Mental Health Service
Strategic Plan

2015-2019
A plan to improve the mental health and wellbeing of people living in Sydney Local Health District

Sydney, it’s your local health district
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In 2012-13 our inpatient services admitted 2958 people and provided 74,765 days of care. Our community mental health services provided over 128,000 occasions of service for more than 14,000 people.
This Mental Health Service Strategic Plan has been developed to improve the mental health of the people and communities in Sydney Local Health District (SLHD).

Mental ill health represents a significant health issue in our community. Consumers of mental health services and their carers are frequently amongst the most vulnerable members of our community with wide-ranging health and support needs, especially when these mental health issues are enduring.

The National Survey of Mental Health and Wellbeing (2010) confirmed that one in five people aged 16-85 in Australia is directly affected by mental ill-health. Many more people are indirectly affected as a family member, friend or colleague.

• The prevalence of mental illness for people in the 16 to 24 year age range (26%) is one third higher than the average for the overall adult population. Thus there’s a need to strengthen early intervention services that target younger Australians.
• At any one point in time, 2-3% of our population will be affected by severe mental illness, 4-5% by moderate to severe mental illness, and 9-10% by moderate mental illness.
• Mental illness ranks fourth as the major cause of life-years lost (after heart attacks, stroke and cancer).

As documented in the Survey, a number of health and other conditions also co-occur with mental illness. These include intellectual disability, organic brain disorders (such as dementia) and alcohol and drug related problems. In addition, people with a mental illness are more likely to have poor physical health, while some physical illnesses also increase the risk of developing a mental illness.

There are many challenges in building and sustaining high quality, safe, equitable and accessible mental health services and health promoting practices, while ensuring that the services are safe, respectful, healthy and productive workplaces. In SLHD, these challenges include our population growth, cultural diversity, changing models of care, service integration and coordination and ensuring the workforce skills and capacity match community needs. It is also critically important that the latest innovation, research and evidence is translated into mental healthcare practice.

This Plan identifies key strategies that reflect these imperatives. It also reflects the priorities of consumers, carers, related service providers and staff, expressed through community and staff consultations.

Core strategies include:

• Enhancing community mental health services and improving the continuity of care and care pathways between inpatient and community services;
• Upgrading SLHD inpatient and ambulatory mental health physical facilities;
• Improving the physical health of people with mental health problems through a range of evidence-based strategies including developing ‘shared care’ services with primary care providers and targeted health promotion;
• Building the research, evidence and evaluation components of mental health services in collaboration with the University of Sydney and other partners;
• Working collaboratively with the non-government sector and primary care providers to improve: communications; continuity of care, access to services; and participation of consumers and carers; and
• Enhancing consumer and community participation through a broad range of strategies including supporting consumer groups, developing the service delivery role of peer support workers and developing a strong recovery focus in service delivery.

Improving the mental health of the community requires collaborative working relationships with many partners. These include the private sector (GPs and other clinicians), the non-government sector, other SLHD health services, government services provided by education, child protection, youth, employment, housing and homelessness, aged care providers, police and the justice system.

This Strategic Plan is linked with the SLHD strategic framework. It reflects the core values of the NSW government which are: Collaboration, Openness, Respect and Empowerment. The plan will be regularly reviewed to reflect the strategic directions and priorities of the NSW Government, the Ministry of Health and the Mental Health Commission. Our progress will be measured and evaluated to ensure improvements are made in health outcomes.

The Board and Senior Executive of the SLHD are absolutely committed to improving mental health services and facilities to ensure that they meet the growing needs of our communities. This Strategic Plan provides the framework for achieving this.

Dr Teresa Anderson
Chief Executive

The Hon Ron Phillips
Board Chair
INTRODUCTION

The overall goal of this Strategic Plan is to improve the mental health of people and communities living and receiving healthcare in Sydney Local Health District (SLHD).

There are significant challenges that will affect the provision of mental health services into the future.

These include:

- Providing enhanced community-based and inpatient services to meet the continuing population growth;
- Providing accessible services to Aboriginal and culturally diverse communities;
- Providing care for the large homeless populations;
- Responding to changing models of care;
- Developing more effective screening, detection and treatment of physical health problems for people with enduring mental health problems;
- Enhancing partnerships with related government-funded services, particularly in regard to homelessness, employment and training and supported accommodation;
- Recruiting and retaining a skilled workforce across the range of disciplines required to provide a comprehensive mental health service;
- Ensuring research, evidence and evaluation inform service delivery.

In dealing with these challenges we will continue to work in partnership with other mental health service providers, as outlined in the NSW ‘Whole of Government’ approach to address mental health related problems and the Interagency Action Plan for Better Mental Health. Partners include General Practitioners, the Inner West Sydney Medicare Local, non-government organisations and related government departments such as Education, Police, Ambulance, Housing and Family and Community Services.

Improving the mental health of people and the provision of improved mental health services are priorities for both the Commonwealth and NSW governments. This has been recognised in the commitments given through the National Mental Health Strategy that commenced in 1992, in successive National Mental Health Plans and in policy statements and agreements issued through the Council of Australian Governments.

The framework for our strategic plan is aligned with key Commonwealth and NSW Government policies and plans that support improving mental health as a priority.

In 2012, the Council of Australian Governments issued The Roadmap for National Mental Health Reform 2012 – 2022. The Roadmap provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers in order to deliver a more seamless and connected care system. The Roadmap aims to provide a basis for the implementation of reforms that will significantly contribute to the wellbeing of people with mental illness, and their families and communities. These will be detailed in a new national plan to be issued in 2014.

In A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention, the National Mental Health Commission sets out a framework for improving mental health and services:

- Mental health must be a high national priority for all governments and the community;
- We need to provide ‘a complete picture of what is happening’ and closely monitor and evaluate change;
- We need to agree on the best ways to encourage improvement and get better results; and
- We need to analyse where the gaps and barriers are to achieving ‘a contributing life’.

The Report Card makes ten recommendations with actions related to:

- Consumer surveys of experiences and access to services;
- Improving physical health;
- Reducing use of involuntary orders and elimination of seclusion and restraint;
- Improving the mental health of Aboriginal and Torres Strait Islander peoples;
- Ensuring safety and quality of care;
- Eliminating homelessness on discharge from care; and
- Preventing suicides.

In 2013 the NSW Mental Health Commission commenced a planning process to develop a mental health strategic plan for NSW and has issued its first discussion paper, Living well in our community – Towards a Strategic Plan for Mental Health in NSW. This also sets out a number of themes similar to the Report Card.

The framework of our Mental Health Strategic Plan is also linked to the:

- Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014;
- National Safety and Quality Health Service Standards (2011);
- Australian Council on Healthcare Standards – EQuIPNational;
- NSW 2021: A plan to make NSW number one;
- State-wide strategic plans and policies related to Mental Health;
- NSW Mental Health Clinical Care and Prevention model (2010);
- Current and former SSWAHS plans: Aboriginal Health; Disability; Youth Health; Carers; and
- Sydney Local Health District strategic, research and clinical plans.

Operational / quality plans having a two year timeframe will be developed for Mental Health Services.
Planning Process

Significant consultation has occurred with local communities, consumers, staff, service partners and carers in the development of the SLHD Strategic and District Healthcare Service plans and conjoint planning with the Inner West Sydney Medicare Local. This consultation has identified a number of issues specifically related to mental health services that provide the basis for strategies to improve the mental health of our communities and the quality of mental health care services.

Consultation related to the development of this plan has also occurred with mental health staff through workshops to consider issues related to service priorities, and with mental health NGOs through interagency meetings.

The NSW Mental Health Clinical Care and Prevention (2010) model provides service and facility planning guidelines using projected 2021 populations for both inpatient and community service planning. This model has been used to guide service and facility development.

This plan has been structured to broadly reflect the SLHD Strategic Plan. It focuses on Our Consumers and Carers; Our Communities and Partners; Our Services and Facilities; Our Staff recruitment and retention; Our Education and Research and Our Organisation.

We are committed to providing mental health services that are evidence-based, outcome-focused and promote respect, sensitivity, integrity and recovery...

Diagram 1: Mental Health Strategic Plan
Our District Vision

To achieve excellence in healthcare for all

Our District Mission

Ensuring the community has equitable access to high quality patient-centred healthcare that is:

• Timely, evidence-based, culturally appropriate and efficient;
• Provided by highly skilled staff who are committed, accountable and valued;
• Supported by leading edge research, education and technologies; and
• Supporting the healthcare of populations in other LHDs, States and Territories across Australia and other countries through research, education and the provision of tertiary and quaternary referral services.

Our District Values

Collaboration – Improving and sustaining performance depends on everyone in the system working as a team.

Openness – Transparent performance monitoring and reporting is essential to make sure the facts are known and acknowledged, even if at times this may be uncomfortable.

Respect – The role of everyone engaged in improving performance is valued.

Empowerment – There must be trust on all sides and at all levels for people to improve performance in a sustainable way.

Patient and Family Centred Care

The Mental Health Service Strategic Plan has been developed to be fully consistent and support the SLHD vision, mission and values within the Sydney Local Health District Strategic Plan (2012-2017). It also follows the District’s Patient and Family Centred Care model.

It focuses on:

• Our Patients, Consumers and Carers
• Our Communities
• Our Services
• Our Staff
• Our Education
• Our Research
• Our Organisation
• Our Environment
• Our Facilities

Mental Health Service Principles

• All residents have equity in access to mental health care services. People who are disadvantaged will be provided with assistance to access services where necessary;
• Mental health services across the District will be of the highest quality;
• Consumers, communities, staff and service providers will be treated with courtesy, dignity and respect;
• Mental health care will have a focus on recovery and be responsive to the needs of individuals, families and communities;
• Individuals and communities will be supported to be actively engaged in mental health care and programs. They will be provided with information and supported to make informed choices about their health. Autonomy in decision making will be respected;
• Mental health programs and strategies will be developed with communities and other agencies to improve the health of local communities. Strategies will be developed that are focussed on increasing effectiveness and sustainability;
• Services will be provided as close to home as possible and integrated across hospitals, in the community and with the NGO and private sectors;
• Coordinated care will involve consumers, carers, family members and service partners. Partnerships and opportunities to improve mental health and mental health care will be developed;
• The workforce is valued and will be consulted and included in the development and implementation of initiatives. Personal and professional development opportunities will be provided to enable staff to meet ongoing changes in the health system;
• Mental health services will be provided in a safe and healthy environment;
• New models of care, healthcare practices and technology based on evidence will be used to ensure that consumers and communities receive the best and most appropriate service available. Innovation and research will be encouraged to ensure safe and appropriate interventions;
• Services will be provided in an efficient and cost effective manner and will be evaluated and remodelled as required;
• Environmental sustainability will be fundamental to the design and delivery of clinical and non-clinical services and infrastructure.
OVERVIEW OF SYDNEY LOCAL HEALTH DISTRICT

Sydney Local Health District (SLHD) is located in the centre and inner west of Sydney, and comprises the Local Government Areas (LGAs) of the City of Sydney (part), Leichhardt, Marrickville, Canterbury, Canada Bay, Ashfield, Burwood and Strathfield. The SLHD is responsible for providing care to more than 582,000 people. It covers 126 square kilometres and has a population density of 4,210 residents per square kilometre (ABS 2006).

