NSW Community Mental Health Services Priority Issues Paper

NSW Ministry of Health

December 2023

Contents

Executive Summary

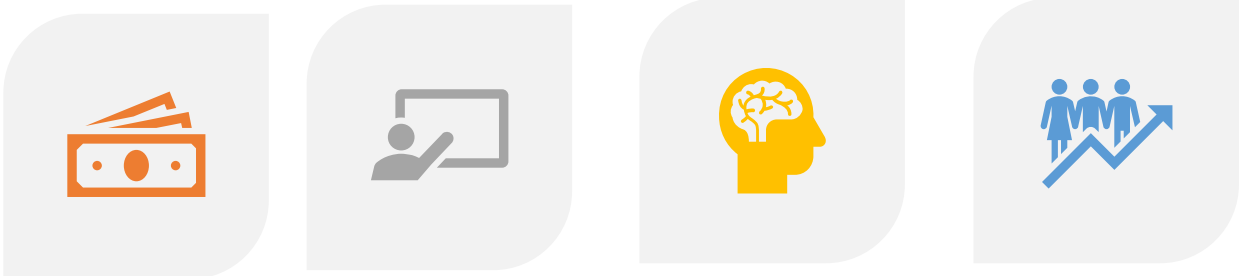
This paper provides strategic guidance for achieving better community mental health care (CMHC) outcomes in NSW. CMHC services in NSW are provided through Community Mental Health Teams (CMHTs) and other community-based initiatives. The target group for CMHTs are people with persistent and serious mental illness, who may have experienced long hospital stays or recent discharge.

People in NSW are experiencing increasing levels of mental health issues; 17% of adults have high levels of psychological distress, and 41% of people aged 16 to 85 years have experienced a mental disorder in their lifetime. The National Mental Health Services Planning Framework (NMHSPF) estimates that approximately 200,000 people in NSW (aged 25 and 64 years) have some form of severe mental illness requiring care. Given the high level of mental health concerns, an effective CMHC system has never been more important and is critical to the improvement of mental health outcomes in NSW.

The data, as well as feedback from stakeholders, suggests that the CMHC system is experiencing significant challenges in meeting increasing service demand. Over the past 10 years, to 2020-21, NSW has been providing CMHC to an increasing number of people (approximately 146,000 in 2020-21) with more client contacts (around 3.4 million in 2020-21). However, in the same time period, the number of fulltime CMHC workforce positions in NSW per 100,000 people has declined (and is the second lowest nationally at 48.9). In addition, over the past 5 years, average number of treatment days per patient decreased (although this is the highest nationally at 16.9 days). The average number of service contacts also decreased (although is also the third highest nationally). Although NSW spends a considerable amount on CMHC, with a 13% increase in funding over the past 10 years, comparative analysis shows that NSW's per capita spend is the second lowest nationally.

The objective of this paper is to investigate and summarise the key issues in the CMHC sector with a view to informing future funding and reform opportunities, informed by the views of key stakeholders and a review of current literature. Key stakeholders included Local Health Districts (LHDs), Specialty Health Networks (SHNs), the Mental Health Branch, mental health peak bodies representing mental health consumers, carers, community managed organisations (CMOs) and workforce groups. The paper identifies four key priority areas for attention. The project was guided by the expertise of a time-limited Project Steering Group.

Four key priority areas identified:



Enhanced funding for community mental health

Workforce and training

Emergency mental health care

Expansion of psychosocial supports

Enhanced funding for community mental health services: ♦ More equitable access and adequate funding for CMHTs ♦ Better outcomes for vulnerable populations ♦ Difficulty navigating mental health services ♦ Improved shared care between General Practitioners and CMHC

Workforce and Training improvements: ♦ Significant workforce shortages in all mental health workforce areas, exacerbated by high staff turnover, high vacancies and low retention rates ♦ The Peer, Aboriginal and Psychiatric workforces were identified as the most critical areas to address ♦ Better education and training to support a skilled and competent workforce and aid staff retention and attracting new staff to the sector

Better emergency mental health care in the community: ♦ Increase in mental health presentations and pressure on Emergency Department (EDs), due to lack of alternative supports in the community ♦ EDs are becoming the default access point into the mental health system

Expansion of psychosocial supports: ♦ Psychosocial supports services are critical to mental health recovery ♦ Two psychosocial projects are in progress to inform future psychosocial support requirements in NSW

It is expected that addressing the key CMHC priority areas above will result in considerable improvements in mental health outcomes for the people of NSW.

What would success look like?

Evidence and metrics to measure success would include:

- improved consumer and carer experience
- decreased wait times for CMHC services
- decreased emergency mental health presentations
- decreased readmission rates to services, and
- ultimately, a reduction in the number of individuals in NSW who attempt self-harm or complete suicide.

Next steps:

Three areas are identified for further consideration that may inform future detailed investment decisions:

1. In-depth service mapping utilising appropriate service planning and simulation tools in the next 6-12 months.
2. Findings from the two psychosocial research projects (the Commonwealth Psychosocial Research Project and NSW Psychosocial Research Project) will inform future arrangements for the provision of psychosocial supports including roles and responsibilities between the Commonwealth and NSW.
3. Consideration of future funding opportunities, including decisions around the future of existing time-limited programs funded by COVID-19 pandemic assistance.

It is important to note that some future funding priorities for NSW mental health (e.g. inpatient services) will be outside the scope of this document.

Chapter 1 – Methodology

To identify and investigate the key gaps and opportunities in NSW community mental health services a mixed methodology approach was used. This approach was chosen to provide a broad view of the service gaps and provide evidence-based, actionable priorities.

Qualitative research:

- Liaising with the Mental Health Commission of NSW to note priority areas identified in Living Well and Living Well in Focus 2020 – 2024.
- Seeking the completion of a survey in relation to community mental health from LHDs, SHNs, and the Pillars; Clinical Excellence Commission (CEC) and the Agency of Clinical Innovation (ACI). In total 20 completed surveys were received.
- Consultations with the Mental Health Branch.
- The identification of top priority areas for the Alliance for Mental Health members followed by individual interviews with the Alliance for Mental Health members, the Official Visitors and the NSW Consumer Peer Workforce Committee: ten interviews in total were conducted with an additional three written submissions. ***For interview participant details, see 1.1.1Appendix A***

Data Analysis:

Data on community mental health across NSW and Australia was analysed to highlight and support the identified themes. Australian Institute of Health and Welfare (AIHW) datasets were used as well as several other data sources. ***For a list of data sources used, see 1.1.1Appendix B***

A review of literature and submissions:

A review and thematic analysis of current relevant literature was conducted in relation to community mental health. These reports included recent mental health related inquiries and their recommendations, and recent reports analysing the current NSW mental health system. A thematic analysis of submissions to the *Legislative Council inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales* was also conducted.

The findings of the desktop review of literature and submissions analysis were both used in the report to provide a further evidence base for the qualitative findings. ***For a list of the literature reviewed, see Appendix C*****1.1.1Appendix C**

Draft report

The Mental Health Branch collated the material above and drew together a draft thematic analysis for the project steering group to comment on. This thematic analysis is the basis of this report.

Project Steering Group:

The project has been guided by the expertise of a time-limited Project Steering Group. The Project Steering Group met twice monthly between August and November 2023 to guide and provide advice on the project and included identifying and prioritising gaps and issues; reviewing the draft report within identified timeframes and providing advocacy for the project. ***For Project Steering Group Terms of Reference and membership see Appendix D1.1.1Appendix D***

Chapter 2 - A snapshot of community mental health services in NSW (as at 1 December 2023)

High psychological distress and mental disorder prevalence in NSW

There was a **7%** increase in adults experiencing high or very high psychological distress between 2013 and 2021 (from 10% to 17%)[i]

41% of people aged 16 to 85 years (or 2.5 million people) have experienced a mental disorder[ii]

Increase use of crisis services to Nov 2023[iii]

Calls to the NSW Mental Health Line increased by **6%** compared to Nov 2022

Mental health emergency department presentations increased by **5%** compared to Nov 2022

Emergency department presentations due to self-harm and suicidal thoughts increased by **5%** compared to Nov 2022

Community clinical hours increased by **5%** compared to Nov 2022

In 2020-2021

The NSW Community Mental Health (CMH) service provision rate was the second lowest in Australia. 17.9 people per 1,000 received a service. This is ahead of Victoria (12.1), but below the national average of 22.4.[iv]

NSW had the highest rate of community care treatment days per client (16.9 days) in Australia.[v]

146,498 people received a CMH service

3.4 million CMH client contacts occurred

12% of CMH contacts involved a person with an involuntary mental health legal status[vi]

Increase in CMH service provision[vii]

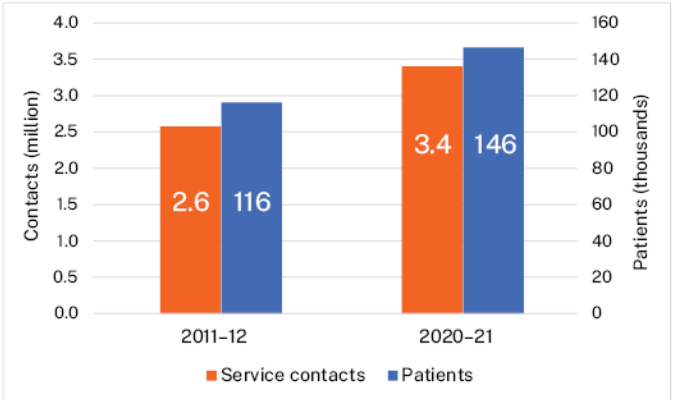
↑21%

The increase in CMH patients over the past 10 years (approx. 30,000 more people)

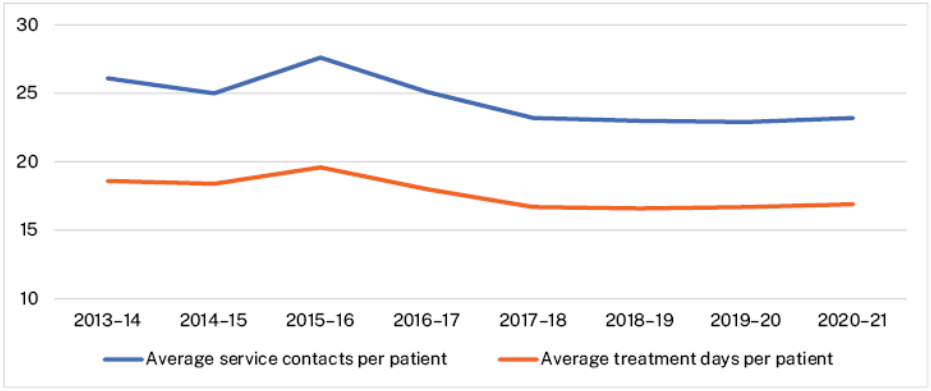
↑24%

The increase in CMH service contacts over the past 10 years (approx. 800,000 more contacts)

CMH patient and service contacts



Decrease in average service contacts and treatment days per patient[viii]



Note: AIHW data for average treatment days begins in 2013-14

↓19%
The decrease in average service contacts per patient since 2015-16

↓16%
The decrease in average number of treatment days per patient since 2015-16

- The average number of service contacts per patient peaked at 28 contacts in 2015-16. Since then, it has declined to 23 contacts in 2020-21
- The average number of treatment days per patient also peaked in 2015-16 to 19.6 days and has also been on the decline since, at 16.9 days in 2020-2021

Funding over time[ix]

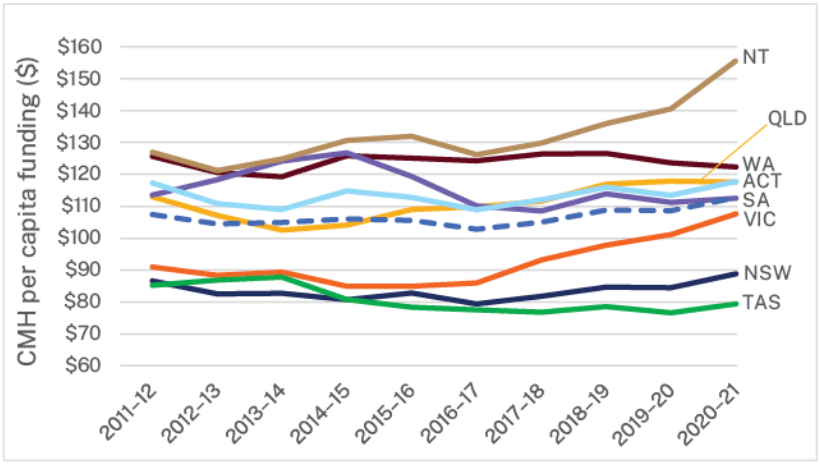
CMH funding increased by **13%** between 2011-12 and 2020-21.

This increase is below Victoria (**28%**), Northern Territory (**24%**) and Queensland (**16%**) for the same time period.

Note: All CMH expenditure referred to in this infographic is from the 'Community Mental Health services' expenditure category, as reported by AIHW. This does not include the 'Residential mental health services' or the 'NGO grants' categories.

