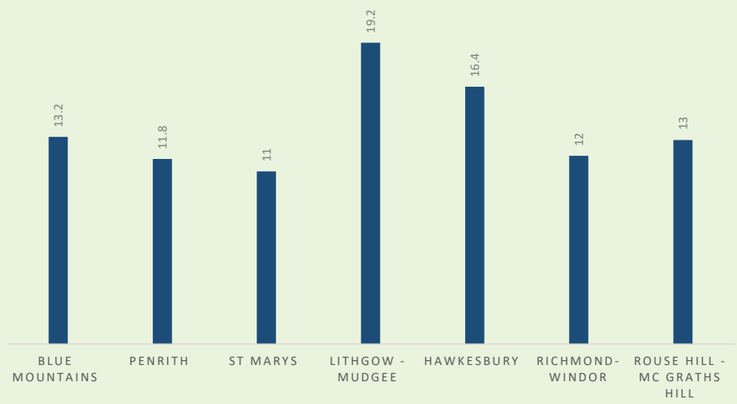


DEATHS BY SUICIDE [25, 47, 60]

50 deaths by suicide in 2017

This was a rate of 13.1 per 100,000 population, higher than the NSW rate of 10.8 per 100,000 persons

Deaths by suicide by Statistical Area 3 areas, 2014-2018 (age-standardised rate per 100,000 population)



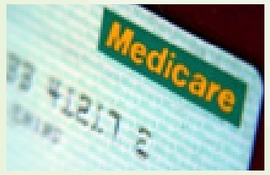
PREVALENCE OF MENTAL ILLNESS and ESTIMATED DEMAND FOR MENTAL HEALTH SERVICES, 2020 [17]

The estimated demand for mental health services below has been based on an analysis of the NMHSPF using the best available evidence and expert opinion. Interpretation of these estimates should consider that these numbers do not necessarily reflect actual demand because people do not always choose to access services or there may be other barriers to service acces such as location or cost.

Number of persons / Prevalence (Treatment Population)

	5-17 years	18-64 years	65+ years	65+ with BPSD	Region-wide (NBM)
At risk / early intervention	957 (3,871)	34,678 (8,669)	4,096 (467)	0 (0)	48,346 (13,007)
Mild	6,614 (3,307)	23,888 (11,944)	4,746 (2,373)	1,640 (820)	36,888 (18,444)
Moderate	3,340 (2,672)	12,084 (9,667)	2,373 (1,899)	954 (764)	18,751 (15,002)
Relapse prevention	0 (0)	39,731 (5,960)	9,832 (836)	0 (0)	49,563 (6,795)
Severe	1,729 (1729)	8,445 (8,445)	1,995 (1,995)	740 (740)	12,909 (12,909)

PRIMARY CARE MENTAL HEALTH SERVICES [48-50]



37,758 or **10.1%** of residents accessed a **GP mental health treatment plan** in 2017-18

This was the ***second highest*** proportion of residents among other Australian metropolitan PHN regions (Australia, 8.5%)

62,093 or **18.9%** of residents utilised a **mental health-related prescription medicine** in 2016-17

6,909 or **1.86%** of residents accessed a Medicare-subsidised clinical **psychiatry service** in 2017-18

This proportion was ***lowest*** among Lithgow (1.2%) and St Marys (1.5%) residents

6,529 or **1.75%** of residents accessed a Medicare-subsidised **clinical psychology service** in 2017-18. This proportion was ***significantly lower*** than the national average (2.09%)

13,029 or **3.5%** of residents accessed a Medicare-subsidised **other psychologist mental health service** in 2017-18. This proportion was ***lowest*** among Lithgow residents (2.5%)

1,232 people from identified disadvantaged groups received short-term **psychological therapy services** via the PHN funded psychological therapy services streams in 2018-19

headspace

1,206 young people aged 12-25 years received early intervention mental health support from the Penrith and Lithgow headspace service in 2018-19

SPECIALIST ACUTE AND COMMUNITY MENTAL HEALTH CARE SERVICES [51]