By 2026, the local SLHD population is expected to reach 728,319 people. Significant planned urban developments include: the new Green Square Development in Zetland and Beaconsfield in the City of Sydney; urban consolidation along the Parramatta Road corridor; urban renewal in the Bays and the Central to Eveleigh rail corridor and new developments in Rhodes, Breakfast Point, the former Carlton United Brewery site and Redfern Waterloo.

Figure 1: Projected population SLHD 2011 – 2031

The District population is ageing, with the number of residents aged over 70 projected to increase by 29 per cent over the next decade. The growth in the aged and the older population of SLHD is especially important for healthcare delivery over the forthcoming decade, with an increase of 29.2% and 28% in the 70-84 age group and the 85+ age group respectively predicted.

Almost half of the SLHD population speaks a language other than English at home, including significant numbers of refugees, asylum seekers and special humanitarian entrants. The major languages spoken include Chinese languages, Arabic, Greek, Korean, Italian and Vietnamese. According to the 2011 Census, SLHD suburbs with the highest proportion of residents speaking a language other than English at home include Campsie, Haymarket, Lakemba and Wiley Park.

A significant Aboriginal population resides in the SLHD, mostly located in the Redfern/Waterloo area, in the City of Sydney LGA and in Marrickville. Aboriginal people are widely recognised as having poorer health and access to appropriate health services.
One in five people aged 16-85 in Australia is directly affected by mental ill-health. Many more are indirectly affected as a family member, friend or colleague.

(National Survey of Mental Health and Wellbeing 2010.)
The Mental Health Service (MHS) is committed to ensuring the highest standard of service is maintained throughout the District. We are committed to providing mental health services that are evidence-based, outcome-focused and promote respect, sensitivity, integrity and recovery principles for the consumer/patient, their family/carer and their community.

The SLHD Community and Consumer Participation Framework (2013-2015) commits the District to involving consumers at every level and in all aspects of healthcare delivery.

The accreditation process established through the Australian Council on Healthcare Standards and the National Safety and Quality Health Service Standards (NSQHS Standards) is used to ensure that key standards and criteria are met. The Review of Community Mental Health Services (2012) highlighted the need to adopt a more recovery-focused service.

The National Standards for Mental Health Services (2010) are based on key principles that are consistent with national policy and requirements for the delivery of mental health services in Australia. These are also the basis for the services provided in the SLHD. Key principles include:

• Mental health services should promote an optimal quality of life for people with mental health problems and/or mental illness;
• Services should be delivered with the aim of facilitating sustained recovery;
• Consumers should be involved in all decisions regarding their treatment and care, and as far as possible, provided with the opportunity to choose their treatment and setting;
• Consumers should have the right to have their nominated carer(s) involved in all aspects of their care;
• The role played by carers, as well as their capacity, needs and requirements should be recognised as separate from those of consumers;
• Participation by consumers and carers should be integral to the development, planning, delivery, evaluation and policy development of mental health services;
• Mental health treatment, care and support should be tailored to meet the specific needs of the individual consumer; and
• Mental health treatment and support should uphold internationally recognised principles of mental health law which emphasise:
  o voluntary access to mental health care
  o involuntary hospitalisation as a last resort measure
  o the least restriction imposed on the rights and choices of consumers taking account of their living situation
  o an appropriate level of support within the community
  o incorporating the perspectives of their carer(s)
• Consumers and carers are involved with planning, implementation, review and policy development at all levels of the Mental Health Service

A mental health service must be responsive to people with diverse experiences that can impact on their ability to seek help and engage with mental health services. This includes understanding and being responsive to the unique issues experienced by people from culturally and linguistically diverse backgrounds, people who are gender variant and sexually diverse, people who may have experienced trauma and its impact, people from across the lifespan and people with coexisting conditions and complex needs.

Key Issues for Our Consumers and Carers

Consumer and carer involvement

The National Standards for Mental Health (2010) are very clear about the requirement for the involvement of consumers and carers in the planning, service delivery, evaluation and quality review of programs. This is also emphasised in the ACHS EQuIP National standards, local service level audits, community consultations and in policies of the MHS. It is clear that consumer and carer involvement is central to innovative, responsive mental health services.

The report of Health Workforce Australia, Mental Health Peer Workforce Study (2014) has made a number of recommendations to increase the participation by both consumers and carers in the provision of mental health services that cover the following domains:

• Health workforce reform for more effective, efficient and accessible service delivery;
• Health workforce capacity and skills development;
• Leadership for the sustainability of the health system;
• Health workforce planning;
• Health workforce policy, funding and regulation.

 Provision of training and support for consumers, carers and staff, which maximise consumer and carer representation and participation in the mental health service, is a priority. This includes training in advocacy and peer support and the provision of mentoring and supervision.

The Review of Community MHS also identified a number of issues regarding consumer participation including that the role of consumer consultants should not be considered as a replacement for direct participation by consumers who use services.

A further gap for the District is the lack of a carer support worker who can undertake systems advocacy for carers in the mental health service. CALD and Aboriginal carers have also been identified as requiring more support through expanding partnerships with the Redfern Aboriginal Medical Service, Carer Assist and the Transcultural Mental Health Service (TMHS).

District community participation frameworks are being developed to provide a formal structure for consumer and carer participation in the overall planning, development and provision of services. Historically, mental health consumers and carers have made significant contributions to these committees, and opportunity exists for continuing participation.
While, a new structure for the provision of peer support is also being implemented across the MHS. This will clarify the role and change the focus of the employed consumer / peer support staff to ensure that they are essential members of the community mental health services.

**What we will do:**

- Develop systems and processes, consistent with the SLHD Consumer and Community Participation Framework, that ensure consumer, carer and community participation in the planning, delivery and evaluation of mental health services;
- Implement relevant recommendations from the Mental Health Peer Workforce Study related to expansion of both the roles and involvement of peer workers;
- Provide/fund training for consumers and carers to obtain skills related to effective participation in their expanded role;
- Expand the numbers of peer support workers across the District (subject to funding); and
- Enhance partnerships with NGOs related to consumer and carer support, education and information to enhance participation, particularly for our CALD and Aboriginal communities.

**Promoting Mental Health and Prevention of Illness**

In the development of the draft *NSW Mental Health Promotion Strategic Plan, Building Better Mental Health, A Framework for the promotion of mental health and prevention of mental ill-health in NSW* (May 2010), strategies were developed to improve mental health literacy and improve recognition of the early signs of mental illness, provide information regarding services in community languages and support improving physical health.

In the SLHD a mental health promotion framework was developed to support specialised mental health promotion staff working with mental health services to implement the Mental Health Promotion Action Plan and support local initiatives. This includes expansion in schools of the *KidsMatters* for younger children and *MindMatters* programs targeting young adolescents.

The secondary prevention priorities focus on the needs of people who have experienced mental illness. These include vocational training, smoking cessation and managing physical health issues. Prevention services ensure that the CALD and Aboriginal communities needs are identified to provide targeted approaches. Depression prevention in older people is a targeted program currently operated through the Specialist Mental Health Service for Older people.

Additional priorities identified in the *National Mental Health Plan* are mental health literacy, recovery-focused mental health services and social inclusion.

**What we will do:**

- Continue to support the uptake of *KidsMatters* and *MindMatters* as a whole-school approach to mental health promotion;
- Support primary schools taking a whole-school approach to enhancing mental health;
- Work in partnership with consumers and mental health services staff, to plan, implement and evaluate interventions to address smoking and improve physical health;
- Offer and review the Mental Health First Aid course as part of multi-strategy initiatives to strengthen the literacy and understanding of mental health by communities and related service providers;
- Provide a variety of mental health literacy education that promotes access to services, help seeking behaviours, stigma reduction and improved worked practices;
- Support mental health promotion and prevention initiatives (particularly those with a recovery focus) undertaken by consumers, carers and mental health service staff;
- Increase the participation rate of consumers in appropriate physical activity, nutrition and smoking cessation programs;
- Develop and implement programs aimed at education and prevention of depression, anxiety and delaying the onset of psychosis;
- Develop and promote stigma reduction/elimination programs; and
- Take an active part in the SLHD steering committee - ‘Improving the Physical Health and Wellbeing of People with Mental Disorders’.

**Social Isolation**

Social isolation is common for people with a mental illness and can be described as a state of being unintentionally alone with a lack of fulfilling social connection, resulting in the experience of loneliness and distress. Social exclusion is underpinned by reduced abilities to socialise and impairment of social functioning. Social isolation is compounded by continuing community attitudes that stigmatise people with a mental illness.

The second Australian National Psychosis survey conducted in 2010 gives a contemporary picture of the impact of reforms and initiatives made since 2000. While there have been many achievements in the area of reducing social isolation, loneliness is ranked second after financial matters as a major challenge. Those reporting having no friends remained constant at 13%, and 45-47% reported a need for more friends.

Social isolation has also been highlighted as a significant issue in SLHD consultations with consumers, carers and service providers.

There is evidence that social skills training and peer led programs are effective at enriching the lives of people with a mental illness. Involvement in education, employment, recreation and other community activities are also important.

Both the Australian and NSW governments have funded programs, primarily through the NGO sector, to address social isolation, strengthen the education
and resilience of both carers and consumers and promote the co-ordination of mental health services. Examples include the Personal Helpers and Mentors Program, a range of carer support and respite services and employment and education support programs for consumers.

The Partners in Recovery program, commenced in late 2013, has the potential to greatly expand the co-ordination and linking of services. The program operates at both the individual consumer and system levels to enhance community interaction and participation.

What we will do:

- Continue to work closely with NGOs providing support programs that address social isolation;
- Work with consumers and peer support staff to further investigate consumer needs and solutions that may minimise social isolation;
- Support the development of innovative peer-led interventions for both individuals and groups; and
- Support community education and health promotion programs that increase awareness of mental illness and reduce stigma.

Improving the physical health of people with mental health problems

As documented in the NSW Ministry of Health (MoH) policy directive, Provision of Physical Health Care with Mental Health Services (2009), the physical health of those who experience mental illness is recognised as worse than almost every other group in western societies. Their life span is consistently twenty to twenty five per cent shorter than the general population. Sixty per cent of this early death is due to physical illness, with cardiovascular disease being the biggest contributor to early death.

As documented in the directive, there are a number of contributing factors to this excess mortality including smoking and other substance abuse problems, poor nutrition, diabetes, the use of psychotropic medications that contribute to the development of metabolic syndrome and type II diabetes, inactivity, obesity, and hypertension.

The MoH also published a companion guideline, Physical Health Care of Mental Health Consumers, in 2009. The guideline provides clinicians with information and guidance about physical health screening, assessment, interventions and the collaborative role of general practitioners and other service providers including dental services. To complement this policy directive, the SLHD has focused on implementing the Connecting Care program across all aspects of its care delivery and service provision including Mental Health Services.

In SLHD a Physical Health Care Working Party has been established to lead the implementation of of the policy directive. In recognition of the needs highlighted by the Working Party, the Chief Executive has approved the establishment of a new collaboration model - mental health clinician and GPs in ‘Shared Care’. The pilot model will co-ordinate and enhance the provision of physical health care services for and with our consumers in conjunction with general practitioners and other primary health care providers.