NSW has the second lowest per capita expenditure on CMH care in Australia[x]

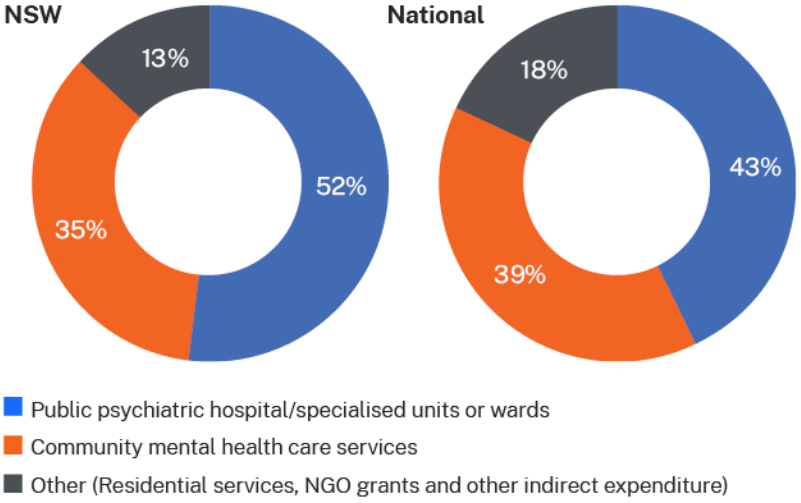
Community Mental Health per capita funding ($) by state and territory – past decade



CMH per capita expenditure ($) 2020-21	
Tasmania	$79
New South Wales	$89
Victoria	$108
Queensland	$118
Northern Territory	$156
National average	**$113**

In NSW, CMH accounts for **35%** of the total NSW public mental health care expenditure, which is below the national average of **39%**.[xi]

Proportion of public mental health spend

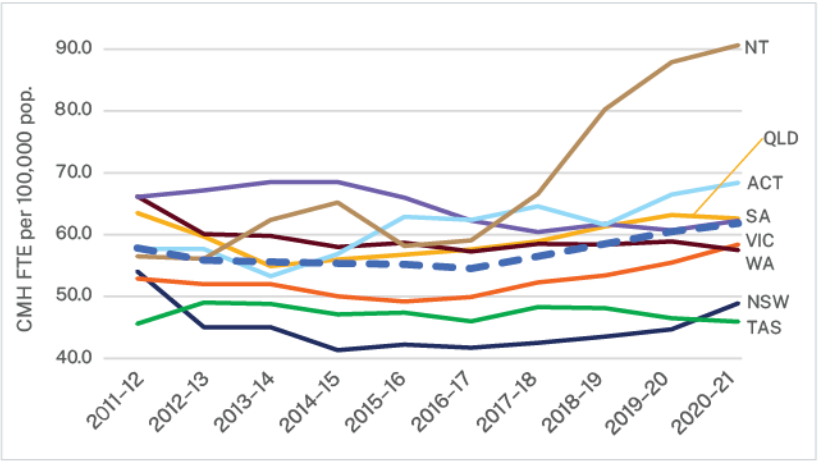


CMH staff decreased in the past decade[xii]

CMH staff FTE per 100,000 population declined from **54.1** to **48.9** in the past decade.

Between 2012-13 and 2019-20 NSW had the **lowest CMH staff FTE** per 100,000 population. In 2020-21 staff FTE per 100,000 population increased, however NSW is the **second lowest nationally**.

NSW CMH FTE per 100,000 population - past 10 years



CMH staff FTE per 100,000 population, 2020-21	
Tasmania	45.9
New South Wales	48.9
Victoria	58.4
Queensland	62.6
Northern Territory	90.7
National average	**56.6**

For further community mental health data including tables, charts and commentary see *Appendix E1.1.1Appendix E*

For a reference list, see *Chapter 3 - Infographic Reference List*

Chapter 3 - The key priorities

Through the thematic analysis of the issues raised from the consultations and reviewing the literature, several consistent themes emerged. These themes have been synthesised below into four key priority areas. These areas depict experiences of community mental health services, identify system issues and highlight the interplay between public mental health services and other service providers.

Each of the *four key priority* areas below are discussed in the Report and are broken down into **Findings** – which includes evidence from the consultation thematic analysis, literature and other data sources, and **Context** – which includes examples of what is already being done to address the key priority.

Four key priority areas identified:

1) **Enhanced funding for community mental health services – including:**
    - Community Mental Health Team capacity
    - Vulnerable priority groups
    - Service Navigation
    - Interface with Primary Health Care
    - Physical Health Care

2) **Workforce and Training – including:**
    - Workforce shortages (recruitment and retention challenges) across all disciplines
    - More support for targeted workforce groups
        - Peer Workforce
        - Aboriginal Mental Health Workforce
        - Psychiatry Workforce
    - Education and Training

3) **Emergency mental health care – including:**
    - Improve and expand emergency mental health co-responder models
    - Emergency Mental Health Care in Emergency Departments

4) **Expansion of Psychosocial Supports**

Priority 1 – Enhanced funding for community mental health services

Summary

Community Mental Health Services need to be **strengthened** as teams are under significant pressure to meet service need. Teams are managing **high numbers of referrals** and **high caseloads**. Service **eligibility criteria** and appropriate supports are viewed as being too narrow and consumers should have access to a **broad range of services** and therapies dependent on their individual needs. Funding has been directed to **vulnerable priority groups** over time, however access to these specialist services is not always equitable within and between districts. **Service navigation** can be challenging for consumers, better integration between Commonwealth, State, CMO and other health providers will support **seamless service delivery**. Better **collaboration and communication** between inpatient, primary health care and community mental health services is also required. **Families and carers** should be more meaningfully included at both a system and individual levels. **Rural and regional** mental health consumers experience additional challenges accessing care due to service availability, distance and isolation.

Community Mental Health Team capacity

Findings

A key priority arising from the consultations with LHDs, SHNs and other stakeholders is the need to strengthen acute community care teams and ongoing community teams that operate within 'Community Mental Health Teams' or CMHTs. While a range of alternative valuable community-based initiatives exist, the effectiveness of our public mental health system rests on the functioning of our CMHTs, which are funded and run out of LHDs and SHNs.

The sector and the system have consistently communicated that CMHTs must be multidisciplinary including Aboriginal Mental Health Workers, Mental Health Nurses, Peer Workers, Psychologists, Occupational Therapists and Social Workers with support from a Psychiatrist; be consistent and equitable in their eligibility criteria, accessible, and adequately funded across the state. While there has been some investment over the past five years in specialist services (for example, Safeguards teams), there has not been a significant standalone funding boost to bolster CMHTs.

These teams perform a vitally important role, and when properly resourced and staffed, are extremely effective at keeping people safe in the community and out of hospital. The model of assertive outreach allows for active care coordination and the provision of intensive interventions for people living with serious mental illness.

The target group for CMHTs are people with a persistent and serious mental illness, who may have experienced long hospital stays or recent discharge, and frequently experience co-morbidities such as alcohol and other drug issues and psychosocial issues such as homelessness. This cohort would benefit from frequent and intensive care and treatment; these benefits include shorter and fewer hospital admissions, greater patient satisfaction, reduced severity of psychiatric symptoms and improved general functioning. [1]

A strong theme from consultations, and outlined in previous reports such as *The NSW Mental Health care system on the brink: evidence from the frontline,* is that as a result of under-resourcing, CMHTs may focus on serving patients on Community Treatment Orders (CTOs) or provide short term crisis intervention.[2] Many

LHDs through the consultation process have emphasised the importance of increased funding and upskilling CMHTs across adult, older persons, child and adolescent and youth services.

A key concern is that the acuity and complexity of those who are sub-threshold for care at a CMHT is rising, suggesting capacity constraint is a factor.

The under-resourcing and capacity constraints of CMHTs has been further investigated using National Mental Health Planning Services Framework (NMHSPF) epidemiology.[3] *Table 1 – CMH service provision and demand in 2020-21* below demonstrates that in 2020-21, CMH service provision in NSW only accounted for 71% of NMHSPF estimated population in the 'severe' category for 25-64 year olds.

NMHSPF estimates that approximately 2.6% of the population aged between 25 and 64 years will have some form of severe mental illness requiring care, equating to around 200,000 people in NSW in 2020-21. However, AIHW data shows that in 2020-21, CMH services in NSW were provided to 146,498 patients (which includes 18-64 year olds, and may also include assistance provided to children, adolescents or older people and forensic health services).[4] This indicates a possible under-servicing of the 'severe' population of approximately 29%. Based on this, it is possible that at least 58,000 people in NSW are not receiving the services that they require. The level of under-servicing of those who require mental health services may even be greater, as the NMHSPF estimate does not include those in the younger and older age groups, nor individuals with 'moderate' mental illness.

By applying similar methods to other states and territories (in the same period) it can be seen that Victoria serviced 80,500 CMH patients (severity not specified). The calculations in Table 1 indicate that Victoria is only meeting 48% of the expected NMHSPF demand, while Northern Territory exceeded provision to the expected demand (129%). Three states and territories provided services to between 95% to 100% of the expected population (ACT, WA, and SA). It is likely that different states and territories have different methods of identifying community mental health clients, however AIHW data is released as being nationally comparable and representative.

Table 1 – CMH service provision and demand in 2020-21

State / Territory	ABS Pop ('000), 2020-21	NMHSPF estimated demand for CMHC in 'severe' category	CMHC Patients (severity not specified) 2020-21	% of demand met for 'severe' category, NMHSPF estimate
New South Wales	8,072.163	207,212	146,498	71%
Victoria	6,503.491	166,945	80,500	48%
Queensland	5,156.138	132,358	113,493	86%
South Australia	1,781.516	45,732	43,860	96%
Western Australia	2,660.026	68,283	67,654	99%
Tasmania	557.571	14,313	10,158	71%
Northern Territory	232.605	5,971	7,711	129%
Australian Capital Territory	454.499	11,667	11,579	99%
Australia	25,422.788	652,603	481,453	74%

The importance of the biopsychosocial model of care was also emphasised in the consultations, which includes non-pharmacological therapy when possible. A respondent suggested there "*needs to be a greater focus on psychological and social interventions such as Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT) groups along with psychoeducation that would assist sustained recovery*".

Better inclusion of families and carers was also highlighted through the consultations. Families and carers can be are critical with supporting consumers, their wellbeing and their connection to the community. Family and carers should be meaningfully included (when agreed by consumer) at both a system and individual level for example within assessment, care planning and discharge planning.

The consultations also identified the importance of continuity of care, and research suggests lack of continuity of care can result in social isolation, economic hardship, and threats to quality of life.[5] Participants noted improved integration and communication between inpatient and community mental health services are important.

Physical spaces and physical environments where mental health care is provided were observed to be inconsistent, from new, modern purpose built facilities in some locations, to other services operating in facilities built over 50 years ago that have not been refurbished or services operating from re-purposed older buildings. It was reported this inconsistency impacts teams' ability to offer some services; for example, availability of rooms to run group therapy.

A number of respondents also noted CMH Services are now being delivered on hospital sites and saw this as a disadvantage as some consumers find it traumatising to come back to the hospital to see their CMHT. There was general agreement through the consultations that CMH Services should be delivered in standalone premises, away from hospitals in a non-stigmatising location like a shop front. Further work is needed to understand how locations of care effect experiences and quality of care.

Respondents suggested there should be better access to 'step up step down' services and intermediate models of care locating sub-acute services in the community. Respondents also advocated for an increase in the Peer-Supported Transfer of Care (Peer-STOC) initiative that provides additional person-centred and recovery focused supports to individuals with complex mental health needs during their transition to home or community after an inpatient admission.

Context

What are NSW Health Community Mental Health Services?

NSW Health Community Mental Health Services are the ambulatory (not inpatient/bed based) component of the NSW public mental health system. They are delivered by LHDs and SHNs, often separated from a hospital campus, in the commercial or community hub of the locality they serve. These services are usually organised around serving one or more local government areas (depending on the catchment population). Local CMHTs include nursing, medical, peer worker and allied health staff. Usually, tasks are divided between smaller groups of clinicians who manage intake, perform initial assessments, care coordination for individuals with complex needs, and work with long-term consumers utilising a rehabilitation model. Community Mental Health Services are declared facilities under the NSW *Mental Health Act 2007*, which means that they can provide involuntary community care under a Community Treatment Order.

In 2020-21, NSW Health provided:[6]

- 2688 public specialised mental health hospital beds (33.3 per 100,000 population), providing 844,836 patient days of service (104.5 per 1,000 population)
- 11,027.4 Full-time Equivalent (FTE) staff (136.4 per 100,000 population, including 125.9 FTE consumer workers and FTE carers)

- 11,914 supported housing places (23.7 per 100,000 population)
    - 3.4 million CMHC care service contacts to 146,498 consumers (17.9 consumers per 1,000 population).[7]

NSW Health supports a range of community mental health organisations to provide mental health and wellbeing supports to the NSW community through the Ministerial Approved Grants (MAG) program. In 2021-22, $172 million was committed to the program across the state. Activities funded through the Program have contributed to the achievement of current NSW Health priorities, strategies, and policies across Aboriginal health, aged care, chronic and disability care, community transport, drug and alcohol, children and families, mental health, palliative care, population health, women's health, and other priority areas. Mental Health organisations funding through the MAG Program include BEING (Mental Health Consumers), Mental Health Carers NSW, and the Mental Health Coordinating Council (the peak body for the CMO mental health sector).