NBMLHD inpatient Mental Health Services

- Nepean Hospital and Blue Mountains Hospital Mental Health Acute Inpatient Unit
- High Dependency Unit – Mental Health Centre, Nepean Hospital
- Nepean Hospital Mental Health Triage and Assessment Centre (TAC)
- Nepean Psychiatric Emergency Care Centre Unit – Emergency Department
- Specialist Mental Health Older People Service
- Peer Led Aftercare Service

NBMLHD Community Mental Health

- Anxiety Disorders Clinic
- Assertive Community Treatment Team
- Blue Mountains Access Team (Mental Health Assessment and Acute Care Team)
- Plains Access - Community Assessment and Liaison Centre Nepean Hospital
- Penrith, Katoomba, St Marys, Springwood, Windsor and Lithgow Community Mental Health Teams
- Older Persons Community Teams (Plains and Blue Mountains)

- Penrith, St Marys, Katoomba and Springwood Clozapine clinics
- Suicide Prevention Outreach Team
- Whole of Family Mental Health Services
- Child and Youth Mental Health Services (CYMHS)
- Early Psychosis Intervention (EPI) Program
- Perinatal Mental Health

Community Mental Health Services and Programs contracted by NBMLHD

- Community Living Support Service
- Housing and Accommodation Support Initiative
- Younger Person's Program
- Youth Community Living Support Service
- Resolve Program

From 01/12/2018 to 30/11/2019:

2,209 mental health inpatient separations

11 days – the average length of stay in the psychiatric emergency care centre

7,400 unique clients were contacted by one of the NBMLHD community mental health teams

Appendix F: Overview of regional mental health system issues

The following key issues and themes were identified from evidence collected from the following:

1. NBMLHD/NBMPHN consultations for this regional plan[54-56,58]
2. NBMLHD/NBMPHN HealthPathways Clinical Working group meetings for mental health and suicide prevention
3. NBMPHN Primary Mental Healthcare Needs Assessment, 2019[11].

MENTAL HEALTH SYSTEM ISSUES		
At risk groups	**Low to moderate support needs**	**High to very high support needs**
1. System issues relevant to all levels of mental health need.		
2. Limited awareness and use of local and online services to support people with low-intensity mental health needs.	3. Unequal distribution, access to and uptake of psychological services in some parts of the region. 4. Capacity in the provision of psychological services across the region. 5. Service gaps for people with low to moderate mental health support needs.	6. Service gaps for people with high to very high support needs. 7. Poor continuity of care for patients discharged from acute mental health services. 8. Loss of psychosocial support service capacity across the region.
Integration, partnerships, communication and information sharing		
9. Communication challenges between providers impacting on coordination of care. 10. Providers have poorunderstanding of service availability/accessibility across the region.	11. Roles and responsibilities of PHN and LHD. 12. Data sharing challenges impacting on effective services planning. 13. Key integration issues between primary care and LHD results in people with lived experience having to repeat their story to multiple providers.	
Suicide preventions and aftercare		
14. Limited awareness of referral pathways and support services available among people who are at higher risk or have attempted suicide, their families and support people. 15. Poor communications around transfer of care leading to unsafe transitions between services.	16. Lack of alternatives to hospital or presenting to the Emergency Department. 17. Poor availability of high quality data to support analysis of suicide and self-harm rates, demand for local services and evaluation of integrated service models.	
Workforce capacity and development		
18. Identified regional workforce gaps leading to difficulty accessing services delivered by key mental health professionals. 19. Need for greater investment in the peer workforce.	20. Need for greater investment in a culturally competent workforce across the region. 21. Need for workforce training and skills development among GPs, mental health clinicians and other health professionals across a number of areas.	

Wentworth Healthcare
Level 1, Suite 1, Werrington Park Corporate Centre,
14 Great Western Highway
Kingswood NSW 2747

T 4708 8100

POSTAL ADDRESS
Wentworth Healthcare,
Bldg BR, Level 1, Suite 1,
Locked Bag 1797,
Penrith NSW 2751

For more information about Wentworth Healthcare
or Nepean Blue Mountains PHN visit
www.nbmphn.com.au

400_1221

NSW GOVERNMENT
Health
Nepean Blue Mountains
Local Health District

phn
NEPEAN
BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

Wentworth Healthcare Limited (ABN 88 155 904 975) provider of the Nepean Blue Mountains PHN.