What we will do:

- Ensure that maintaining the physical health of consumers is made a priority in all aspects of service delivery;
- Build capacity into the mental health workforce to support / maintain the good physical health of consumers;
- Strengthen our collaborative partnerships with GPs, primary health, dental services and other NGO service providers to maintain a focus on physical health care;
- Support consumers to participate in the management of their physical health care through education and conjoint recovery planning;
- Provide appropriately equipped exercise facilities within all inpatient services and develop links with fitness service providers in the community;
- Work with food service providers in inpatient settings to ensure meals/foods provided are in-line with the Agency for Clinical Innovation Nutrition Standards: for Consumers of Inpatient Mental Health Services in NSW;
- Ensure that evidence-based smoking cessation programs are implemented within all services;
- Ensure that discharge summaries include information related to physical health and provide recommendations regarding evidence-based monitoring and intervention;
- Continue to support research programs related to physical health of people with a mental illness;
- Implement regular audits of clinical information to ensure that physical health examinations / assessments are conducted for all consumers; and
- Establish the new ‘Shared Care’ service across the SLHD and develop a robust evaluation process.

Ensuring a recovery focus in all service delivery

A national framework for recovery-oriented mental health services: Guide for practitioners and providers was issued by the Australian Health Ministers Advisory Council in 2013. In this framework ‘recovery’ is defined as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’.

The framework defines recovery and lived experience, the practice domains and key capabilities necessary for the mental health workforce to function in accordance with recovery-oriented principles, and provides guidance on tailoring recovery-oriented approaches to respond to the diversity of people with mental health issues. It is underpinned by extensive research and consultation and informed by lived experience.

The framework supports cultural and attitudinal change and encourages a fundamental review of skill mix within the workforce of mental health services, including increased input by those with expertise through experience.

The framework describes a recovery oriented mental health service as one that values the lived experience of
consumers and carers, supports personal responsibility for mental health and wellbeing, reinforces peoples strengths and consumer driven goals, and implements trauma informed practice principles during interactions.

A quality-based mental health service acknowledges the possibility of trauma in the lives of people who access mental health services. This trauma may be related to cultural experiences including displacement, racism, sexual and physical assault, torture, poverty, natural disasters and the stigma and shame associated with experiencing mental health issues. Trauma can be collective and intergenerational, such as the experiences of the stolen generation for Aboriginal people. Understanding and acting on unresolved trauma is important in recovery.

The Fourth National Mental Health Plan (2009–2014) affirms that mental health service providers will work within a framework that supports recovery both as a process and as an outcome to promote hope, well-being, and autonomy. Mental health clinicians are urged to recognise an individual’s strengths including coping skills, resilience and rights to self-determination.

The Review of Community MHS (2012), makes recommendations regarding the development of a recovery oriented culture and the use of an audit tool within the Community LHD MHS.

What we will do:

- Develop a workforce that includes peer support workers knowledgeable in recovery oriented service provision with good access to relevant training;
- Collaboratively develop recovery focused services that embrace trauma informed approaches and reduces orientation towards coercive interventions;
- Ensure that the 100% of consumers, and if appropriate, the carers / family are partners in collaboratively planning their own care, and that clear action plans are developed;
- Ensure that recovery planning with the consumer, carer and other service providers promotes opportunities to move beyond the need for public mental health services;
- Implement the use of a regular recovery audit tool that can give a clearer benchmark for recovery orientated culture and assist in ongoing quality improvement; and
- Support consumers, carers and staff to increase knowledge and skills related to recovery and in the use of recovery oriented language.

Access to Services

The National Standard for Mental Health (2010) emphasises ‘access to services’ as a key factor in providing comprehensive and effective services. Having good access is important for Aboriginal communities, people from a CALD background and people with a severe and persistent mental illness and their carers.

As noted by our consumers and staff in the consultation process, there are a number of people with a mental illness who are not accessing specialised mental health services provided by the public or NGO sectors. This highlights the need for creative approaches to providing service information beyond organisations traditionally seen as being a mental health service provider.

Issues impacting on effective ‘access’ include:

- Obtaining information regarding mental illnesses, medications and clinical treatments and provision of translated information and effective interpreter services;
- Effective provision of information about who provides what services in Inner West Sydney;
- Information regarding other community services including employment, education and social programs;
- Effective communication between service providers and coordination of services;
- Information regarding specific non-clinical support services; eg, supported housing and respite; and
- Information for carers regarding the status of their loved ones while receiving care and treatment from the MHS.
The ‘Mental Health Line’ was established by NSW Health in 2011-12 to improve access to both information and services across NSW. It uses a single number, 1800 011 511, across NSW that transfers calls 24 hours per day, seven days per week to the appropriate Mental Health Service.

Accessing the mental health services through the hospital emergency departments has also been identified as a significant issue in consultations. This needs to be addressed through reviewing the facility design of the units and the models of care.

What we will do:

• Work with the ‘Mental Health Line’ to evaluate this service;
• Enhance information available through multi-media for consumers and carers on a range of topics including translation into community languages;
• Include the enhancement of health interpreter services in service developments both in the community and inpatient services;
• Improve the intranet and internet pages for the SLHD Mental Health Service and include links to directories and related service partners;
• Support the establishment / operation of interagency forums in conjunction with consumers and carers to enhance the provision of information and co-ordination of services;
• Expand our work with NGOs in supporting the provision of supported accommodation, employment, training and social / recreational programs;
• Expand conjoint programs with GPs which have a focus on improving both physical and mental health;
• Support the provision of training in mental health literacy and awareness among front-line staff in related service providers and community organisations e.g. Housing, Community Services, Centrelink, clubs, churches, recreational and sporting associations;
• Improve access through hospital emergency departments by enhancing models of care and facility design.
Key Issues for Our Communities and Partners

Stress, trauma and related mental health problems of Aboriginal people and their communities

The NSW Government and the SLHD are committed to improving the mental health and social and emotional wellbeing of Aboriginal people and their communities. The Social Justice Report (2005) cited the following key components of health improvement for Aboriginal people:

- **Availability** - public health and health care facilities and programs have to be available in sufficient numbers across Australia;
- **Accessibility** - health facilities must be within safe physical reach for all sections of the population especially disadvantaged groups such as Indigenous Australians;
- **Acceptability** - all medical services must respect medical ethics as well as the culture of individuals;
- **Quality** - as well as being culturally appropriate, health services must be of a good quality.

These issues have become the basis of the ‘Close the Gap’ campaign which has highlighted a range of physical, social and emotional health issues that need a coordinated approach.

The *NSW Aboriginal Mental Health and Well Being Policy* (2006) presents a number of strategies that have been endorsed to improve the mental health of Aboriginal people living in the communities serviced by the SLHD.

The *NSW Department of Health: Aboriginal Older Peoples’ Mental Health Project Report* (2010) identified eight Principles of Care when providing a service for older Aboriginal people. Two priorities were identified for inclusion in NSW SMHSOP Benchmarking Self Audit Tool.

The SLHD has a strong commitment to improving Aboriginal health and wellbeing through the implementation of the District Aboriginal Strategic Plan which prioritises action in the following areas: Mental Health, Drug Health, Chronic Disease & Ageing, Early Years Children & Young People, Oral Health and Infectious Diseases, Sexual Health and Health Promotion.

The Sydney Metropolitan Local Aboriginal Health Partnership Agreement has recently been implemented to improve Aboriginal health and service co-ordination between the SLHD, the Redfern Aboriginal Medical Service, Northern Sydney Local Health District, South Eastern Sydney Local Health District, St Vincent’s Health Australia and the Sydney Children’s Hospital Network.

Linked to the partnership is the *NSW MoH Aboriginal Workforce Strategic Framework 2011-2015* which focuses on addressing health workforce skill gaps as well as supporting the economic and social well being of Aboriginal people.

There is evidence that social skills training and peer led programs are effective at enriching the lives of people with a mental illness. 

**Involvement in education, employment, recreation and other community activities are also important.**
The key priorities of the Framework are to:

- Increase the representation of Aboriginal employees to 2.6% across NSW Health;
- Increase the representation of Aboriginal people working in all health professions;
- Develop partnerships between the health and education sectors to deliver real change for Aboriginal people wanting to enter the health workforce and improve career pathways for existing Aboriginal staff;
- Provide leadership and planning in Aboriginal workforce development;
- Provide employment to Aboriginal university graduates in health professions; and
- Build a NSW health workforce which closes the gap in health outcomes between Aboriginal and non-Aboriginal people by providing culturally safe and competent health services.

A mandatory training program, *Respecting the Difference – An Aboriginal Cultural Framework for NSW Health* is being implemented to achieve cultural safety and improve access to our services for Aboriginal people.

Aboriginal Mental Health staff are based at the Camperdown Community Mental Health Centre and work across the SLHD in both inpatient and community services. There is one trainee position that undertakes tertiary level undergraduate training through Charles Sturt University. Support is provided by the SLHD Director of Aboriginal Health to implement mental health related strategies identified in the SLHD Aboriginal Health Plan, and provide education, training and professional supervision for Aboriginal staff.

What we will do:

- Enhance / expand working partnerships with Aboriginal health and medical services provided by the Redfern Aboriginal Medical Service and related community-based organisations including Aftercare, RichmondPRA, NEAMI and homelessness services;
- Develop / enhance partnerships with related government services that provide Aboriginal health-related programs. These include Justice Health, Police, Housing NSW, Education and Communities and Family and Community Services;
- In conjunction with School-link and Mental Health Promotion staff, expand input to support school-based programs such as *KidsMatter* and *MindMatters* to ensure an increased focus is placed on Aboriginal students;
- Expand services to meet identified needs of Aboriginal people and their communities by:
  - Ensuring physical health issues are managed in partnership with Aboriginal Medical Services, GPs and other primary health service providers;
  - Implementing programs to address isolation, depression and dementia for elders;
  - Improving the coordination of care for Aboriginal people admitted to mental health inpatient units;
  - Implementing programs for parents and children in conjunction with drug health and Community health services;
- Implementing early psychosis intervention and other youth-focused initiatives in conjunction with our headspace service partners;
- Expansion of group programs for Aboriginal men and women.

• Workforce development through expansion of the Aboriginal Mental Health training program and enhancement of the links with universities; eg the Bachelor of Health (Mental Health) program at Charles Sturt University and the Aboriginal Health College of NSW;
• Support the implementation of Aboriginal cultural competency training for general mental health service staff through the ‘Respecting the Difference’ education program and other related training; and
• In partnership with NGO-provided carer services, develop specific education and support programs that recognise the impact of trauma for Aboriginal carers and their families.

People with mental illness who are homeless

Homelessness is a significant factor in SLHD which severely affects people with a mental illness. The National Partnership Agreement and the NSW Homelessness Action Plans have developed a cross-government and multi-agency approach to ensuring that no person is discharged from care into homelessness.

The NSW Going Home Staying Home Reform Plan (2012) outlines strategies for reforming specialist homelessness services in NSW to increase the focus on prevention and early intervention and make services easier for clients to access.

Homelessness is described by NSW Housing as ranging from primary (sleeping rough) to tertiary (living in insecure housing such as boarding houses and caravan parks). Due to the transient nature of this population, accurately quantifying homelessness is very difficult to achieve.

Aboriginal people are more likely to live in improvised dwellings or in Specialist Homelessness Support program accommodation than non-Aboriginal people. The rate of Aboriginal homelessness is a particular issue. Estimates indicate a rate of 566 per 10,000 Aboriginal people in City of Sydney, Leichhardt and Marrickville LGAs compared to 125 per 10,000 non-Aboriginal people in the same area.