For a list of Community Mental Health services provided see Appendix F

Vulnerable priority groups

Findings

There was broad agreement during the consultations that some groups in the community experience significant inequities in accessing health services, and improving equity in terms of access and health outcomes for vulnerable populations is a key priority. A number of groups have been identified:

- Aboriginal people
- People experiencing a mental health crisis including those experiencing self-harm and suicidal ideation
- Families and carers of mental health consumers
- Those in the perinatal period
- Sexuality and Gender Diverse People (LGBTIQ+)
- People with an Eating Disorder
- People from culturally and linguistically diverse (CALD) populations
- People with disabilities
- Children and young people
- Older people
- People in contact with the Justice System
- People with co-occurring mental health conditions and Alcohol and Other Drug use disorder
- People living in regional and rural NSW

It was noted through the consultations that although funding has been directed to these groups over time, access to these specialist services is not always equitable within districts and between districts. It was suggested "*all areas should have the same sort of service options available*". Districts and Networks identified investment opportunities across the range of sub-population priority groups.

Context

Over recent years significant investment in services for priority groups has been supported as demonstrated by the following examples:

Vulnerable Populations funding (approximately $22 million annually from 2020) is provided to LHDs (based on need and demographics) for assertive community care to help focus on providing care in the community rather than in hospital. The program successfully funded 180 additional specialists, community-based mental health clinicians and peer support workers. These health professionals work in a range of clinical areas including Child and Adolescent Mental Health Services, Intellectual Disability, Forensic Mental Health, Aboriginal Mental Health, and Older Persons Mental Health. This funding allows for additional mental health clinicians to care for patients in the community which significantly enhances the capacity of services across the state.

The **Towards Zero Suicide** (TZS) package includes the Building on Aboriginal Communities' Resilience initiative. This supports Aboriginal Community Controlled Health Organisations (ACCHOs) to deliver community designed and led programs to local Aboriginal communities across NSW and increase access to culturally responsive suicide prevention activities. 25 ACCHOs are currently funded under the initiative. TZS also supports mental health and wellbeing initiatives for trans and gender diverse people, including $2,185,750 to ACON for a suicide prevention program.

Service Navigation

Findings

Through the consultations, issues around navigating mental health services was identified as a key priority area. Difficulty in mental health service navigation has an impact on service access for those in need of mental health support services. Accessibility and knowledge of available mental health services is essential for people to receive the support, care and treatment they need to improve mental health outcomes. When services are not accessible there can be significant and long-lasting consequences for individuals, their families and friends and the broader health system.[8] Good referral pathways connect individuals with the right services to improve their outcomes.

There are many pathways which can lead to an initial assessment by a CMHT. These include referral by General Practitioners (GPs), Emergency Departments (EDs), private mental health practitioners, mental health inpatient units (in the case of a discharged consumer), other medical specialists (such as a paediatrician or a geriatrician) and some consumers self-refer. Referral from external agencies to NSW Health is usually by contacting the NSW Mental Health Line service.

A lack of integration of services and different assessment processes among the various service providers (Commonwealth, state and CMO services) was identified in the literature as contributing to service navigation complexity.[9] These service coordination issues often lead to confusion among consumers about how to enter and move between services.[10] A main theme identified in this area was that a more coordinated mental health system would assist in a seamless delivery of services to improve service navigation for the consumer, including navigating out of care.

Navigating the mental health service system is particularly challenging for people who are attempting to access services for the first time and do not have any prior links with service providers, as well as the existing stigma associated with seeking help for the first time. In a recent survey by BEING, ease of service navigation of community-based mental health services was rated poorly.[11]

Access and navigation can be even more difficult for Aboriginal people, people from CALD communities, and people living in rural and remote areas, who experience additional social, cultural and geographic barriers. In particular, Aboriginal people experience discrimination, communication issues with healthcare professionals, a lack of affordable transport and healthcare services and a lack of culturally appropriate services and information on available services.[12]

Another main theme arising from the consultations was the need for improved and expanded navigation services (for example, peer-led navigation services). This service could assist with cross service boundaries to help people navigate a diverse and complex system and provide information about the types of services available. The Mental Health Commission of NSW also identified a critical need to enhance referral pathways and facilitate connections to appropriate services and supports. The Commission's *Peer Navigation: Desktop review* report found that peer navigators can have a very positive impact on people with moderate-to-serious mental illnesses and that they benefited from the peer navigator's acquired knowledge of systems and services.[13]

Context

Recognising the complexities of the mental health system (detailed earlier in this report), the Mental Health Line (1800 011 511) aims to support consumers to navigate NSW mental health services. GPs can support the referral to other services, and Primary Health Networks (PHNs) fund tools to help people navigate the system.

There is a recognised need to improve the NSW Mental Health Line service model and NSW Health is investigating options to enhance this service.

There are a range of directories and online supports available, funded through and delivered by the Australian and state governments, private providers and CMOs. For example:

- WayAhead directory: Database of mental health services in NSW
- Ask Izzy: Website that connects people in need with housing, a meal, money help, domestic and family violence support, counselling services, etc.
- Head to Health: Find online mental health supports
- Virtual psychologist: Online mental health support for people living in rural and remote Australia
- Carer Gateway: Information for Carers on accessing help for the person they support
- Health Direct: Access health information and advice 24/7 (jointly funded by the Commonwealth, state and territory governments) for all Australians.

Telephone help lines, and more recently online chat services, are often the first point of contact for people experiencing mental distress. These services are convenient, accessible and effective at providing a quick response to people in urgent need of assistance. People reach out for a range of reasons, including for advice and support for themselves or loved ones, or to find out what mental health services are available in their local community. The provision of digital services and online services to assist in navigation may help address accessibility barriers, particularly for low cost, low risk, and easy to access services. These services can increase choice for people, allow them to access the treatment they need in a way that is convenient, and complement other face-to-face treatments.[14]

The Mental Health Commission of NSW have conducted a Peer Navigation Project to examine whether peer navigators could leverage their experience, community connections and familiarity with local services, to

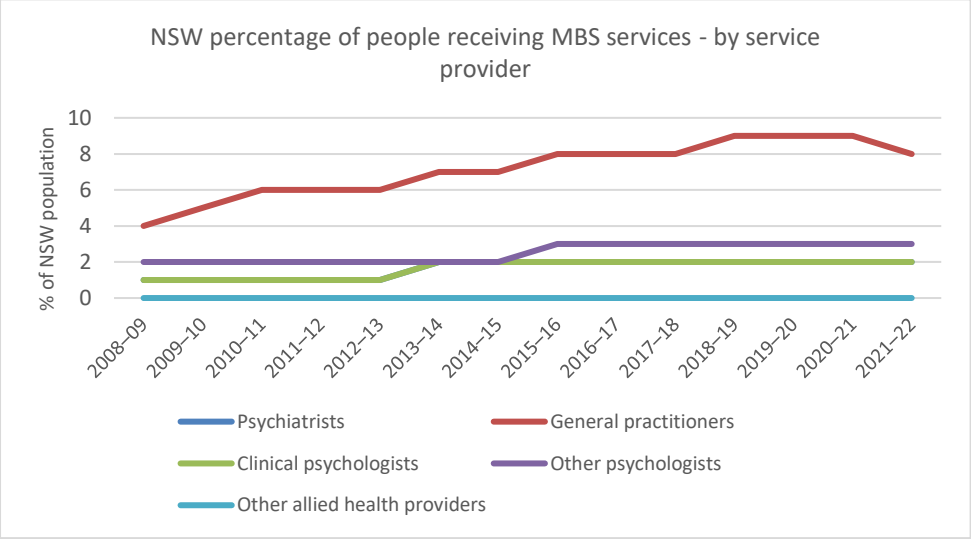
help others access the most suitable care and support. Four pilot peer navigation sites were funded by the Commission to help people better understand what support is available in their community and take a 'no wrong door' approach to care. These peer navigators provided support, coaching and mentorship to people with mental health concerns, not only connecting them to relevant services for ongoing mental health support but also services that can assist with employment, transport and housing.

Interface with Primary Health Care

Findings

Primary health care is often the first point of contact with the health system when people seek help for a mental health issue. Primary care includes services such as general practice, private psychiatrists and private psychologists. GPs play a vital ongoing role in providing mental health care services, often supporting both the consumer's physical and mental health conditions concurrently. GPs can provide mental health assessment, treatment and discuss treatment options (including medication), create a mental health treatment plan, and provide referrals to other mental health services. As can be seen in the figure below, GPs provide Medical Benefits Scheme (MBS) subsidised mental health services to more people in NSW than other mental health service providers, and this has been increasing over the past 10 years.

Figure 1 - Percentage of People in NSW receiving MBS Services by Service Provider



Source: AIHW Mental Health Online Report: Medicare-subsidised mental health-specific services (Table MBS.4)

The National Standards for Mental Health Services 2010[15] emphasises the importance of continuity of care so that consumers can move between services as their needs change, ensuring they receive the most appropriate service at any time. GPs play a crucial role in the continuity of care of mental health consumers primary care needs which leads to better health outcomes.

Through the consultations shared care between GPs and CMH Services was identified as a key area for improvement. It was highlighted that better communication between providers is needed. This includes sharing of information, developing shared treatment plans and simpler referral processes. Of critical concern was the coordination of care across care settings and levels of acuity. As described by one participant: *"There is a need to recognise that GPs are delivering the majority of mental health care, and the majority of prescribing [of medication], while community mental health do not have systems to share information or*

escalate cases or coordinate support around one person". This suggests improvements are needed to allow for better sharing of information between CMHTs and GPs to allowing for effective liaison and communication when caring for the same consumer.

Context

GP shared care is a model of care in which a GP and a mental health service work together to provide care to a patient with mental health issues. It involves the GP and the mental health service sharing responsibility for the consumer's care, with the GP providing most of the consumer's primary care, and the mental health service providing specialist support. A shared care model clearly specifies which service will be responsible for identified aspects of their physical health care. The consultations noted that Central and Eastern PHN currently provide a mental health shared care program which support the recovery and physical health of consumers whose care is shared by a GP and the District (available at Sydney LHD, South Eastern Sydney LHD, and St. Vincent's Health Network Mental Health Services).

The Youth Mental Health Initiative in partnership with Headspace (funded through the Bilateral Schedule on Mental Health and Suicide Prevention) is an example of good service integration. LHDs will be funded to provide complementary specialist care to young people presenting to headspace services with severe and complex mental health needs through this initiative.

Physical Health Care

Findings

People with a lived experience of mental health issues should enjoy the same rights, opportunities and health as the general population. However, when compared with the rest of the NSW community, people living with mental health issues face poorer physical health outcomes, shorter lifespans and more frequent experiences of stigma and discrimination.[16]

Throughout the consultations concerns were raised in relation to both GPs and LHDs in meeting the physical health needs of people with mental health. These concerns/observations include:

- Lack of consistent physical health monitoring, particularly for consumers on some medications
- Main focus is often the mental health issue, and physical health is overlooked
- Consumer's engagement can be limited in terms of their own physical health needs
- Limited integration of mental health and physical health services
- Dieticians and Exercise Physiologists should be core part of Multidisciplinary Teams.

Context

NSW Health has developed the Physical Health Care for People Living with Mental Health Issues Guideline. A whole of health approach to support the physical health of people living with mental health issues. A Physical Health and Mental Health Forum was held in 2022. This was an important activity that aided in the promotion of the Guideline and provided an opportunity to share practice improvement projects and learnings. In addition, a resources webpage has been published (Physical Health Webpage), this page supports the implementation of the Guidelines and includes resources, tools, and videos designed to assist with implementation. A Physical Health and Mental Health Project Grants Program was held during 2022-23, open to all Districts and Networks.

NSW Health has also established the *Mental Health Living Longer* data linkage project, which is Australia's largest ongoing data linkage aimed at understanding and reducing premature mortality in people who use NSW mental health services.[17]

Priority 2 – Workforce and Training

Summary

Significant **workforce shortages** across the mental health workforce is a critical gap impacting effective service delivery. Shortages are further exacerbated by **high staff turnover**, **high vacancies** and **low retention rates**. The most critical areas to address are the **Peer, Aboriginal and Psychiatric** workforces. **Education and training** of the workforce is also a key priority, as this supports a skilled and competent workforce and aids in staff retention and attracting new staff to the sector.