A recent 2013 survey of homelessness conducted by the City of Sydney identified 726 people in the Sydney CBD who were either ‘rough-sleepers’ or who were accommodated in hostels for the homeless. A more in-depth survey in 2010 of the prevalence found 82% of rough sleepers reporting substance abuse issues, 54% a mental illness, 48% dual diagnosis, 55% tri-morbidity and 63% serious medical issues.

The main reason people sought Specialist Homelessness Services assistance in coastal Sydney was problematic drug/alcohol/substance abuse (30%), more than double that for NSW (13%). Domestic violence was a lesser reported issue in coastal Sydney (7%) when compared to the state (15%).

The Redfern Waterloo Public Housing Tenant Survey 2011 commissioned by Housing NSW also identified that drug and alcohol related problems are the most significant issue they experience within the estate.

Issues for the health system in SLHD identified in the Regional Homelessness Action Plan for Coastal Sydney 2010-2014 include:

- High rates of substance abuse;
- Mental health, disability, dual diagnosis and behavioural disturbance; and
- Discharge processes to ensure people are not discharged into homelessness, particularly from Emergency Departments.

SLHD has developed a Homeless People Taskforce to ensure that effective processes are in place to address the health-related issues of people who are homeless.

What we will do:

• Ensure that a multi-sector approach is taken to maximise the number of mental health consumers obtaining and maintaining secure accommodation;
• Work with community organisations to provide co-ordinated services at the local level; eg, the multi-organisational approach taken with the Camperdown Common Ground project;
• Implement the NSW and Regional Homelessness Action Plans within the context of the Housing and Mental Health Agreement;
• Conduct regular audits of the accommodation status of patients admitted to inpatient units in both inpatient units (RPA and Concord) to support the implementation of the NSW government policy that there is to be no discharge to homelessness;
• Expand the Housing and Support Initiatives under the Housing and Mental Health Agreement, particularly aimed at extended care support and support for young people; and
• Ensure services intervene early to reduce the risk of homelessness.
People with mental illness who are unemployed

Employment and training are significant factors for consumers and carers in achieving recovery. In 2009 in the Vocational, Education, Training and Employment (VETE) snapshot of 3,165 Mental Health consumers across both the SLHD and the SWSLHD: 72% reported having worked previously – before becoming ill; 47.3% wanted work and 26% were involved in either open employment or job seeking.

Data from the Department of Health and Ageing report, Survey of High Impact Psychosis demonstrates employment participation of people with psychotic disorders is around 22%. Employment of consumers being supported by the Housing and Support Initiative is reported at 13%.

A focus of the VETE program has been the development of partnerships with employment service providers, and the implementation of practices consistent with individual placement and support principles. In addition, the VETE program has established informal partnerships across all community mental health teams. The program has established SLHD-wide employment leadership groups with representation from all clinical teams, regular monthly meetings with employment services partners and established connections with local Centrelink services.

Developing effective partnerships between the mental health staff and employment services is essential to achieving positive outcomes for our consumers.

What we will do:

- Support the SLHD to increase the employment of people with a mental illness in a range of positions both in the hospitals and in the community services;
- Improve linkages with employment service providers to enhance collaborative care, and strengthen working relationships between mental health staff, employment service providers and consumers;
- Monitor ongoing outcomes from employment support services to ensure consumers are being supported by the best locally available services;
- Enhance local leadership and capacity within mental health services to enable better support for consumers who have less complex vocational presentations;
- Maintain staff awareness of changes to social support/benefits systems enabling ongoing financial support for consumers;
- Increase the training programs for mental health staff in vocational rehabilitation and recovery; and
- Develop links with education providers to increase access to education for people with mental health problems.
The NSW Multicultural Mental Health Plan 2008-12 established a number of strategies to improve mental health services for culturally and linguistically diverse (CALD) communities.
Needs of CALD communities, especially refugees

It has been recognised that culture influences ideas about health, mental illness and treatment and that mental health assessment, treatment and care planning requires an understanding of these concepts.

The NSW Multicultural Mental Health Plan 2008-12 established a number of strategies to improve mental health services for culturally and linguistically diverse (CALD) communities. These include increasing the provision of in-language counseling, improving access to interpreters, improving access to carer support services and increasing the cultural competency of mental health staff. Similar strategies have been outlined for refugees in the NSW Refugee Health Plan.

The Australian Department of Immigration & Citizenship Settlement Database recorded 1,604 humanitarian arrivals who initially settled in SLHD between July 2008 and June 2013 (7.5% of the humanitarian arrivals in NSW). The majority (1,055 or 66%) settled in Leichhardt LGA, and the lowest number (26) settled in Canterbury LGA. People who entered Australia as refugees or humanitarian arrivals came from a wide range of countries. The ten countries of birth with the highest number of humanitarian arrivals residing in SLHD between 2008 and 2013 were China (231), Burma (221), Iraq (167), Iran (141), Sri Lanka (134), Sierra Leone (102), Egypt (85), Pakistan (81), Indonesia (46), and Lebanon (31).

Humanitarian arrivals often have complex health problems related to either their prior limited access to health care and/or their individual experiences of persecution or trauma. General health issues for humanitarian arrivals include psychological problems, injuries and other physical effects of torture, poor oral health, infectious and vaccine preventable diseases, health problems related to poor nutrition, child development and protection issues and issues regarding unaccompanied minors.

In SLHD, a Mental Health Multicultural Access Committee meets quarterly and includes representation from NGOs and related service providers including the NSW Transcultural Mental Health Centre (TMHC) and the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) that have state-wide roles in provision of multicultural mental health services and in the care of people affected by torture and trauma. This committee has developed an action plan which identified strategies to: increase access to services; monitor the use of translation services; and review the provision of mental health services to CALD communities.

The TMHC, the STARTTS and the NSW MoH have developed information and documentation tools focused on people from CALD communities. The Referral Guide aims to increase clinicians’ awareness and utilisation of culturally or linguistically relevant services for CALD clients. The Checklist aims to increase clinician awareness of CALD issues and facilitate the collection of culturally relevant information during CALD client assessment.

NGOs have been funded by the Commonwealth to provide services to refugees arriving in Sydney. These services include housing, employment, education that need to work together with mental health services to meet identified needs.

What we will do:

• Enhance our partnerships and improve communication with the TMHC and STARTTS services, especially in regard to humanitarian refugees;
• Establish and maintain effective links with NGOs that provide initial support for refugees and other related services to enhance the provision and coordination of services;
• Work with Carer Assist and other carer support services to increase the number of services and support groups for carers;
• Implement cultural competency training for mental health staff to enhance the quality and access to services;
• Implement the Transcultural Assessment Module developed by the TMHC for outcome assessments and care planning in conjunction with the Transcultural Referral Guide and the Assessment Checklist;
• Monitor the accessibility and use of interpreters and enhance the provision of interpreter services linked to new service and facility developments;
• Ensure access is provided to translated information regarding mental health services in the context of attitudes towards stigma in different cultural groups;
• Include funding for health translation services in the financial modeling of enhancement to inpatient and community services; and
• Develop research projects to further our understanding of CALD communities and how to work with them on prevention, early intervention and use of services.

People with Multiple Problems – mental disorders and substance abuse

A number of studies have determined that people with a mental disorder and substance abuse problems have a higher risk of severe and chronic medical, social and emotional problems. They also have greater cognitive impairment, higher risk of suicidal behaviour and greater use of health services.

The misuse of drugs and alcohol may exacerbate the symptoms of mental illness and the existence of a mental illness may also exacerbate drug and alcohol misuse. People with comorbid mental health and substance use disorders are less likely to engage in treatment, respond well to treatment and complete treatment programs, and have increased risk of drug and alcohol relapses.

A SLHD Mental Health and Drug Health Steering Committee has been established, through a formalised partnership, to link sector clinical committees to ensure collaboration in care coordination, clinical reviews, tracking of high-risk consumers and development of local protocols.
What we will do:

• Implement the partnership agreement with the Drug Health Service that has established a framework for coordination of clinical services at both the LHD and service provision levels;
• Review and develop policies and initiatives to ensure collaboration and coordination of services, define clinical pathways and link with related service providers in the community;
• Support the development of education and training programs to increase the capacity of staff to provide clinical assessment, treatment and management of substance misuse in conjunction with consumers and carers;
• Establish additional clinical / consultancy services to enhance coordination of care between the Mental Health Service, Drug Health Service, hospital emergency departments and community services;
• Support the implementation of the NSW Health Smoke Free Environment policy; and
• Develop and implement ways of supporting consumers in reducing or ceasing nicotine use.

Improving mental health services for older people and their carers

Population growth to 2036 is projected to be greatest in the population aged 80 years and over with an increase in older people experiencing depression, psychosis and dementia/behavioural problems. Significant increases are also expected in the group of people aged 55-70 who may be clients of Adult Mental Health Services and who may have limited access to Aged Care Services and community residential options.

The Specialist Mental Health Service for Older People (SMHSOP) provides both inpatient and community services to older people generally aged 65 years and over. Acute psychogeriatric beds and older person-specific ECT services are provided at the Concord Centre for Mental Health, and consultation/liaison services are provided to hospitals within the LHD as required.

Multidisciplinary Community SMHSOP teams based at Canterbury and Camperdown provide services across SLHD. The target group for these services is older people living in the community at home or in a Residential Aged Care Facility who have developed or are at risk of developing a mental health disorder such as depression or psychosis or who may have severe behavioural problems associated with dementia. The SMHSOP is currently developing a Community Model of Care for their consumers, their carers and families.

The SMHSOP will continue to work closely with Aged, Chronic Care and Rehabilitation Services, other aged care providers and Adult Mental Health Services to increase knowledge of available services, improve referral pathways and access to services for consumers and carers.

It is recognised that there are low rates of access by Aboriginal consumers. The SMHSOP will work to increase access to services by fostering collaborative working relationships with Aboriginal staff, building awareness of SMHSOP services and developing referral pathways.

Intervening early to maintain mental health for children and young people

Mental health issues in childhood and adolescence are increasing in frequency and severity. Evidence shows that promotion, prevention and early intervention programs are effective in reducing the severity and prevalence of mental health problems in childhood and adolescence.

A recent report from the Faculty of Child and Adolescent Psychiatry in the Royal Australian and New Zealand College of Psychiatrists (RANZCP) presents a range of strategies covering health promotion, prevention, early intervention and relapse prevention, all of which are relevant to the development of services in the SLHD. Access Economics and the RANZCP have also issued reports on the cost effectiveness of early intervention.

Recent commitments from the Australian government have focussed on the provision of early intervention services for young people, including additional headspace services in Ashfield by 2015, but there is still a need to expand early psychosis intervention services for adolescents and young people.
What we will do:

• Develop a plan for service development in conjunction with the planning process for the SLHD Child Health and Wellbeing Plan. This should include health promotion, prevention, early intervention, acute care, maintenance care and relapse prevention;
• Increase our engagement and involvement with headspace initiatives;
• Continue to advocate for the expansion of the early psychosis intervention service;
• Enhance our links with NGOs, related government services and the private sector to ensure a comprehensive service is provided;
• Work with Department of Family and Community Services (FACS) to streamline services for children and young people leaving care who require continuing intervention and support from the Mental Health Service;
• Focus on improving the mental health of Aboriginal families in conjunction with other community-based services; and
• Place emphasis on assertive outreach as opposed to hospital-based assessment and treatment for acutely unwell adolescents.