Workforce shortages (recruitment and retention challenges) across all disciplines

Findings

The activities of the mental health workforce include promotion, prevention, early intervention, treatment and recovery. This workforce consists of people who work exclusively in the mental health sector, such as psychologists, psychiatrists, mental health nurses, Aboriginal mental health workers, and peer workers. It also includes those that work in other health settings who frequently treat, interact with, care and support people experiencing mental health issues, such as allied health, GPs and nurses.[18]

Figure 2: Overview of the Mental health Workforce, 2021

Source: Workforce - Mental health - AIHW[19]

Both in the consultations and literature reviewed, significant shortages across the mental health workforce was emphasised as a crucial gap impacting effective service delivery. The *Productivity Commission Inquiry Report - Mental Health* (2020) identified critical shortages in many professions including: psychiatry, psychology, mental health nursing, and other relevant allied health professions.[20] A lack of a skilled and available workforce directly impacts upon access to early intervention and assessment and to capable and skilled teams for clients with acute and complex needs, such as first episode psychosis or acute mental health crisis care.

The Australian Government, universities and TAFE, professional bodies (e.g colleges), peak organisations, and NSW Health all have a role to play in building the mental health workforce. The extent of mental health workforce shortages was quantified in the *National Mental Health Workforce Strategy 2022-2032* using the NMHSPF. An estimated mental health workforce shortfall of 32% was found using 2019 NMHSPF targets. This shortfall is expected to grow to 42% by 2030 if current shortages are not addressed. These NMHSPF targets show a moderate under-provision in FTE across nearly all mental health workforce categories, with the largest relative gap for:

- Psychologists (35% of the NMHSPF target)
- Indigenous mental health workers (37% of the NMHSPF target)
- Consumer and carer peer workforce (5% and 14% of the NMHSPF target respectively) [21]

Publicly reported supply forecasts and projections for the psychiatric workforce is limited. The most recent publicly reported projections were sourced from the *Psychiatry Factsheet,* by the *Department of Health, 2016,* using Australia's Future Health Workforce dataset. It reported nationally, demand for psychiatrists will exceed supply, with a projected shortage of 74 FTE psychiatrists in 2025 and a shortfall of 124 FTE in 2030.[22]

The *National Mental Health Workforce Development Strategy 2022-2032*[23] identifies the following key workforce challenges:

1. Workforce shortages
2. An overarching increasing demand for services
3. Workforce maldistribution, particularly in regional, rural and remote areas
4. Stigma and negative perceptions associated with working in mental health
5. Limited availability and use of high-quality data to inform workforce planning

Further exacerbating and contributing to workforce shortages is high mental health service staff turnover, identified through the consultations. Literature also supports this finding – the *NSW mental health care system on the brink report (2023)*[24] interviewed 1,300 frontline mental health workers and found that the mental health workforce is under pressure and feeling unable to meet the growing demand for services. These workload issues are leading to high staff turnover, difficulty retaining and recruiting staff, and low morale (and is particularly pronounced in rural areas).

Workforce shortage issues are also affecting the amount of face-to-face time the workforce spends with consumers. Feedback indicates concerns that face-to-face time is lower than expected in the public sector due to high levels of vacancies and demanding administration requirements.

The NMHSPF assumes that 67% of clinician time in the public sector is spent on consumer service delivery time.[25] This includes any time spent on an activity directly relating to an individual (e.g. face to face care, writing notes, individual care planning and liaison). All other non-individually focused time is considered 'Other Time'. This includes travel, professional activities (meetings, evaluation, performance monitoring, supervision, training), business meetings, service evaluation, program planning and research.

Context

The recently released *National Mental Health Workforce Strategy (2022-2032)* aims to attract, train, maximise, support and retain an appropriately skilled, motivated and coordinated mental health workforce to meet the evolving needs of the mental health system into the future. NSW Health is represented on the

Mental Health Workforce Advisory Group tasked to oversee the implementation of the Strategy and consider workforce specific clauses under the *National Mental Health and Suicide Prevention Agreement*. It will also facilitate collaboration across governments, portfolios, and the broader sector. This will help ensure investments and reforms are not fragmented or undertaken in isolation of other relevant health workforce strategies and initiatives.

The Strategy Implementation Roadmap[26] includes addressing critical medical, nursing and allied workforce shortages with an initial focus on priority professions as agreed in the National Agreement – psychiatry, psychology, mental health nursing, and other relevant allied health professions within one to two years. The Roadmap also notes as a priority to examine innovative service delivery models that support increased engagement of the Lived Experience (Peer) and First Nations (Aboriginal) workforces in different contexts.

By increasing access to clinical supervision and quality mental health placements and traineeships, the Strategy provides an opportunity to increase workforce supply. Reviewing the supply of mental health training placements and encouraging the mental health and education sectors to support placements will also reduce training bottlenecks. Raising awareness of training pathways to encourage students, graduates and existing clinicians to choose careers in mental health is also included in the Strategy.

In implementing the Strategy, the Australian Government will work with state and territory governments, peak bodies and professional colleges to explore opportunities to improve training and registration pathways and identifies actions and areas where collaboration is needed across the sector and governments.

A key strategic outcome in the NSW Health strategy: Future Health 2022-2032 is a fit-for-purpose workforce with the capabilities to deliver the vision: *"Our staff are engaged and well supported: Our people are supported to deliver safe, reliable, person-centred care driving the best outcomes and experiences."*[27] To realise this outcome The NSW Health Workforce Plan 2022-2032, The NSW Health Talent Strategy 2022-2032 and the NSW Regional Health Strategic Plan 2022-2032 provide a framework for the implementation of the workforce-related strategies across the health sector and to improve talent management. The strategies promote collaboration with tertiary education providers and other relevant bodies to align curriculum and training pathways to current and future health needs. They also address workforce issues that are specific to regional, rural and remote communities.

There are critical shortages in nearly all mental health workforce areas which need to be addressed. However, three workforce groups were raised consistently in the consultations and emphasised in literature. These are the: *Peer workforce, Aboriginal workforce and Psychiatrists*. Due to the specific attention these groups have received, they are discussed in further detail below, while NSW Health remains aware that gaps in other workforce groups also require attention.

More support for targeted workforce groups

Peer Workforce

Findings

The value of the peer workforce is recognised in several national strategies and guidelines. The National Lived Experience (Peer) Workforce Development Guidelines identified that *'a thriving mental health Lived Experience (Peer) workforce is a vital component of quality, recovery focused mental health services*.[28] The *National Mental Health Workforce Strategy 2022-2032* also noted that *'the Lived Experienced (Peer)*

workforce is an integral part of the mental health workforce, with valuable skills and experiences that assist consumers of mental health services and their families, carers and kin, on their recovery journey'.[29] These Guidelines also note that a national peak peer workforce organisation could support the development of professional leadership for the peer workforce.[30]

One of the main gaps identified in the interviews was the need to build the peer workforce in all areas of mental health service provision. Another theme and potential opportunity identified was that the development of this workforce has the potential to alleviate workforce shortages, and help drive a cultural shift towards more consumer-centred care and reduce stigma and discrimination.

The critical need to increase support for the current and future peer workforce was a consistent theme identified in the consultations. These supports include:

- Building capacity and workforce numbers
- Improved career pathways
- Appropriate renumeration
- Setting peer workforce targets
- Standardised peer workforce activities, reported within record management systems
- A Peer Workforce Community of Practice, including a database to connect Peer Workers
- Peer leadership including amongst peer, in governance structures and throughout the mental health system.

Context

NSW Health is developing the *NSW Peer Workforce Framework* to support ongoing development of the mental health peer workforce. The Framework aligns with the previous *NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022*. Currently NSW employs over 230 peer workers. [31]

NSW Health supports the professional development of the peer workforce through the funding of Certificate IV Mental Health Peer Work scholarships administered by the Mental Health Coordinating Council. Continuing professional development is supported by the annual Consumer Workers' Forum, the Intentional Peer Support training, and by the Peer Workforce Coordinator role. The NSW Consumer Peer Workforce Committee, comprised of LHD peer workers, provides support and advocacy for the public mental health peer workforce. The NSW Government also funds BEING to run the annual Consumer Workers' Forum.

The Ministry is currently reviewing consumer engagement processes, including the role and purpose of the Consumer Sub Committee of the Mental Health Program Council. This will be done in consultation with consumers, Mental Health Commission, ACI, and BEING.

NSW Health currently monitors and reports on the growth of the peer workforce – a performance indicator is included in District and Network Service Agreements. Peer work positions are also considered when new programs are established. Peer workers are supported to access professional development through regular forums, peer supervision training, and scholarships for the Certificate IV Mental Health Peer Work.

Aboriginal Mental Health Workforce

Findings

Aboriginal people experience a higher rate of mental health issues than non-Aboriginal people (deaths from suicide are almost twice as high, hospitalisation rates for intentional self-harm are 3 times as high, high/very high psychological distress rates are 2.4 times higher).[32] However, it is difficult to determine if mental health service usage by Aboriginal people is as high as need, potentially due to service access and cultural safety issues. In addition, the inadequacy and inequity of mental health care for Aboriginal people has been extensively reported by leading Indigenous mental health researchers and advocates.[33]

Given these mental health service access and quality issues for Aboriginal people, an adequate, sustainable Aboriginal mental health workforce is critical. Aboriginal Health Workers can play a crucial role in improving access to mental health care through community liaison and engagement, advocacy, health promotion and education, culturally safe services, cultural education and brokerage, community development and disease prevention.[34]

Context

Aboriginal workforce development in NSW Health is a priority. The overall representation of Aboriginal people employed in mental health services in NSW Health was 168 in 2022. An investment of $21 million ($3 million in first year then $6 million recurrently) was made by the NSW Government in 2021 under the Mental Health Recovery Package to expand the Aboriginal workforce by employing peer workers and care navigators. The Mental Health Branch is leading two initiatives for Closing the Gap in partnership with the Aboriginal Health and Medical Research Council and Centre for Aboriginal Health. Both initiatives include opportunities to improve and strengthen Aboriginal workforce in NSW. These projects are targeted to the ACCHOs, LHDs, and SHNs.

Aboriginal mental health trainees

NSW Health is addressing the issue of developing a stronger Aboriginal workforce through the *NSW Aboriginal Mental Health Workforce Training Program*. This mental health traineeship program aims to ensure the provision of accessible, culturally appropriate mental health services to Aboriginal people. The objectives of the program are to:

- Increase the number of qualified Aboriginal Mental Health Professionals in the workforce
- Increase the knowledge of mental health services staff about health beliefs and needs of Aboriginal people
- Improve the responsiveness of mental health services to the needs of Aboriginal consumers
- Improve the effectiveness of mental health services, including promotion, prevention, early detection, intervention and treatment for Aboriginal people and communities
- Increase the number of Aboriginal people accessing the range of mental health services.

Twenty-seven Aboriginal mental health trainees are currently employed in LHDs and SHNs in 2023.

Psychiatry Workforce

Findings

Consultant psychiatrists make up about 10% of the NSW Health mental health workforce. A minimum of five years full-time advanced training through the *Royal Australian and New Zealand College of Psychiatrists* is required to specialise as a psychiatrist. Since 2013 the number of psychiatrists in NSW has grown 19%, to 1,091 in 2018. Psychiatrists in NSW most commonly work in private practice (36%), then in the public sector (30%), and the remainder work in both public and private settings.[35]

The consultant psychiatrist workforce includes Staff Specialists, trainees, Visiting Medical Officers (VMOs), and locums. The Psychiatry Workforce Plan 2020-2025 states that *"a skilled and supported psychiatry workforce is essential for maintaining safe, effective and efficient mental health care systems in NSW now and into the future".*[36]

Whilst in some areas there has been some improvement in registrar numbers throughout the life of the Plan, feedback indicates that consultant psychiatrist vacancies continue to rise statewide. Staff Specialist positions, which have a lower hourly rate but afford the opportunity for significant contribution to leadership, safety and quality and education work have been particularly difficult to fill. However, VMO roles (which pay at a higher rate but are more focused on clinical contact only) are also now increasingly difficult to fill. The result is that, even in inner metropolitan Sydney, services are dependent on the most expensive model (locum coverage) to allow for services to remain open. This comes at the expense not only of premium labour, but continuity of care.

The Royal Australian and New Zealand College of Psychiatry (RANZCP) in their recent response to the National Mental Health Workforce Strategy note that one of the biggest barriers to receiving treatment is a critical and chronic shortage of psychiatrists and mental health workers, and that treatment delays are likely to lead to mental health issues becoming more chronic, more severe, more difficult and costly to treat. The RANZCP state that "the evidence shows prevention and early intervention are the cheapest and most effective forms of mental health care."[37]

Context

Consultant psychiatrist expertise is critical in leading the multidisciplinary care of consumers utilising a biopsychosocial model. All consumers in hospital and community care have an identified responsible consultant psychiatrist as the clinician ultimately is responsible for the outcome of that care episode.

The *NSW Health Psychiatry Workforce Plan* (2020 - 2025) is a key step in growing and developing the psychiatry workforce. It identifies nine strategies to support the psychiatry workforce meet the needs of people living with a mental illness, their carers, families and kinship groups. The Workforce Plan was informed by stakeholder feedback. The aim is to support a skilled psychiatry workforce to maintain safe, effective and efficient mental health care systems in NSW now and into the future. NSW Health recognises that there is more work to be done regarding the consultant psychiatry workforce. This includes working on retaining staff specialist cover by ensuring LHDs and Networks provide the aspects of these roles that make them attractive (e.g. clinical leadership work), while also considering approaches to staff specialist Award reform.