Mental Health Partnerships

A key component of the NSW Government’s goal to improve the care and support provided for people with a mental illness, their families and carers is implementation of the strategies in the NSW Interagency Action Plan for Better Mental Health.

The strategic directions of this plan are:

• Getting in early – improving prevention and early intervention;
• Breaking the cycle - improving community support services; and
• Coordination of emergency responses.

Partnerships have been developed with a number of community organisations and related government departments. The partnerships are based on formal and informal agreements and provide frameworks to work together to improve the provision and coordination of services.

Significant partnerships have been developed for:

• Supported accommodation with Housing NSW, HASI-funded services (including Aboriginal HASI) and Community Housing Associations through the Housing and Mental Health Agreement;
• headspace services for young people in Camperdown and a future service in Ashfield;
• Health Promotion and Drug Health services;
• Conjoint Programs with other government departments including FACS and its branches, Ageing and Disability & Home Care and Housing NSW;
• Carer Support in conjunction with Carer Assist, an NGO providing education and carer support programs and other NGOs providing carer services;
• Community programs including the Commonwealth-funded Personal Helper and Mentors Service and Partners in Recovery programs;
• Redfern Aboriginal Medical Service;
• Inner West Sydney Medicare Local and general practitioners; and
• Emergency Services with the Police Force and Ambulance Service.

Service co-ordination committees have been established:

• Under the Housing and Mental Health Agreement for supported accommodation and the Going Home Staying Home program with homelessness services;
• With the local Police and Ambulance services;
• With Ageing and Disability and Home Care within the Department of Family and Community Services for people with intellectual disabilities; and
• To focus on access, coordination and improvement of services to CALD communities with mental health services, health language services (interpreters), Transcultural Mental Health Service and other NGOs providing related services.

The ‘Partners in Recovery’ program works across services and sectors to improve the coordination and integration of services for people with severe and persistent mental illness with complex needs, their families and carers. Focusing on achieving systemic change, this program will also help to identify gaps in services and service integration / coordination.

Working with general practitioners, especially in the area of improving the physical health of consumers, has been identified through the consultation process as a key priority. The framework provided by the Inner West Sydney Medicare Local will enhance our partnerships and communication links with GPs and other primary care providers.

What we will do:

• Strengthen partnerships with community service organisations through reviewing / updating of existing service level agreements and the development of new agreements as appropriate;
• Involve our service partners in the planning and development of services;
• Review the cross-agency co-ordination of mental health related services and consider establishing a mental health interagency for Inner West Sydney;
• Participate in steering / operational committees established for the provision of services; eg, Partners in Recovery and headspace services;
• Participate in a consultation process with SLHD NGO-funded services to align services with strategic priorities relevant to future procurement of services;
• Enhance our links and partnerships with primary health carer providers to improve pathways of care with GPs and other services; and
• Review current service models to best utilise resources and workforce.
Our Current Services

A wide range of mental health services are provided across the SLHD by over 780 staff. Community-based services are delivered through community health centres located at Redfern, Camperdown, Marrickville, Croydon and Canterbury. Inpatient services are provided at Concord and Royal Prince Alfred hospitals (see table below for services at each CHC and see appendix 1 for detailed listing of services). The total annual budget for the provision of mental health services in the SLHD is over $90 million.

The Mental Health Service provides the spectrum of inpatient and community-based services across the life span, delivered in partnership with related government departments, the private sector and other community-based organisations. In 2012-13 our inpatient services admitted 2,958 people and provided 74,765 days of care. The community mental health services provided over 128,000 occasions of service for 14,314 people.

A major objective of this plan is to improve the mental health services for the communities serviced by the SLHD. This includes ensuring that the services provided reflect the cultural mix of the communities.

Future resourcing requirements are linked to population expansion and deficits in both community and inpatient services. The resources required are based on the 2021 LGA population projections from NSW Health applied in the Mental Health Clinical Care and Prevention Model (2010) (MH-CCP). This service model provides the estimated resource requirements, both inpatient and community services, for each of the major age groups – child & adolescent aged 0-17, adults between 18 and 64 and older people aged 65+. The MH-CCP indicates additional resource investment is required in order to meet demand for community mental health services in the future.

Community Mental Health Service Development

There are seven major community mental health services:

1. Community Mental Health Team
   This “core” team or community mental health team provides a range of mental health services. The team includes care coordinators, consultant psychiatrists and trainee psychiatrists.

2. Acute Care Team (Crisis)
   The Acute Care Team provides assessment and home based treatment. The Team provides assessment and short term treatment for people with acute mental health problems.

3. Early Intervention in Psychosis
   This team treats young people with first episode psychosis. The most common age range is 18-25.

4. Assertive Outreach Treatment
   This team provides intensive treatment to people with significant mental health problems, many of whom have had multiple hospital admissions or extended admissions.

5. Child and Adolescent Mental Health
   Community services comprise centre-based tertiary care for children and adolescents at Concord, assertive outreach for adolescents based at Camperdown and consultation to secondary care services for children located at Camperdown, Canterbury, Croydon and Marrickville.

6. Older Persons Mental Health
   An age specific team for older persons generally aged 65+.

7. Aboriginal Mental Health
   This team provides case management and consultation services for Aboriginal people.

Each of these services are provided across the District with some teams are based at several locations. The table below indicates which teams are based at which Centres.

<table>
<thead>
<tr>
<th>Location Service/Team</th>
<th>Community Mental Health</th>
<th>Acute Care (Crisis)</th>
<th>Early Intervention</th>
<th>Assertive Outreach Treatment</th>
<th>Child Mental Health</th>
<th>Adoles’t Mental Health</th>
<th>Aboriginal Mental Health</th>
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<td>Camperdown Mental Health Centre</td>
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A review of the adult Community Mental Health Services was conducted in 2012 to improve the quality, efficiency and effectiveness of adult public mental health services.

The recommendations highlighted the need to increase:

- Multidisciplinary staffing levels of community-based mental health services;
- Assertive outreach for vulnerable groups of people with severe mental illness;
- Crisis resolution and intensive home treatment as an alternative to hospitalisation; and
- the number of psychiatrists.

The increasing population will raise the demand for community mental health services across all age groups. The community mental health services are currently significantly understaffed using the MH-CCP guidelines. Working within the integrated mental health model of care, the enhancement of community mental health staff will increase our ability to maintain our consumers at home and reduce both the need for admissions to an inpatient service and their length of stay.

In 2013, a new Assertive Outreach Team for Canterbury / Croydon and new models of case management integrated with GP care, and increased psychiatrists at Camperdown, Marrickville, and Croydon was developed. This significantly increased the provision of comprehensive and timely care and enhanced the links with inpatient services and the non-government sector.

Community enhancement funding in 2014 was targeted at enhancing the core component of the Community Mental Health Team and specifically GP shared care coordination. There will be an enhancement of four care coordinators who have a primary goal of working in partnership with GPs. The GP shared care coordinator positions will explicitly target improving physical and mental health treatment for people with persistent and severe mental health problems.

Over the past 10 years there has been increased funding to NGOs providing new models of mental health care. Many provide psychosocial rehabilitation and recovery services and link people with mental health problems to the services they require; others provide clinical services (headspace and Medicare funded services).

As part of the NSW Health review of services provided by the NGO Grant Program, recommendations are being implemented to align funded services with the strategic priorities of both the MoH and the LHDs. While clarification of the timeframe is yet to be confirmed, the Mental Health Service will work closely with the NGOs to support communication and consultation in this process.

The following are examples of community-based funded services in the SLHD:

**headspace**

The Australia-wide headspace model complements the mental health services provided to adolescents and young people in providing early treatment for young people with emerging or existing mental health problems. The Camperdown headspace has been established for several years and the Ashfield headspace commences in 2015.

**Housing and Accommodation Support Initiative**

The Housing and Accommodation Support Initiative (HASI) is a three-way partnership between the Mental Health Service, mental health NGOs that provide non-clinical support services and accommodation providers. Current mental health NGOs that provide HASI services are Aftercare and New Horizons Enterprises. A total of 67 places are now funded through this program.

Supported accommodation services established prior to the HASI program are also provided by Aftercare (23 places) and RichmondPRA (33 places). In 2013 HASI packages were established to support residents of Assisted Boarding Houses. The MH-CCP guidelines now project requirements for HASI services. These are detailed in Appendix 1.3.

**Personal Helpers and Mentors**

The Personal Helpers and Mentors program was established through Commonwealth funding to provide low level support packages for consumers through New Horizons, Aftercare and NEAMI.

**GPs/ ATAPS**

General practitioners and associated allied health providers through the ‘Access to Allied Psychological Services’ (ATAPS) are the major providers for people with depression, anxiety and psychosocial issues.

**Redfern Aboriginal Medical Service**

The Redfern Aboriginal Medical Service provides a range of primary health and mental health care services for Aboriginal people.

**Partners in Recovery**

The Commonwealth-funded Partners in Recovery program was established in 2013 to achieve a systemic improvement in the coordination and integration of services and sectors. This program is designed for those who traditionally “fall through the gaps” between service providers.

What we will do:

- Implement the recommendations of the Review of the Community Mental Health Services;
- Work with the MSW MoH and the NSW Mental Health Commission to plan the community mental health service requirements and support the provision of enhancement funding; and
- Participate in the planning and implementation of the integrated service model.
Inpatient Mental Health Service Development

The population of the S LHD is expected to increase from 599,000 people in 2014 to over 642,000 by 2021. This has implications for the range and quantity of both inpatient and community services and facilities.

The Mental Health inpatient services provide comprehensive care for both residents of the District and those that live outside the District. The inflow of patients from outside the SLHD reflects the historic availability of tertiary level services, particularly for mental health intensive care, older persons and adolescent services. The following diagrams analyse the utilisation of inpatient services for all separations (discharges, transfers, deaths) in 2011/12 at the Concord Centre for Mental Health (CCMH) and at Royal Prince Alfred Hospital (RPA).

Diagram 1 shows that almost 30% of the people hospitalised in the Concord Centre for Mental Health were residents of other local health districts.

At RPA, 25% of inpatients were from other local health districts.

The following diagram represents the utilisation of all public mental health inpatient services by the residents of the SLHD. The use of services provided by other LHDs reflects referral pathways, proximity of residence, access to emergency departments of other hospitals and the use of specialised services. About 23% of SLHD residents were cared for in other local health districts.

Clinical services planning for the expansion of inpatient mental health services in the SLHD was included in the SSWAHS Mental Health Services Plan Improving Mental Health in Sydney South West - A Service Plan for 2007 to 2016 which was endorsed by NSW Health.

The Concord Centre for Mental Health (CCMH) on the Concord Repatriation General Hospital campus was established in 2008 through a relocation of services previously at Rozelle Hospital. In addition to the transfer of services, provision of tertiary-level adolescent services were included in the CCMH. The CCMH is now operating at full capacity across all services.

The Professor Maire Bashir Centre, located at RPA, provides a range of inpatient services. This includes expanded services for eating disorders, high dependency, gender separation, postnatal depression, assessment and short-stay. Sydney University will access inpatient services linked to research programs. There is potential to transfer inpatient services for residents of Marrickville to the new unit.

The Unit aims to provide quality, transformative inpatient mental health care in collaboration with the University of Sydney and in partnership with consumers, families and other service providers.

The mental health services within the Professor Marie Bashir Centre comprise:

- a mental health assessment unit
- a six-bed short stay unit
- an adult acute psychiatric unit with capacity of up to 25 patients
- a gender-specific high dependency unit with maximum capacity of 22 patients
- an Eating Disorders service comprising six inpatient beds
- a day program and outpatient clinic; and
- a University of Sydney intensive assessment unit and 7 mental health beds.
The short stay unit is a coordinated service involving inpatient and community Mental Health services, Emergency Medicine, Drug Health and Toxicology. The facility also focuses on delivering innovative models of care for patients with presentations including high acuity mental illness, early onset psychosis, homelessness and women with perinatal mental health disorders.

What we will do:

- Provide care in the least restrictive environment utilising involuntary hospitalisation as a last resort;
- Provide services that are culturally sensitive and safe for Aboriginal or Torres Strait Islander people and people from CALD backgrounds;
- Minimise the use of seclusion and restraint within the unit, with the aim of eliminating the use of seclusion on the acute psychiatric unit;
- Improve the quality and effectiveness of communication and transition of care in collaboration with the Inner West Sydney Medicare Local, GPs, other Sydney LHD services and related community service providers;
- Establish a clinical research facility, collaborating with the University of Sydney and research institutes on campus;
- Provide expert assessment of complex mental health presentations for consumers living both within and outside the local catchment area;
- Provide inpatient eating disorders treatment for consumers living both within and outside the local catchment area;
- Focus on the physical health and wellbeing of consumers admitted to the Centre via:
  - Comprehensively reviewing the physical health of inpatients with particular focus on the identification and management of metabolic syndrome;
  - Prioritising nicotine replacement and assertive quit smoking interventions;
  - Promoting healthy lifestyles and engagement in regular physical activity.
- Schedule therapeutic activities during and after hours to better equip consumers for return to the community and an earlier discharge if appropriate;
- Maintain a tradition of innovative teaching and training for undergraduate and graduate health professionals;
- Enhance the employment of peer support workers as integral members of the clinical teams; and
- Implement the model of care for the Short Stay and Acute Mental Health units to reduce pressure on the Emergency Department.

**Mental Health in General Hospital and Emergency Department Settings**

The general hospitals in the SLHD admit over 140,000 inpatients and provide 1.8 million outpatient services annually. The SLHD has many Level 6 services providing complex treatments to patients from across the state (eg the Burns Unit at CRGH, HIV/AIDS, Renal Transplant program and the Australian National Liver Transplant Unit, the Pain Management Service at RPA). For patients accessing these services, the general hospital is the primary locus of care.

Patients with a major physical illness, particularly those in complex care settings, have high rates of psychosocial distress and mental disorder. In addition patients with existing mental health disorders experience difficulties accessing and negotiating the health system. Nearly 130,000 presentations are seen in SLHD general hospital Emergency Departments. In recent decades the proportion of people who present with a mental health problem has increased, and in 2012 the majority of people in general hospital inpatient units had presented through the ED. There are major challenges for mental health services in providing specialist mental health support for these patients, particularly those requiring psychiatric admission.

Consultation-liaison multidisciplinary services provide assessment and support to facilitate the provision of mental health care in the general hospital as well as in the EDs. There remain significant areas of unmet need, and expansion of services to extend the availability of specialist mental health expertise to other medical areas in partnership with those services is required.

What we will do:

- Continue to support the provision of mental health expertise in the care of patients in general hospital services;
- Maintain a patient-centred focus that encompasses the mental, physical and social wellbeing of the patient in all clinical settings.
- Continue to support and develop clinical partnerships with medical services for patients with pre-existing mental health conditions and for those who develop mental health problems during the course of their physical illness;
- Meet the challenges of increased Mental Health ED presentations, and work in partnership with EDs to achieve the National Emergency Access Targets for these patients;
- Implement the recommendations of the 2013 Redesign project that focused on Mental Health inpatient flows;
- Facilitate the proposed clinical partnership with ED, Drug Health and Toxicology in the Short Stay Unit in the Professor Maris Bashir Centre); and
- Support the ongoing development of specialist training in Consultation-Liaison Psychiatry and Mental Health Liaison Nursing through engagement with the RANZCP Training programs and Sydney University.
OUR RESEARCH

The NSW Health, Mental Health and Drug & Alcohol Office developed the NSW Health Mental Health Research Framework in 2010 to:

• Provide a structure to develop agreed research priority areas, drawing from and adding to existing the research effort across the mental health program area;
• Provide a structure for the equitable distribution of mental health research grant funding according to agreed research priority areas;
• Engage research organisations, clinical academic researchers and clinicians in the process of aligning their research activities with these priority areas and improve the capacity to effectively translate research knowledge into practice; and
• Promote collaboration and coordination between funded research bodies, clinical academics, clinicians, consumers and carers.

Australia’s health research program is funded by governments, non-government organisations and industry. In 2007/08, the Commonwealth Government spent $55 million on mental health related research. Funding for research is generally delivered through competitive grants, such as National Health & Medical Research Council (NHMRC), the Australian Research Council (ARC) or other smaller schemes. There is also indirect support via funding of organisations which have research as one of their roles, such as universities and hospitals or direct industry funding of research (eg, pharmaceutical industry support of drug trials).

Recent national plans and reviews including the Fourth National Mental Health Plan 2009-2014 and the National Health and Hospital Reform Commission, emphasise the need to focus on translational and multidisciplinary research practice. A population health framework is adopted that recognises that mental health and illness result from the complex interplay of biological, social, psychological, environmental and economic factors at all levels.

Under this Plan, research and evaluation will cover relevant areas such as:

• Effectiveness of treatment;
• Community support services; and
• Service coordination models, prognosis and course of illness.

It includes recommendations to develop a national mental health research strategy to drive collaboration and inform the research agenda and refers to both quantitative and qualitative research, and research led by consumers and carers.

NSW Context

The NSW Office for Science and Medical Research is the lead government agency responsible for policy and funding for medical research. There is a dedicated ‘Health’ theme that aims to improve the health outcomes for the people of NSW. The Department of Ageing, Disability and Home Care also contributes to medical research in NSW.

For mental health research, the Mental Health and Drug & Alcohol Office (MHDAO) of the Ministry of Health contributes significant funding to mental health research, through direct infrastructure grants, capital grants, single projects, and literature or scoping reviews. MHDAO also commissions research as required.

MHDAO supports clinical and basic mental health scientific research in the fields of:

• Mood disorders;
• Schizophrenia and associated disorders;
• Trauma, stress and anxiety disorders;
• Addictions; and
• Neurophysiology.

In addition, a number of mental health services and the nongovernment sector engage in clinician- led research and /or clinical academic research in the development of evidence-based methods to be used in mainstream practice.

Research in the Sydney LHD

The SLHD Research Strategic Plan (2012-2017) outlines the vision for SLHD to be a world leader in research which drives excellence in health and healthcare. A key strategy in this endeavour is productively growing research in mental health services and especially in the Professor Marie Bashir Centre in collaboration with the University of Sydney.

The development of the SLHD Public Health Unit Observatory is in progress. This will provide partnership opportunities between the Observatory and Mental Health Services linked to population based data collection/research.

Research at the Sydney LHD Mental Health Service and the University of Sydney includes:

• Youth Mental Health at headspace and BMRI

Evaluation of phenotypic and biomarker (imaging, circadian and neuropsychology) trajectories of the development of young adult mental disorders within the youth mental health services at these sites, particularly focusing on mood disorders funded under an NHMRC Centre for Research Excellence grant. Research and clinical trials of novel and personalised treatments and secondary prevention, including oxytocin, melatonin agonists, circadian behavioural treatments and the use of ehealth platforms.

• Neuropsychiatry and Cognition

The Ageing Brain Centre and associated units at the BMRI evaluates the course of cognitive decline and the interaction of mood, sleep and neurological disorders within a translational clinical research and treatment approach. Interventions being trialled include cognitive training and remediation, and behavioural and pharmacological approaches to sleep disruption also funded as an NHMRC Centre for Research Excellence.
• Cardiometabolic Health in Psychosis
  The development of sustainable models of service provision to deal with the high rates of premature mortality in psychotic patients; the development of a national registry; circadian disruption studies; and, interventions for improving adherence.

• Treatment resistance and relapse prevention:
  Exploring factors associated with treatment resistance, poor outcome and the high rate of relapse in patients with psychosis.

• Child and adolescent psychiatry (Rivendell Adolescent Unit, Thomas Walker Hospital):
  Three NHMRC funded studies evaluating the effects of fluoxetine in children and adolescents with autism, the impact of puberty on physical and psychological development and examining persistence of symptoms and mediators of outcome in children with ADHD. Other recent studies include surveying adolescent attitudes of self harm and long-term follow-up of juveniles with bipolar disorder.

• Old age psychiatry:
  Exploring factors associated with people living in squalor and unclean living conditions. Other studies have surveyed medication use and prevalence of depression in old age care facilities. Further studies are planned to explore treatment outcome of older patients with delusional disorder, factors that predict better outcomes after electroconvulsive therapy and examining the effects of education and feedback to GPs on the prevalence and outcome of depression in old age.

• Mental health nursing studies:
  Several studies were completed over the last three years investigating nursing education and practice, and the views of mental health nurses on a variety of subjects. A conjoint research position is proposed to support mental health nursing research.

• Shared Care Project with Primary Care:
  The formal evaluation with the Inner West Sydney Medicare Local of the Shared Care Project which aims to increase sustained collaboration and improved communication between consumers, their general practitioners and community mental health workers.

• Professor Marie Bashir Centre
  Clinical research and developing innovative models of service delivery is a key objective of the Centre, aiming to establish a world class clinical research facility, collaborating with research institutes on campus on projects including:
  - Improving the physical health of consumers with mental illness;
  - Developing models of care for young consumers with mental illness;
  - Enhancing care pathways for homeless consumers;
  - Researching novel physical treatments for mood and psychotic disorders; and
  - Developing and formally evaluating service delivery roles for peer support workers in inpatient settings.

• Allied Health Research
  A number of allied health staff within the mental health service have completed or are completing research projects in a variety of areas. There are existing strong relationships between the allied health disciplines and local universities (particularly University of Sydney), and a number of allied health staff are currently enrolled in research higher degrees covering a range of topics.

• Eating Disorders Day Program
  The Eating Disorders Day Program has demonstrated strong initial outcomes for consumers attending this program. A rigorous research framework has been established to further evaluate the outcomes achieved by consumers attending this program. Some current research projects include:
  - Evaluation of longitudinal outcomes for program participants;
  - Development and testing of a novel instrument to measure “normal eating” in the context of eating disorders;
  - Evaluating consumers’ experiences of engaging in practical food groups

What we will do:
• Continue to maintain a focus on translating the results of research into improving service practices;
• Further develop linkages between the MHS and the University of Sydney / Brain and Mind Research Institute with an emphasis on strengthening clinical research, and translating findings in to practice;
• Work cooperatively with the University of Sydney to support the establishment of senior conjoint academic appointments;
• Implement research projects to address identified issues in the provision of clinical services particularly focused on high need groups in the communities of the SLHD; eg, CALD, Aboriginal people and older people; and
• Engage academic services and staff with frontline clinicians to investigate issues of clinical significance.
Our mental health service is built upon the quality and strength of our workforce. In order to provide services that are patient and family centred, that treat patients with dignity, compassion and respect, it is imperative that our staff be supported in performing their work.