Education and Training

Findings

There is a close relationship between professionals having access to appropriate, high-quality support and mental health workforce retention.[38] Participants in the interviews noted that access to high quality staff training can both support a skilled and competent workforce as well as being a key retention strategy.

Targeted training areas suggested through the consultations included training in a strengths-based approach, open dialogue and increased knowledge in negotiation and de-escalation techniques. Trauma-Informed Care training was specifically highlighted as a priority training area.

Context

Foundational education and training for Australian Health Practitioner Regulation Agency (AHPRA) registered clinicians (e.g. nursing staff, most allied health professions and medicine) and some non AHPRA registered professions (e.g. social work) is established by the appropriate undergraduate degree, which is required prior to employment. Postgraduate qualifications are often achieved prior to or during employment with NSW Health.

The further education and training of the mental health workforce sits across multiple entities. The NSW Health Education and Training Institute (HETI) has primary responsibility for providing further education and training programs to meet the needs of NSW Health staff. Staff can also undertake postgraduate mental health courses in Applied Mental Health Studies and Psychiatric Medicine at Graduate Certificate, Graduate Diploma and Masters levels with a number of scholarships and grants to support the workforce.

In addition, training is coordinated through the LHDs and Networks, including the utilisation of mental health nurse educators to advance clinical knowledge within mental health teams.

Several Communities of Practice (CoPs) have also been established to support different workforce groups or content areas. Some examples are:

- The *Aboriginal Mental Health Social Emotional Wellbeing CoP* which offers cultural support for the Aboriginal Mental Health Workforce
- The *ACI Trauma-Informed Care CoP* which aims to support the implementation of the Trauma-Informed Care Framework
- The *Perinatal, Child and Youth Hub*, a SharePoint site which provides a CoP hosting information and resources to assist with service implementation and quality improvements. It targets NSW Health staff working across the lifespan and is accessible to all health staff.

The ACI have developed the Trauma-informed care in mental health services across NSW: A framework for change. In addition, NSW Health have released an Integrated Trauma-Informed Care Framework: My story, my health, my future that brings together elements of trauma-informed care and integrated care to enhance the experiences of clients and their families and carers accessing NSW Health Services. Trauma-informed care is an approach to healthcare service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage. There is a high prevalence of trauma in the lives of people accessing mental health services.[39] Adopting a trauma-informed care approach has the potential to reduce the use of seclusion and restraint and other coercive practices; enhance therapeutic relationships and their basis in trust, collaboration, respect and hope; and improve outcomes and value.

Priority 3 - Emergency mental health care

Summary

Police alone are not the most appropriate responders to all **emergency mental health situations.** Co-responder models aim to provide **safe outcomes** for all involved. Alternative co-responder models are being investigated. Emergency mental health care should be provided in the **least restrictive setting** and **reduce pressure on EDs**. There has been an **increased in mental health presentations** to EDs, with higher levels in rural and regional areas, this is attributed to the **lack of alternative supports** in the community with EDs becoming, at times, the default access point into the mental health system.

Improve and expand emergency mental health co-responder models

Findings

Forty three per cent of critical incidents over the last five years involved an interaction with a person in mental health crisis.[40] Critical incidents are police incidents which involve a police force member which "results in the death of, or serious injury to, a person (including another police officer)".[41] The percentage of police call-outs to mental health crises is estimated to be between 10—30%.[42] The need for an improved response to emergency mental health situations involving police emerged as a key theme in the consultations. A common theme arising from the interviews was that police alone are not the most appropriate responders to mental health emergencies for several reason – mainly as they do not currently have the appropriate training: *"…police shouldn't be their first point of call, a team ideally should be able to go in and talk to the consumer and use those skills to be able to get the consumer to attend hospital or whatever it is that they need to do,"* and *"…better training* [is needed] *in terms of negotiating and de-escalating."*

Emergency co-responder models involving a mental health clinician have been trialled and used over the years. However, a predominant theme was the need to develop an effective model which can be used across the police force in all Local Area Commands. The aim of an emergency co-responder model would be to provide a safer outcome for all involved, provide care in the least restrictive setting and reduce pressure on EDs.

Media reports on police critical incidents in the community have led to calls to expand the Health-led *Police, Ambulance, Clinical, Early Response* (PACER) program or replace police attendances with a mental health clinical response only. NSW Police recently expressed a desire for a universal model providing 24/7 state-wide access. However, inadequacy of mental health training for police officers has also been identified as an issue.[43] There has been some confusion in the public dialogue between mental health-related callouts (involving, for example, breach of CTOs), and situations where this is an imminent risk to safety (where a police-led response is entirely appropriate).

Context

Currently the PACER program delivers an innovative approach that supports NSW first responders by providing a secondary health response to a mental health crisis in collaboration with NSW Police. NSW Health administers and funds the PACER program and LHDs are responsible for the clinical governance of each PACER program within their district. NSW Police provides in-kind support only (such as a desk, parking space and internet access). Rural and regional LHDs have adapted the PACER model, complemented with

virtual technology to enhance access due to the geographical dispersion of communities and resources. Some consultation participants viewed the PACER program as quite successful: *"…the amount of aggression and violence dropped down a lot and in fact it reduced a lot of people going to the ED."*

Through the PACER model Police can access NSW Health senior mental health clinicians, who are co-located in police stations, providing on-scene and/or telephone assistance when police are responding to these situations. Police can activate the mental health clinician who attends on-scene to assess the person's mental health needs and organise appropriate care.

However, PACER currently only operates in 17 Police Local Area Commands/Police Districts in NSW and the PACER budget is fully allocated, with no further funding available to expand the program. Evaluations conducted have also shown that improvements need to be made to the program before expanding the program.

In 2020, NSW Health engaged external consultants to conduct a formative evaluation of the PACER program. This evaluation is subject to significant limitations due to low volume of data and definitive evaluation is pending for early 2024, when a more comprehensive data set can be obtained.

Early results from the adapted virtual PACER programs using virtual technology to support first responders in rural and regional sites are very promising. Mental Health First Responder in Hunter New England LHD has seen over 100 consumers with a diversion rate from EDs at over 85%.

To address the above PACER challenges the following work is being conducted:

- the development of a statewide co-responder model of care and operating guidelines
- establishment of a Network for PACER clinicians
- an independent summative evaluation
- ongoing allocation of funding
- ongoing meetings with NSW Police considering new models of care.

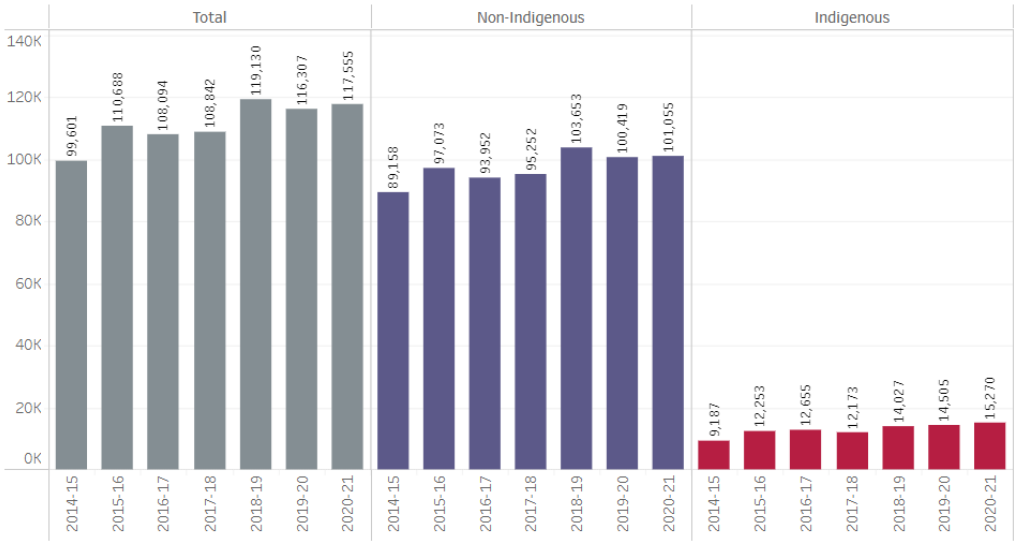
NSW Health is also currently assessing alternative models, such as the South Australian Health/Police co-responder model. Some alternative models include a Peer Workforce.

Mental Health Care in Emergency Departments

Findings

EDs are sometimes the first point of entry to the medical system, and in some communities are the only option for emergency care. In NSW in 2020-21, there were 117,555 mental health related presentations to EDs (defined as having a principal diagnosis of intentional self-harm and symptoms and signs involving cognition, perception, emotional state and behaviour) as shown in Figure 3[44]. These presentations in NSW have generally risen over the past seven years (peaking in 2018-19 to 119,130) and declining slightly in the last two years. The rate per 10,000 of Aboriginal people presenting to EDs are four times higher than non-Aboriginal people, and have risen consecutively over the last four years.[45]

Figure 3 - Mental health-related emergency department presentations in NSW (2020-21)



Source: AIHW, analysis of the non-admitted patient emergency department care (Mental Health Commission of NSW)

The *Shifting the Balance report (2022)* states that these high ED presentations demonstrates "*a lack of alternative supports within the community to support people experiencing mental health challenges at the point of crisis"*. It suggests that a large proportion of people are missing out on psychosocial support services, resulting in EDs across NSW becoming *"the default access point into the mental health system"*. To address mental health-related ED presentations, the report calls for the establishment of adult mental health and wellbeing services with extended hours and recommends that the rollout of additional adult mental health services (provided for in NSW the *National Mental Health and Suicide Prevention Bilateral Agreement)* be urgently expedited to address demand.

Using AIHW National Hospital Data (2016-17), a report commissioned by the *Australasian College for Emergency Medicine Department of Policy, Research and Advocacy* (2020),[46] found that patients presenting to ED with mental health issues:

- Wait longer than patients with a similar severity of physical illness before being assessed and treated. They are 18% less likely to be seen within the appropriate Australasian Triage Scale timeframe.
- Experience a longer period of treatment in ED, with 90% of all patients leaving ED within 7 hours, and people presenting with acute mental health crises leaving within 11.5 hours (and much higher in some states).
- Are more likely than other patients to leave the ED at their own risk – prior to their treatment being completed and against medical advice.
- Are 16 times more likely than people with other ED conditions to arrive via police or other non-health-services vehicles, and nearly twice as likely to arrive via ambulance or by helicopter rescue.
- Are more likely to be assessed by ED staff as requiring urgent care on the Australasian Triage Scale, indicating the acuity of the needs of these patients.
- Are proportionally more likely to identify as Aboriginal than other patients – Aboriginal people make up around 3% of the population, they account for 11% of all ED mental health presentations.

Stakeholder consultations also highlighted that the 'missing middle' have significant difficulties accessing mental health services, driving them to use emergency and acute services due to a lack of alternatives, which can become cyclical for them. This places additional pressure on already over-burdened ED system. As stated by an interviewee: *"there is nothing [for them] to access outside the public hospital system."* The *National Suicide Prevention Plan* supports this, noting that this group of people's needs are not being met due to a combination of factors which may lead them to overly rely on public emergency services. The 'missing middle' describes the portion of people 'whose mental health needs are too complex and enduring for primary care services but not considered severe enough to meet the high access threshold to receive public specialist mental health services.' [47]

There is also a need to expand alternatives to emergency department presentations for mental health issues, through strengthening community based intervention to avoid transport and presentations to EDs for those in mental health/suicidal crisis, which can further add to the mental distress the person is experiencing. Consultations called for these programs (such as Safe Havens or assertive community mental health clinicians within a CMHT) to be scaled up to improve equitable access across regions and longer operating hours.

Context

NSW Health is committed to ensuring that 81% of people presenting to ED will be admitted, referred to another hospital or discharged within four hours. People experiencing a mental health emergency who present to EDs should receive timely access to a mental health assessment and decision to admit or discharge them.

Activities addressing delays in EDs for mental health consumers included:

- LHDs and SHNs optimising consultation/liaison psychiatry support to EDs
- Dedicated ED mental health staff (for example, nurse practitioners)
- A review of mental health emergency care in rural areas to ensure timely assessments and decision making, as recommended in the Anderson Review into *Improvements to Security in Hospitals* (2020).[48]
- A review of mental health patient flow through EDs of NSW hospitals. The review will consider the availability and timeliness of mental health patient flow through Emergency Care services, including EDs. Recommendations from the review are due in late 2024 and will further inform the future NSW Health strategies in this area.
- ED avoidance strategies including:
    - Safe Havens (a non-clinical space for people who experience distress or suicidal thoughts). This is a TZS initiative.
    - PACER and its virtual regional counterparts who see consumers with a view to divert from EDs if safe to do so.
    - Some specific LHD initiatives including the MHAAT at Cumberland Hospital.
    - Utilisation of the Initial Assessment and Referral Tool which is a standardised clinical decision making framework.

Priority 4 - Expansion of Psychosocial Supports

Summary

Psychosocial support services are recognised to be **extremely beneficial and critical** to mental health recovery and **support people to live well in the community, connected to services, housing, employment, family and friends and social networks**. NSW Health **invests significantly** in a suite of evidence-based psychosocial programs for consumers with severe mental illness. **Two psychosocial research projects** are currently being conducted to inform future psychosocial support requirements in NSW. The results of these studies will be critical in guiding **future investment decisions**.

Findings

The provision of psychosocial supports is impacted by eligibility for NDIS supports (for the individual and their carer) and availability of supports to people whose needs do not meet NDIS thresholds but do require access to psychosocial services.

A common theme arising in consultations was that existing psychosocial supports for individuals with severe and enduring mental illness should be significantly strengthened in line with the *Productivity Commission Mental Health Inquiry Report* (2020)[49] findings. Two psychosocial research projects are currently being conducted to inform future psychosocial support requirements in NSW. The results of both studies are considered by the sector to be critical guides for future investment which should sit along-side the findings of any service mapping for community mental health services. The two projects are:

Commonwealth Psychosocial Research Project:

Under the *National Mental Health and Suicide Prevent Agreement*, the Commonwealth, State and Territory governments have committed to undertake an analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme (NDIS). *Health Policy Analysis* will conduct this analysis and a Psychosocial Project Group comprised of the Commonwealth, state and territory governments has been established to oversee this work. The outcomes of the analysis will inform future arrangements for the provision of psychosocial supports – this will include roles and responsibilities between the Commonwealth and state governments. The final report is due to be completed by March 2024.

NSW Psychosocial Research Project:

NSW Health is undertaking a separate NSW Psychosocial Research Project to identify unmet need for psychosocial support outside of the NDIS. NSW Health has engaged David McGrath Consulting to conduct this analysis using the NMHSPF.

The project is critical to the next phase of commissioning for some of the NSW Government's key community based psychosocial support programs and in the context of implementation of the National Agreement.

NSW is running a project in parallel with the national analysis of unmet need because:

- The methodology for the Commonwealth analysis will not deliver the level of detail to meet NSW's needs and the timeframes do not align with other NSW priorities.
- There is minimal opportunity for NSW stakeholders to have input into the Commonwealth research project and this has been raised as a concern by the sector in NSW.

- The NSW Project will include validation analysis of the Commonwealth project. This is critical in informing discussions around future psychosocial provision arrangements, including roles and responsibilities between the Commonwealth and states.

Psychosocial support has been identified as a key priority area as it is recognised to be extremely beneficial and critical to mental health recovery with a strong evidence base to support this. Psychosocial supports have been found to be critical in the prevention of acute crises, hospital admissions and presentations to emergency departments.[50] The *Productivity Commission's Mental Health Report (2020)* also recognised the critical role of psychosocial supports for mental health recovery. However, a gap exists in that many people who require psychosocial supports are currently not receiving them due to a lack of services provided.

Psychosocial supports are community based, recovery-oriented supports, primarily delivered by CMOs, which support people with severe and complex mental health challenges to live independently and participate in the community. These services are delivered by multidisciplinary teams, which include peer workers. Due to the benefits of psychosocial supports to mental health recovery, there has been increasing sector pressure to expand community mental health psychosocial supports to address the identified gap of unmet need. The *Productivity Commission's Mental Health Report (2020)* estimated that 50,000 people in NSW with severe and complex mental illness are missing out on psychosocial support services. The Report recommended increased funding for psychosocial supports, and one level of government solely responsible for psychosocial support, outside the NDIS.

The *Mental Health Coordinating Council's* (MHCC)response to the 2023-24 NSW Budget also recommended increased mental health support by an additional 10,000 packages, modelled on Housing and Accommodation Support Initiative (HASI) and Community Living Support (CLS), at a cost of $91.25 million a year. It also recommended expansion of 'Step-Up Step-Down' services to 2,000 places around NSW for people to avoid crisis and hospital admission (modelled on HASI Plus and Pathways to Community Living Initiative (PCLI).

Significant gaps in NSW mental health services and community supports have also been highlighted by NSW Council of Social Services[51]. To address these gaps, an expansion of specialised programs, such as HASI and CLS (as well as significant investment in 'step-up, step-down' services) has also been recommended. The MHCC recommended an additional investment of $430 million per year for psychosocial support, early intervention services, continuity of care and rehabilitation services.

Context

In 2023-24, NSW will invest more than $98 million in the NSW Mental Health Community Living Programs.

NSW currently provides a suite of evidence-based psychosocial programs to adults with severe mental illness. This suite includes HASI, CLS, HASI Plus and Mental Health Community Living Supports for Refugees (MH-CLSR). Independent evaluations of these programs have proven them to be very effective.

Evaluations of HASI and CLS[52] found that the programs are making a real difference to people's lives and in people achieving their goals. It was also identified as being cost effective – the programs generate more in cost offsets than the cost of the programs, with a net saving of $86,000 per person for the NSW Government over 5 years. Additional findings include a reduction in contact with community mental health services (by 64%), reduced hospital admissions (by 74%), reduced length of hospital stay (by 75%), near zero new

criminal charges or community corrections orders. In 2023-24, more than $80 million will be invested in HASI and CLS and will support more than 1,799 people.

Evaluations of HASI Plus found that[53] hospital admissions for mental health reduced by 56%, length of stay in hospital reduced by 80%, the average cost per person to participate in the program was significantly lower than the cost of a hospital admission or comparable programs. In 2023-24, more than $12.6 million will be invested in HASI Plus.

Evaluations of MH-CLSR found that[54] the program was being governed and delivered according to the intended model of care and that it was a valuable addition to the existing suite of community-based psychosocial support programs in NSW. An impact evaluation of MH-CLSR will commence in 2023-24. In 2023-24, over $5.5 million will be invested in MH-CLSR.

PCLI supports the transition of people severe and persistent mental illness (SPMI) who have experienced or at risk of long hospital stays (12 months or more) into appropriate community-based living. Stage 2 of the PCLI supports adults with SPMI aged between 18 and 64. An independent evaluation of the first 6 years of the PCLI by the University of Wollongong, Australian Health Services Research Institute, showed that people with SPMI and complex needs can live successfully in the community with the right level of support. The evaluation found that Stage One of PCLI has resulted in estimated annual savings of $32.8 million in care costs for the 156 consumers who had transitioned into residential aged care or home care by December 2020. The program has improved health outcomes and experiences for people with SPMI, as well as improving experiences for their families and carers. It has also improved practice and experiences of health service staff and promoted in-sectoral collaboration and partnerships. And it has delivered significant improvements in system efficiency and effectiveness, reducing hospital stays with few readmissions, and providing pathways into appropriate care in the community. Progressing PCLI Stage 2 Specialist Living Support services remains a NSW Health Priority.

Chapter 4 – System Enablers

In considering where priority gaps are in community mental health, any investment to reduce these will only be optimised if the system is set up to provide effective service administration, workforce deployment and easy navigation to the services being provided.

NSW Health are implementing a number of cross-sector projects to support service improvements, these projects will guide future activity in mental health and act as system enablers, examples of these projects are:

Time for Care

As part of the Future Health strategy, a key priority for NSW Health is improving the experience and support offered to our staff. The Time to Care initiative look at relieving the administrative burden for frontline clinicians in NSW Health. A listening tour has been conducted to better understand the frontline clinicians experience across the NSW Health System. Through these consultations seven core divers for administrative burden that reduces clinicians' time spent on patient care have been observed these are:

1. Recruiting processes require significant time for candidates, managers and directors
2. Roster management and time tracking requires significant administrative time to complete
3. Onboarding and ongoing education are not consistently available when most needed
4. System integration limitations require staff to document high volumes of sometimes repetitive information across multiple systems
5. Patient flow and communications currently depend on fragmented and ineffective channels of communication
6. Local staff are spending time adapting guidelines and checklists to the local context
7. Variability in inventory and equipment management practices.

The implementation will take 18 months with quick wins in the first three months, meaningful improvements between 3-12 months and transformational change 12 months and beyond. The Ministry will collaborate with frontline clinicians within districts and networks, state-wide services and pillars.

Single Digital Patient Record (SDPR)

NSW Health is now working on a single streamlined system to record patient records to replace and consolidate what is currently available. This will improve patient experience through better continuity of care, reduce the need for patients and their carers to recall and repeat health information and provide patients with secure access to relevant medical data. A contract with Epic Systems has recently been entered into and a Steering Committee is being established. It is anticipated the overall implementation timeline will be approximately 6 years with the Statewide rollout planned between 2026 and 2030.

NSW Health Single digital 'front door'

A single digital front door in healthcare is a single-access digital platform through which patients can receive care and access various healthcare services. Benefits include improvements in accessibility, efficiency, engagement and improved patient experience. NSW Health are developing a new web portal called "Engage Health' an online entry point to easily access digital health services and includes access to the HOPE platform, Child Health Reminders service and the School Vaccination Program. The portal can be expanded

in the future to include new digital health services as they are made available. In addition, NSW Health are also developing a “NSW Health App”, the prototype is one of the digital channels that could make it easier for people to navigate NSW Health hospitals and health services. Both of these digital solutions provide opportunities for mental health in relation to future service provision and service navigation.

Chapter 5 – What next?

Three areas have been identified for further consideration that may inform future detailed investment priorities:

1. In depth service mapping

The Alliance for Mental Health have strongly advocated for a gap analysis utilising the NMHSPF to provide a more data informed view of the gaps in community mental health (resource gaps) and the actions required to address these.

In depth service planning would utilise several appropriate service planning and simulation tools. The learning from this report (Community Mental Health Services Priority Issues, November 2023), combined with a detailed service planning paper could form the basis for any future longer term budget initiatives.

For examples of service planning and simulation tools see Appendix G.

2. The findings of both the current psychosocial research projects underway

There are two psychosocial research projects currently being conducted to inform future psychosocial activity; the Commonwealth Psychosocial Research Project and NSW Psychosocial Research Project (as outlined in Priority 4). The outcomes of these projects will inform future arrangements for the provision of psychosocial supports including roles and responsibilities between the Commonwealth and NSW. These outcomes will guide any future investment decisions.

3. Assessment of future funding opportunities, including the future of current time limited mental health programs

Future funding opportunities should be considered to address the priority areas outlined in this report. There are also a number of mental health programs administered by NSW Health whose funding sources have already ceased or will cease shortly. Program funding is ceasing due to the conclusion of individual program contracts, as well as the imminent conclusion of key mental health funding packages, for example:

- the $130 million **Mental Health Recovery Package**, which was announced in October 2021 and is set to conclude by the end of FY25; and
- the $400 million Commonwealth and State jointly funded **Phase 3 NSW Storm and Flood Recovery Package**, which was announced in July 2021 and is set to conclude by the end of FY24.

These programs were intended to be time-limited in the context of their development and delivery. Most of the funding for these programs was from sources external to the Mental Health Branch, including NSW Treasury, the Commonwealth Government, and previous Ministers' discretionary funds. Further consideration of the future of these programs is required within the context of broader work being undertaken by the Ministry of Health to determine mental health service priorities in NSW.

Appendix A Interview Participants

Organization	Key contact
Alliance for Mental Health	
Mental Health Coordinating Council (MHCC)	Corinne Henderson Interview and written submission
BEING (Mental Health Consumers NSW)	Priscilla Brice Peter Schmidgen
Mental Health Carers NSW	Jonathan Harms
Australian Psychological Society (APS)	Dylan Foote Written submission
Australian Medical Association (AMA)	Dr Michael Bonning
Royal Australian and New Zealand College of Psychiatrists (RANZCP)	Angelo Virgona Written submission
Royal Australian College of General Practitioners (RACGP)	Karen Spielman Charlotte Hespe
Other Key Stakeholders	
Official visitors	*Interview 1* Cameron McLeod Daryn Poulden Patricia Farrar Karen Lovett *Interview 2* Melissa Mahoney Natasha Langovski Terence Kirkpatrick Susan Karpik Barbara Fogarty
NSW Consumer Peer Workforce Committee	*Interview 1* Tamara Northey Melissa Tierney Jacob Pearce Paul Bulmer *Interview 2* Andrew Padayachy Andrew Love Paula Hanlon Heidi Lee Sandra Christensen

Appendix B Data Sources

1. AIHW, Community Mental health Care Tables, 2021
2. AIHW, Expenditure on Mental health Related Service, 2021
3. AIHW, Mental health services in Australia: Specialised mental health care facilities, 2021
4. NSW Ministry of Health, *Mental Health Your Experience of Service Survey 2021–22.* NSW Ministry of Health, Sydney.
5. NSW Ministry of Health, *Mental Health Carer Experience Survey2021–22.* NSW Ministry of Health, Sydney.
6. MH-TRACE, release date: 24 November 2023
7. Epidemiology Flow Charts for the National Mental Health Service Planning Framework – Commissioned by the Australian Government Department of Health and Aged Care. Version AUS V4.3. The University of Queensland, Brisbane.