Our capacity to respond to current and emerging issues and demands relies on staff that are skilled, committed and valued. They must be able to work in safe, respectful, healthy and productive workplaces and share their expertise with others.

Implementation of a framework to address workforce issues will:

- Provide higher quality clinical services for our consumers;
- More effectively address the mental health needs of the communities we work for;
- Build and sustain a valued workforce;
- Support innovation, life-long learning and inquisitiveness in our workforce; and
- Provide high quality and efficient mental health services.

An adaptable, responsive and dynamic mental health service is built upon a workforce that is knowledgeable, creative and responsive to the needs of consumers, carers and communities. A strong learning and development system is essential to ensure the objectives of the mental health service are achieved.

Responsibility for ensuring the effectiveness of the learning and development systems is shared between the Mental Health Service and the Centre for Education and Workforce Development. This shared responsibility is supported through the Mental Health Education Sub-committee of the Mental Health Human Resources Committee.

The Mental Health Service is also committed to the clinical training of health students in medicine, nursing, occupational therapy, psychology, social work and Aboriginal mental health. In 2013 over 650 students received education programs, training, supervision and placements.

The recruitment, training and retention of peer support staff have been identified as significant issues as the workforce expands.

Key Issues for Our Staff and Education

Secure, retain, develop, manage and support our workforce

A skilled workforce is the backbone of any health service. To develop the strongest workforce possible, we need to focus on strategies in the areas of:

- Seeking of skills and talents,
- Building skills and knowledge; and
- Recruitment and Retention.

We need to identify and promote our unique selling points. Skills and talent attracts skills and talent, and our current workforce is a key selling point. People who like their jobs and like the teams they work in tell other people about it, and we cannot underestimate the power of these ‘word of mouth’ recommendations. Additionally, people will be attracted to work in organisations that are considered innovative, dynamic or where they can learn from experts in the field.

It is important to develop an understanding of why people choose a career in mental health and why they stay (and, perhaps more importantly, why they leave) and develop strategies that support our capacity to retain a skilled workforce.

What we will do:

- Build talent from within our current workforce (future leaders and managers);
- Attract current students to apply to join our workforce;
- Maintain a strong, supportive and dynamic training environment where all staff are supported to further develop skills and talents that meet the needs of our communities;
- Develop and support leaders who maintain their focus on the best-possible consumer outcomes whilst supporting staff motivation, engagement and productivity;
- Establish systems that promote and encourage the implementation of evidence-based practices and research;
- Increase the number of Aboriginal people employed in all components of the Mental Health Service;
- Invest in the training and development of the peer support workforce;
- Improve the quality of information on our website to attract the future workforce;
- Increase numbers and quality of student placements;
- Increase links between the Mental Health Service and key university programs;
- Engage CEWD in providing training that will develop a clinically robust and innovative workforce;
- Promote awareness of and access to leadership development opportunities such as group clinical supervision training, the Management Development Program, Master of Business Administration and Master of Clinical Leadership; and
- Review the recruitment strategy for psychiatrists to provide improved coverage through increasing the time allocated to community mental health services.

A good place to work

Achieving the objective of ‘being a good place to work’ requires us to consider a broad range of factors. We must provide the basics of safe working environments and health-promoting and health-supporting practices and we must also ensure that our workforce is supported to balance their work and personal commitments and desires. Additionally, we must also think critically about how we recognise and reward staff; both in terms of extrinsic rewards (recognition, awards, etc) and in terms of intrinsic rewards (doing work that is personally meaningful, satisfying and that is motivating).
A wide range of mental health services are provided across the District by more than 780 staff. The Mental Health Service provides the spectrum of inpatient and community-based services across the life-span, delivered in partnership with related government departments, the private sector and other community-based organisations.
What we will do:

- Promote the psychological health of the District’s mental health workforce;
- Maintain a safe working environment;
- Support teams to operate as productively and effectively as possible;
- Eradicate bullying and harassment;
- Assist staff to contribute positively to the occupational mental health of their colleagues;
- Ensure appropriate emotional and practical support is available;
- Support family-friendly and flexible work practices;
- Ensure all employees are vaccinated against preventable diseases;
- Promote job design that supports the psychological health of the workforce;
- Enhance performance review systems so that staff achievements are acknowledged;
- Evaluate our rewards and recognition structures to ensure we provide a working environment that is challenging and rewarding and working conditions that support staff retention; and
- Implement the recommendations and strategies that arise from ‘Your Say’ staff surveys.

Offer opportunities to build a career with us

Not only do we want to be seen as providing good training or as a good place to commence working, but we also want to support staff to see a long future working in our Mental Health Services.

Our current workforce will remain with us if they can see opportunities to build their skills and careers. People often change positions to find new and interesting work, and these transitions are often horizontal at the same level / grade. For many people, career development and progression is not always about money.

What we will do:

- Enhance performance review systems to encourage skill development and career objectives;
- Continue to offer opportunities to relieve in higher-graded positions for promising staff;
- Support managers and leaders to undertake further training and education;
- Support personal regrading applications in suitably skilled staff within the award structures;
- Promote current research occurring within the area Mental Health Service and investigate opportunities for enhancing “research mentorship” opportunities for clinically based research; and
- Maintain a high % of staff employed by developing prompt recruitment strategies and reducing the time from resignation (or vacancy) to a new recruit commencing.

Ensure our workforce numbers and skills are sufficient to meet our service needs

To effectively meet the needs of our service users we need a competent and well-led workforce, and we also need to ensure that this workforce is appropriately distributed according to the needs of the population. In considering the distribution of our workforce, we need to consider several factors: local demographics; eg, population numbers, cultural mix, age structure, accommodation needs; availability and accessibility of private and non-government support services in the locality; and types of clinical services required.

This is a complex task and requires a detailed mapping of our current workforce and profiling of community needs now and into the future. We also need to ensure that positions in difficult-to-recruit areas receive specific consideration, and that we focus on establishing specific strategies to lead, support and develop clinicians in these areas.

Our aim must be to provide equitable access to the services most needed by local communities. To do this we must understand those needs (both current and future), understand the complex matrix of skills and locations of our workforce and work towards optimising the fit between community needs and service capacity. A strong workforce will ensure that high-quality mental health care is provided.

What we will do:

- Develop a detailed profile of current workforce (skills, responsibilities and location);
- Develop an understanding of the demographics and needs of local communities and develop a workforce that reflects the population mix;
- Provide cultural competency training for all staff;
- Ensure sufficient skills-infrastructure is in all locations to support the workforce and nurture and develop talent;
- Provide effective and efficient management structures to support the workforce with workforce trend monitoring and effective performance management;
- Increase the employment of Aboriginal people in accordance with the NSW Health Aboriginal Workforce Strategic Framework 2011-2015; and
- Increase the employment of people with lived experience of a mental illness as peer support workers and in other positions subject to available funding.
OUR ORGANISATION

The structure for the provision of mental health services emphasises a clinical stream approach to patient care and utilisation of a wide range of professions and resources. It supports the local clinical management structures and effective patient care services established with hospitals and emergency departments. It also maintains strong links with community services that include GPs, NGOs, the Inner West Sydney Medicare Local and related government departments such as Education, Police, Housing and Family & Community Services.

Key features of the structure include:

- Operational management support continuing to be provided by clinical stream senior managers in areas including finance, information system development / analysis / reporting, work health and safety, education and training, recruitment, service and facility planning, partnership development and performance reporting / analysis.
- Clinical Management / Governance being provided through having effective clinical structures at the district level supported by clinical stream leadership positions within medicine, nursing and allied health. A clinical stream clinical committee structure dovetails with local committees regarding a range of functions and responsibilities.

The Director Mental Health is responsible to the Chief Executive for the overall operation and provision of services within the mental health budget allocated by the Ministry of Health. The structures for provision of medical, nursing, allied health and corporate services across the clinical stream have been maintained.

The Director of Clinical Services has responsibility for the operational and clinical management of the Mental Health Service. Inpatient services are managed by a senior nurse manager and a medical director at each hospital.

Management of community services has continued through the District Operations Manager who has a role in developing / maintaining local partnerships with related NGOs, GPs and related government services.

Key issues for Our Organisation

Effective Financial Management – Activity Based Funding

To date, the MHS has been allocated a specific budget through the Chief Executive that is based on the historic build-up of funding for core, new and enhanced services with increases provided for award and other cost-of-living increases. However, it is expected that this will change over time to link with the implementation of the national Activity Based Funding (ABF) system.

The establishment of KPIs for financial management, activity reporting and service performance will be required to oversight and monitor expenditure and to support the introduction of ABF for all services. Systems for monitoring both the admitted and non-admitted activity related to the ABF funding system are being developed.

The Ministry of Health reporting requirements for financial and annual national minimum data set reporting will need to be met through the reporting systems.

What we will do:

- Work with the Financial Management Unit to review the budget build-up provided by the Ministry of Health and allocate budgets based on this analysis;
- As part of the preparation for the introduction of the ABF, identify and agree on the cost of goods and services provided to the MHS that operate from each facility and the indirect costs for the provision of MHS;
- Review the current financial and activity reporting systems to meet the requirements of the ABF, Commonwealth Minimum Data Set and the Ministry of Health Milestone reporting systems;
- Work with the Financial Management Unit of the LHD to provide effective and efficient reporting systems to monitor and report on cost centre costs and staff vacancy rates to enhance the recruitment to vacant positions;
- Develop comprehensive operational plans for the inpatient and community MHS in each LHD and a quarterly reporting system to monitor and support their implementation; and
- Implement broad staff education on the principles of ABF and the implications for service provision.

Effective Clinical Governance

Clinical Governance is based on the principle that all health professionals (clinicians and managers alike), as well as those in corporate governance, are jointly accountable for the quality of consumer care and standards of care delivery. Clinical Governance is the framework by which this accountability is ensured and demonstrated.

The Australian Council on Healthcare Standards (ACHS) defines Clinical Governance as “the system by which the governing body, managers and clinicians share responsibility and are held accountable for consumer / patient care, minimising risks to consumers / patients and for continuously monitoring and improving the quality of clinical care.”

In the Mental Health Service, the features of Clinical Governance are:

- Recognition and acceptance by health professionals, clinical staff, managers, and executive that they share accountability for quality and standards of care within the Service;
- An environment that promotes and fosters quality of care and safe practice;
- Consumer care and clinical priorities are at the centre of all endeavours;
- A partnership between consumers, clinicians and management in clinical services review and development;
- Systems that monitor, identify, report, and evaluate quality of care;
- Effective mechanisms that minimise harm / risk and address any deficiencies;
• Active pursuit of external examples of excellence and related partnerships;
• Encouragement of innovation and best practice; and
• Celebration of success and learning from past experiences.

The Mental Health Clinical Governance focus has been to maintain a sustainable framework with service-wide committees and organisational structures and development of organisational capacity and culture.

Clinical governance within the mental health clinical stream is provided through a combination of both District and clinical stream linked structures. These committees have a significant role to ensure safe, effective services are provided across the District.