Appendix C List of the literature reviewed

1. *The NSW mental health care system on the brink: Evidence from the Frontline.* NSW Branch of the Royal Australian New Zealand College of Psychiatrists, 2023
2. *Shifting the balance - investment priorities for Mental health in NSW.* Mental health Coordinating Council, 2022.
3. *Mental health: Mapping the current reform landscape*. Parliamentary Research Service, 2023.
4. State of Victoria, Royal Commission into Victoria's Mental Health System, 2021
5. Productivity Commission, Mental Health, Inquiry Report, 2020.
6. National Mental Health Suicide Prevention Inquiry, Commonwealth of Australia, 2021
7. Accessibility and quality of mental health services in rural and remote Australia, Commonwealth of Australia, 2018
8. Health outcomes and access to health and hospital services in rural, regional and remote New South Wales, Legislative Council, 2022.

Appendix D Project Steering Group – Terms of Reference

Purpose

The NSW Minister for Mental Health has requested a time limited piece of work summarising the gaps and opportunities in the NSW mental health sector.

The project is due to report in November 2023.

Initial discussions with stakeholders and the Minister have refined the scope to services delivered and funded by NSW Health, with an emphasis on public community mental health care.

Through consultation, key issues within community mental health will be identified along with what actions are needed to address these issues. Any recommendations or priorities will be evidence based or demonstrate promising practice, will be clinically and culturally sound, and have demonstrable return on investment. No cost options and reallocation of funding will also be considered.

The primary outcome of the Project will be an internal report to the Minister. A secondary, publicly available report may also be considered.

The project will build on work previously undertaken to support mental health reform for example through the Mental Health Commission (Living Well)

- Living Well: A Strategic Plan for Mental Health in NSW 2014-2024
- Living Well in focus 2020-2024

The Alliance for Mental Health provided strong advocacy for the Gap Analysis Project through pre-election activities.

Objectives

- Provide guidance and direction on the project at the PSG meeting and between meeting as required
- Provide advocacy for the project
- Assist in identifying and prioritising gaps, issues and solutions
- Review of the strategic gap analysis report to enable delivery to the Minister for Mental Health in November 2023.

Governance Structure

Executive Sponsor

Deb Willcox AM, Deputy Secretary, Health System Strategy and Patient Experience, NSW Health (Chair).

Project Steering Group (PSG)

- Catherine Lourey, NSW Mental Health Commissioner, co-project lead.
- Dr Brendan Flynn, Executive Director, NSW Mental Health Branch, NSW Health, co- project lead.
- Tim Heffernan, Deputy Commissioner NSW Mental Health Commission, Lived Experience expertise.
- Dr Angelo Virgona, Chair NSW RANZCP, Alliance for Mental Health representative providing advice and project delivery support.

- Amy Shearden, Project Manager, NSW Mental Health Branch, providing secretariat and project management support.

Consultation

- Alliance for Mental Health
- NSW Official Visitors Program
- Local Health Districts/ Specialty Health Networks/Pillars
- Mental Health Consumer Peer Worker Committee

As required

- NSW Treasury
- NSW Health Finance
- Department of Communities and Justice

Activity

The Project Steering Group will meet fortnightly and provide guidance and direction on the project. Once proposed gaps and opportunities have been identified, the group will assess the options and agree upon issues for priority.

The Alliance for Mental Health are a major consultation group. Initial meetings will provide an opportunity for the Alliance members to outline their views. Focused consultation will also be conducted to gather additional information. The Alliance will be updated throughout the project.

Additional consultations will be undertaken with key stakeholders to support the identification of service gaps and opportunities.

Approval and endorsement process (Draft – process to be agreed)

1. Socialise draft report structure with the Ministers Office
2. Seek feedback from the PSG on the Themes/Gap/Priorities
3. Circulate to PSG for finalisation
4. Approval through the Deputy Secretary/ Secretary (NSW Health)

Proposed Timeline:

August

- Establish PSG and finalise TOR, including project scope and governance
- Meet with the Alliance for Mental Health. Initial project briefing/consultation
- Further consultations (e.g., LHDs/SHNs/Pillars/OV's)
- Establish supplementation groups to support project development and implementation

September

- Meet with the Minister's Office – Project Briefing
- Further consultation
- Data collection and analysis

October

- Strategic development of Gap priorities and identification of priorities Drafting of final report

November

- Approval and governance process
- Gap Analysis Report due November 2023

Minutes

Action minutes will be developed and circulated to meeting members post meeting.

Feedback/Monitoring

An "Action Plan" will be created to identify the key activities to be undertaken. The key actions from each meeting will be captured in the 'Action Plan'. The Action Plan and progress will be reviewed at the beginning of each meeting to guide the meeting agenda and to monitor activities and deliverables.

Regular meetings are already established between the Mental Health Branch and the Minister for Mental Health, the Gap Analysis Project will be included on the agenda for these meetings.

Context – Alliance for Mental Health

The Alliance for Mental Health is a group of peak bodies representing mental health workers, consumers and carers across New South Wales. They provide advocacy for the mental health sector and are calling for urgent reform and investment in mental health services. They aim to champion system reform and redesign. The Alliance for Mental Health include:

- Mental Health Coordinating Council (MHCC)
- BEING (Mental Health Consumers NSW)
- Mental Health Carers NSW
- Australian Psychological Society (APS)
- Australian Medical Association (AMA)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Australian College of Mental Health Nurses
- Royal Australian College of General Practitioners (RACGP)
- The Black Dog Institute

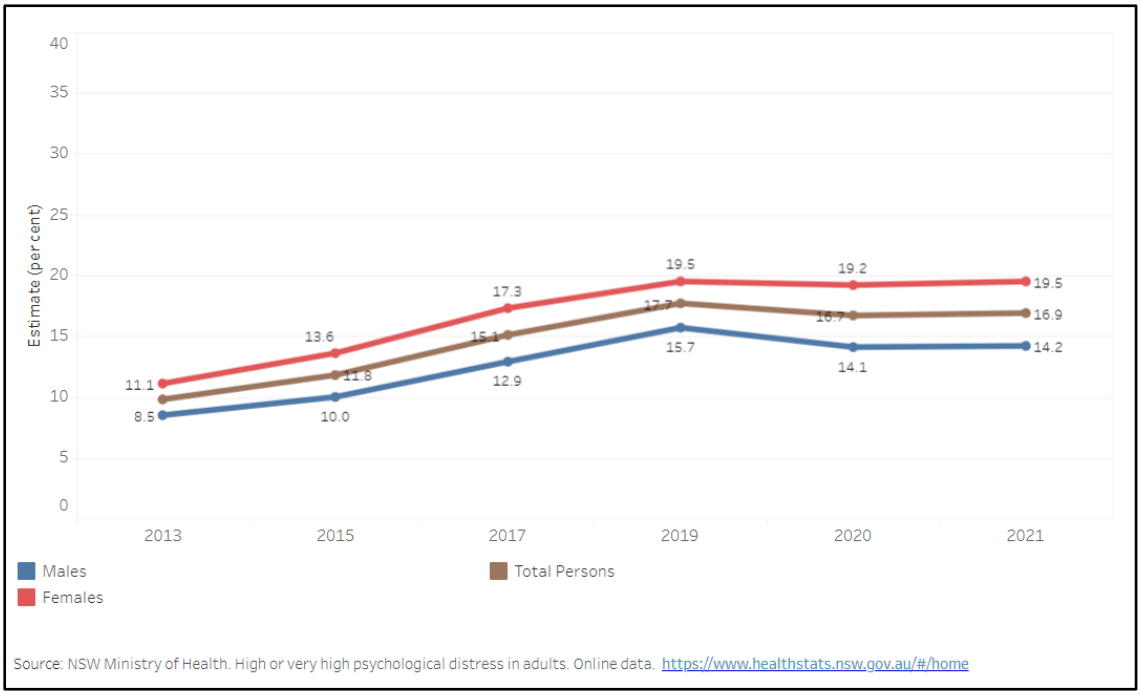
Appendix E Community Mental Health Data Analysis

Increase demand for and provision of community mental health services

High and increasing levels of psychological distress in NSW

There is a strong association between psychological distress and the diagnosis of a mental health condition.[55] As can be seen in the Figure below, high or very high levels of psychological distress among adults have been on the rise since 2013 (10.0%), peaking in 2019 at 17.7% and stabilised at 16.9% in 2021. This 6.9% increase since 2013 equates to around half a million more people in NSW experiencing high or very high levels of psychological distress (using ABS 2020-21 population data). It is likely that these high levels of psychological distress and high lifetime mental disorder rates in NSW (40.5% of people aged 16–85 years in 2020–2022[56]) are resulting in higher service need and demand levels in NSW.

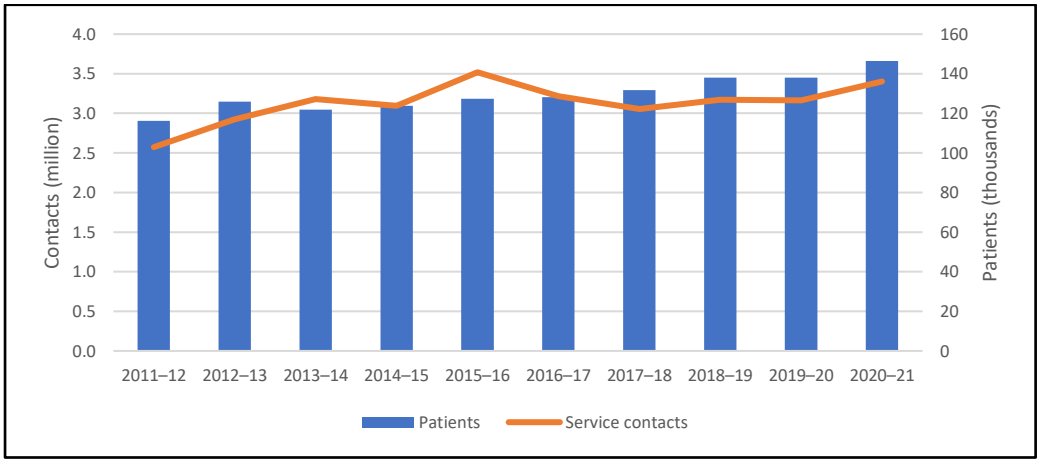
Figure 4 - High or very high levels of psychological distress in adults in NSW



Increase in Community Mental Health (CMH) patients and service contacts in NSW

The Figure below shows that the number of *community mental health (CMH) patients* has increased by 20.7% over the past 10 years. This equates to around 30,000 more CMH patients (around 2020-21; 116,000 from around 146,000 in 2011-12). The number of *service contacts* increased by over 800,000 (24.4%) over the past 10 years (3.4 million in 2020-21 from 2.6 million in 2011-12). Over the same 10 year period, funding for community mental health in NSW has increased by only 13%.

Figure 5: NSW CMH Patient by Service Contacts - Past Decade



Source: AIHW Community mental health care, Table CMHC. 2 (2020-21)

Demand and provision for crisis services has increased

The November 2023 year to date TRACE data below demonstrates that demand and provision for particular crisis services in NSW increased compared to November 2022:

- mental health emergency department presentations increased by 5% (from from 91,752 to 96,120)
- self-harm and suicidal thoughts emergency department presentations increased by 5% (from 47,323 to 49,844)
- average daily calls to the *NSW Mental Health Line* have increased by 6% compared to 2022 (from 511 to 543)
- community clinical care hours increased by 5% compared to 2022 (from 28,860 to 30,408).[57]

However, NSW CMH service provision rate is low

Although there appears to be a need for more mental health service provision due to the high levels of psychological distress, the NSW service provision rate per 1,000 population is 17.9 – the second lowest in Australia (ahead of Victoria; 12.1, and below the national average; 22.4).

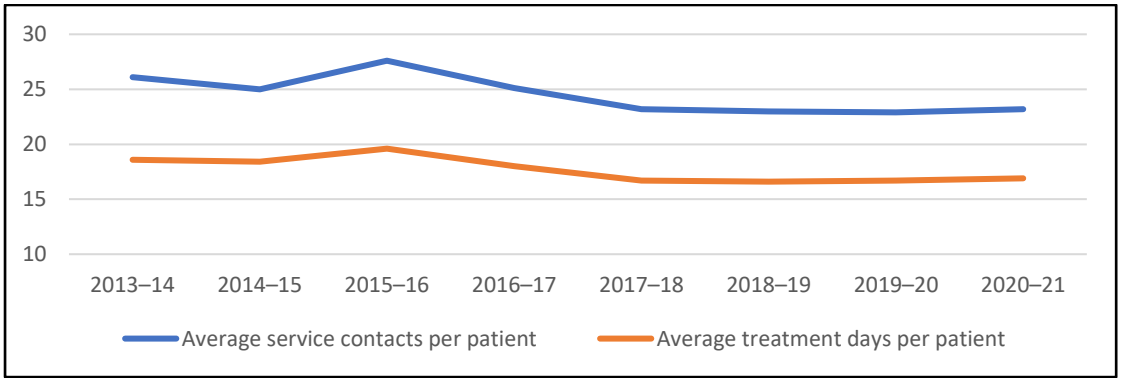
- NSW Health provides community mental health services to 146,498 consumers
- There were 3.4 million community mental health client contacts provided
- NSW had the highest national rate of community care days per client (16.9 days)
- More than 1 in 8 (12%) community service contacts in 2020-21 involved a person with an involuntary mental health legal status.[58]

Average number of CMH service contacts and treatment days per patient has been decreasing

The average number of service contacts per patient and average number of treatment days per patient has been decreasing since 2015-16 (by 19% and 16% respectively). However, the number of CMH patients has increased by 13% (around 19,000 patients) since 2015-16. The reason may be that clinicians have less time to spend with patients due to the increase in service demand – this is supported by the staff FTE data, showing that CMH staff FTE per capita decreased in the past 10 years.