**Committees established at the clinical stream level include:**

- Mental Health Executive
- Executive Clinical & Corporate Quality
- Policy and Procedures
- Serious Incident review
- Medication
- ECT
- Safe Practice and Environment
- Information Management
- Human Resources and Workforce Development
- Multicultural Access
- Age specific Services - SMHSOP, ICAMHS

The Mental Health Executive Committee is the peak governance committee for clinical and corporate quality and safety. It is chaired by the Director Mental Health.

This committee has a predominantly clinical membership and has a role in monitoring and evaluating Clinical Quality initiatives and outcomes. The Executive Clinical & Corporate Quality Committee oversees the process to achieve approved standards and accreditation.

**Clinical Audit Framework**

The Mental Health Service has developed an Audit Framework, a suite of audit tools and an audit schedule that identifies variances in clinical processes and outcomes, identifies and assesses clinical risk and ensures effective implementation and evaluation of recommendations rising from audit findings. The Framework aims to improve the quality of care for consumers and ensure appropriate use of staff skills and training.

The MHS Clinical Audit Framework:

- provides a mechanism for reviewing the quality of everyday care that is provided to consumers;
- builds on a long history of healthcare professionals reviewing case notes and seeking ways to better care for their clients;
- addresses quality issues systematically and explicitly, providing reliable, objective information;
- confirms the quality of clinical services and highlights areas that need improvement; and
- can be used to evaluate the use of new techniques, interventions, procedures and changes in practice which maximise benefit to consumers.

The completion of the Clinical Audit Tools is monitored and reported monthly with specific intervention applied when necessary. Specific processes are outlined in the MHS document *Clinical Audit Program Framework*.

**What we will do:**

- Ensure that all risks are assessed and managed appropriately within inpatient, emergency department and community mental health services;
- Improve reporting and dissemination of information relevant to clinical governance throughout the Service through more effective use of the Service’s intranet and internet;
- Encourage participation in consumer surveys that provide feedback on service quality, capability and efficacy;
- Develop a Mental Health Operational and Quality Improvement Plan that aligns with the Strategic Plan; and
- Continue the review and monitoring process to achieve accreditation through EQuiPNational.

We are committed to using proven technologies to develop new models of care, more effective healthcare practices and a workforce that is diverse in its approach to serving patients and communities.
Innovative and Creative Use of Technology

Contemporary healthcare is highly technological, data driven, networked and supported by rapid and strategic communication systems. The Mental Health Service is committed to using technology in innovative and creative ways to achieve the strategic goals of the organisation.

The Mental Health Service is committed to using proven technologies to develop new models of care, more effective healthcare practices and a workforce that is diversely skilled and flexible in its approach to serving patients and communities. Innovation and research will be encouraged to develop safe, effective, efficient and therapeutic mental health care.

What we will do:

• Use existing technologies and health information to translate the best clinical guidelines into everyday practice;
• Provide systems that allow the right information to be accessible to the right people at the right time in the pursuit of timely and effective healthcare interventions;
• Develop communication systems using hardware, devices and applications that facilitate networking, collaboration and relationships between staff and all stakeholders in the health system that includes inpatient services, community services, general practitioners, NGOs and other government agencies;
• Support innovative and creative technological projects that work towards supporting or improving patient care;
• Support research projects that utilise technology to progress the body of mental health theory, practice and knowledge;
• Apply technological solutions that improve the efficiency and effectiveness of the organisation at all levels that include balancing therapeutic goals, community expectations and cost effectiveness; and
• Review and develop our website and use of technology to ensure communication and accessibility for consumers, carers and the community.
## APPENDICES

### INPATIENT SERVICES

#### 1.1 CURRENT FUNDED INPATIENT SERVICES

<table>
<thead>
<tr>
<th>Beds funded at January 2014</th>
<th>Adol Acute</th>
<th>Adol Non Acute</th>
<th>Adult Acute</th>
<th>Adult Non Acute</th>
<th>Older Persons Acute</th>
<th>Older Persons Non Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>RPA Hospital – Missenden Unit</td>
<td></td>
<td></td>
<td>36</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RPA Hospital – Eating Disorders</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concord CMH – McKay East Intensive Psychiatric Care Unit</td>
<td></td>
<td></td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concord CMH – McKay West Male High Dependency Unit</td>
<td></td>
<td></td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concord CMH – Manning East Female High Dependency Unit</td>
<td></td>
<td></td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concord CMH – Norton Acute Inpatient Unit</td>
<td></td>
<td></td>
<td>24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concord CMH – Manning Acute Adult Unit</td>
<td></td>
<td></td>
<td>24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concord CMH – Broughton Rehabilitation and Recovery Inpatient Unit</td>
<td></td>
<td></td>
<td>35</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concord CMH – Kirkbride Rehabilitation and Recovery Inpatient Unit</td>
<td></td>
<td></td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concord CMH – Walker- Adolescent Non-acute Severe</td>
<td></td>
<td></td>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concord CMH – Jara Acute Older Person Inpatient Unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Rivendell- Adolescent Non-acute</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td><strong>Total all opened beds - 234</strong></td>
<td>0</td>
<td>36</td>
<td>120</td>
<td>50</td>
<td>30</td>
<td>0</td>
</tr>
</tbody>
</table>

#### 1.2 ADDITIONAL INPATIENT SERVICES PLANNED FOR 2015

<table>
<thead>
<tr>
<th>Additional beds planned for 2015</th>
<th>Adult Acute</th>
<th>Adult Non Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RPA Hospital – Professor Marie Bashir Centre eating disorders</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>USyd funded research beds</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Short-stay beds and assessment spaces</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td><strong>Total planned beds</strong></td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>
COMMUNITY MENTAL HEALTH SERVICES

The MH-CCP provides the projected requirements of community mental health staff based on age groupings. It differentiates between ambulatory services linked to the provision of inpatient services and community-based services based on levels of acuity – mild, moderate and severe. Following are the staffing requirements based on 80% of the recommended staffing. The ‘80%’ target is used by the MHDAO for service planning purposes. The 0-17 population staffing includes 20 FTE provided through the Community Health Service.

### 2021 Community Staff Requirements

<table>
<thead>
<tr>
<th>Population</th>
<th>Projected FTE Requirements</th>
<th>Current FTE</th>
<th>Additional Staff Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17</td>
<td>63.0</td>
<td>33.4</td>
<td>29.6</td>
</tr>
<tr>
<td>18-64</td>
<td>181.8</td>
<td>168.8</td>
<td>13.0</td>
</tr>
<tr>
<td>65+</td>
<td>37.3</td>
<td>13.3</td>
<td>24.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>282.1</td>
<td>215.5</td>
<td>66.6</td>
</tr>
</tbody>
</table>

### 1.3 HOUSING AND ACCOMMODATION SUPPORT INITIATIVE

The Housing and Accommodation Support Initiative (HASI) program was commenced in NSW in 2003 to provide housing and related support for people with mental illnesses living in the community. Following comprehensive evaluations, the program was progressively extended to provide multiple levels of care and specialised support to over 1,000 places in NSW. The HASI services are provided through a partnership that provides clinical support through the mental health service, non-clinical support through NGOs and accommodation through Housing NSW and community housing associations.

HASI or ‘supported living in the community’ has been included in the MH-CCP 2010. Following is a summary of the current and projected requirements to 2021 at the 80% level of service provision for SLHD. Supported accommodation services provided through NGO Grant funding to Aftercare and RichmondPRA is also included.

### 2021 HASI Requirements

<table>
<thead>
<tr>
<th>Supported Living in the Community</th>
<th>Actual 2013</th>
<th>MHCCP 2021 80%</th>
<th>Additional Places Required 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low level-HASI</td>
<td>86</td>
<td>105</td>
<td>19</td>
</tr>
<tr>
<td>Medium level-HASI</td>
<td>2</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>High level-HASI</td>
<td>22</td>
<td>53</td>
<td>31</td>
</tr>
<tr>
<td>Very high level-HASI</td>
<td>8</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td>Extended Care-HASI</td>
<td>0</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>118</strong></td>
<td><strong>214</strong></td>
<td><strong>96</strong></td>
</tr>
<tr>
<td>Acronym</td>
<td>Terminology</td>
<td>Definition / Context</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>ABF</td>
<td>Activity based funding</td>
<td>Funding system being implemented across Australia based on admitted and non-admitted patient services.</td>
<td></td>
</tr>
<tr>
<td>ATAPS</td>
<td>Access to Allied Psychological Services</td>
<td>Commonwealth-funded allied health services provided through GP Mental Health Care Plan.</td>
<td></td>
</tr>
<tr>
<td>CCMH</td>
<td>Concord Centre for Mental Health</td>
<td>Mental Health facility providing a range of primarily inpatient services for adolescents, adults and older people on the grounds of Concord Hospital.</td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
<td>Provider of primary health care.</td>
<td></td>
</tr>
<tr>
<td>HASI</td>
<td>Housing and Accommodation Support Initiative</td>
<td>NSW Government funded service that provides accommodation and support for people with a mental illness.</td>
<td></td>
</tr>
<tr>
<td>ICAMHS</td>
<td>Infant Child and Adolescent Mental Health Services</td>
<td>A component of the Mental Health Service provided for children, adolescents and their families.</td>
<td></td>
</tr>
<tr>
<td>IWSML</td>
<td>Inner West Sydney Medicare Local</td>
<td>Primary health organisation funded by the Commonwealth to coordinate / provide a range of health services.</td>
<td></td>
</tr>
<tr>
<td>MH-CCP</td>
<td>Mental Health Clinical Care and Prevention</td>
<td>Guideline developed by the MHDAO for planning of services and facilities based on population projections.</td>
<td></td>
</tr>
<tr>
<td>MHDAO</td>
<td>Mental Health and Drug &amp; Alcohol Office</td>
<td>Division of the NSW Government Ministry of Health.</td>
<td></td>
</tr>
<tr>
<td>MHS</td>
<td>Mental Health Service</td>
<td>Clinical service provided across local health district funded through the SLHD.</td>
<td></td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisation</td>
<td>Community-based health service that receives funding from government and private sources.</td>
<td></td>
</tr>
<tr>
<td>PHAMS</td>
<td>Personal Helpers and Mentors Program</td>
<td>A Commonwealth-funded service that provides general non-clinical support for people with a mental illness and their families.</td>
<td></td>
</tr>
<tr>
<td>SLHD</td>
<td>Sydney Local Health District</td>
<td>Structure established under the Area Health Services Act for the provision of public health services in the Inner West of Sydney.</td>
<td></td>
</tr>
<tr>
<td>SMHSOP</td>
<td>Specialist mental health services for older people</td>
<td>A component of the Mental Health Service that provides services for older people – generally aged 65+.</td>
<td></td>
</tr>
</tbody>
</table>
Agency for Clinical Innovation (2013): *Nutrition Standards for Consumers of Inpatient Mental Health Services in NSW*.


Health Workforce Australia [2014]: *Mental Health Peer Workforce Study*.


NSW Department of Health (2009): *Physical Care of Mental Health Consumers*.


NSW Department of Health (2011): *Aboriginal Older Peoples’ Mental Health*.


SANE Australia (2013): *Growing Older, Staying Well Mental Health Care for Older Australians*.


Sydney South West Area Health Service (2010): *Aboriginal Health Plan*.

Here to help, 24 hours a day, seven days a week, every day of the year, Mental Health Line 1800 011 511.