The *average number of service contacts per patient* peaked at 27.6 contacts per patient in 2015-16. Since then, it has been declined to 23.2 contacts in 2020-21. The *average number of treatment days per patient* also peaked in 2015-16 to 19.6 days and has also been on the decline since, at 16.9 days in 2020-2021.

Figure 6 - NSW Average number of community mental health service contacts and Treatment days

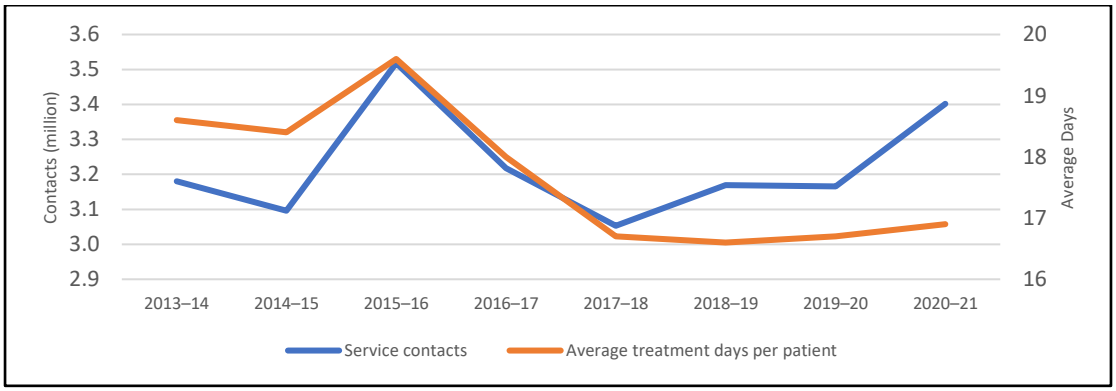


Note: AIHW data for Average treatment Days begins in 2013-14
Source: AIHW Community mental health care, Table CMHC. 2 (2020-21)

Service contacts have been increasing while average treatment days have been decreasing

Since 2017-18, total CMH service contacts have been on the rise, peaking at 3.4 million in 2020-21, however in this same period, average treatment days per patient has not been increasing at the same rate (remaining fairly stable). This may indicate that CMH staff are carrying a significant clinical workload, however, do not have adequate resources to provide sufficient service duration.

Figure 7 – NSW Service Contacts by Average days

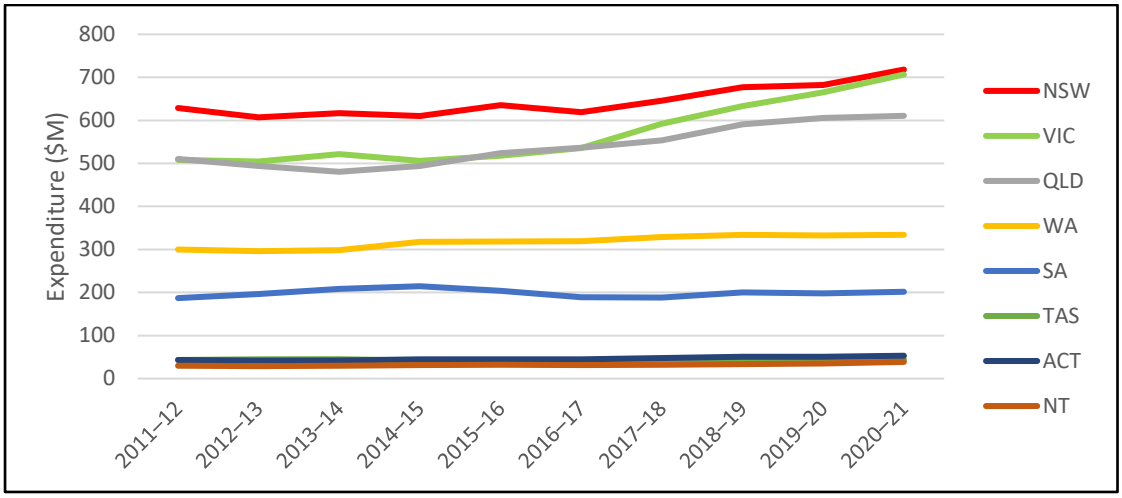


Note: AIHW data for Average treatment Days begins in 2013-14
Source: AIHW Community mental health care, Table CMHC. 2 (2020-21)

Community Mental health funding is not sufficient to meet increasing demand

There has been a lack of significant movement in CMH funding over the past 10 years. In the past decade, while the number of CMH service contacts and patients increased by 24.4% and 20.7% respectively, community mental health funding has increased by only 13%. CMH funding increase from $629 million in 2011-12 to $718 million in 2020-21, an increase of approximately $89 million in 10 years. There was a 5% increase between 2019-20 and 2020-21. This increase is below the funding increases in Victoria (6%) and Northern Territory (10%) and the same as Tasmania (5%) for 2020-21.

Figure 8 - Community Mental Health Expenditure by State and territory over past 10 years

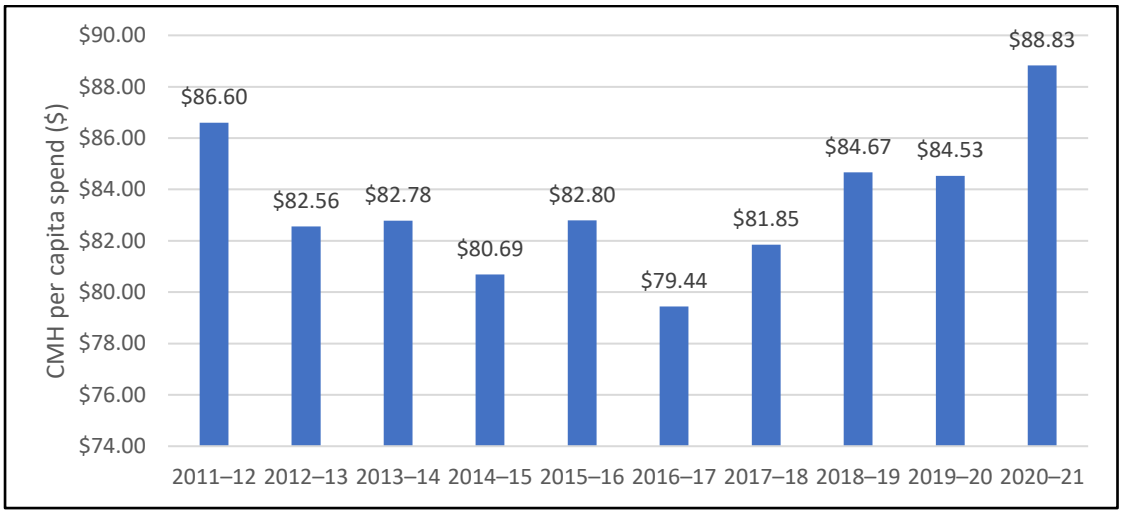


Source: AIHW Expenditure on mental health related services tables, Table EXP. 3 (2020-21)

Second lowest per capita expenditure on CMH in Australia (AIHW):

CMH spend per capita in NSW has increased by only $2.23 in the past decade to $88.83. This is below the per capita increases for Northern Territory ($28.67), Victoria ($16.72) and Queensland ($4.68) in the same period.

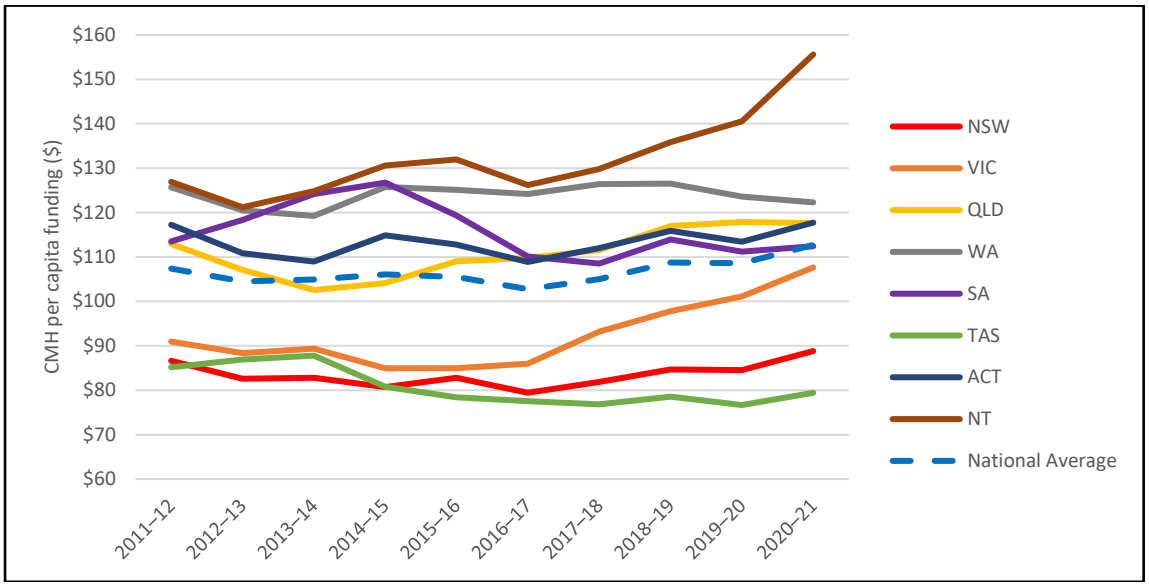
Figure 9 - NSW per capita community mental health funding past 10 years



Source: AIHW Expenditure on mental health related services tables, Table EXP. 4 (2020-21)

NSW's per capita funding on CMH is the second lowest nationally at $89, ahead of Tasmania at $79 and well below the Northern Territory at $156 and the national average of $113. NSW's per capita spend has been consistently below the national average for the past decade.

Figure 10: Community Mental Health per capita funding ($) by state and territory – past decade

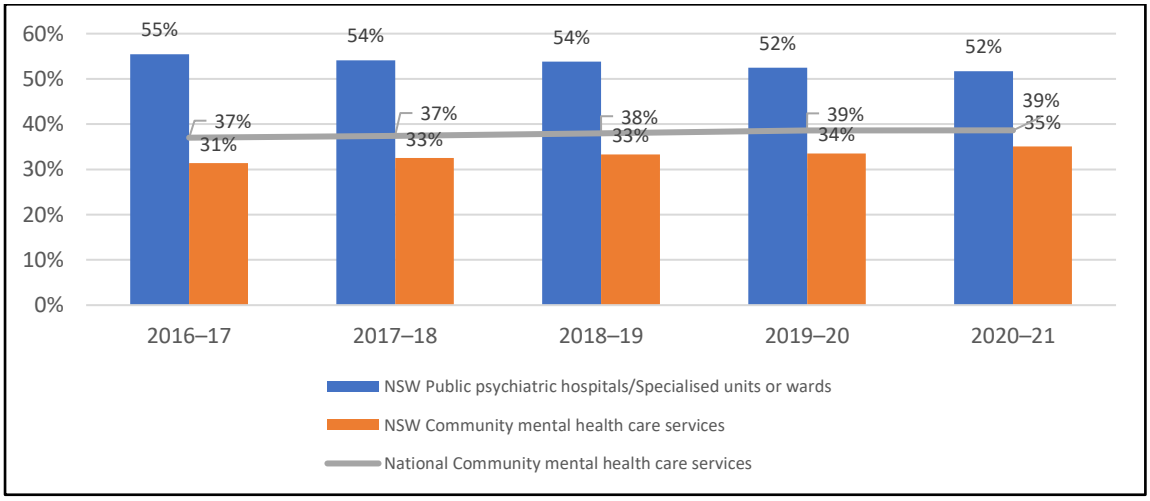


Source: AIHW Expenditure on mental health related services tables, Table EXP. 4 (2020-21)

More expenditure on inpatient care than community mental health:

NSW spent $718 million on CMH services, 35% of the total public mental health care expenditure of approx. $2 billion. This is below national total expenditure of 39%. The largest proportion (52%) of mental health care expenditure was spent on public hospitals ($1.1 billion).

Figure 11: NSW and National: Proportion of mental health spend over time

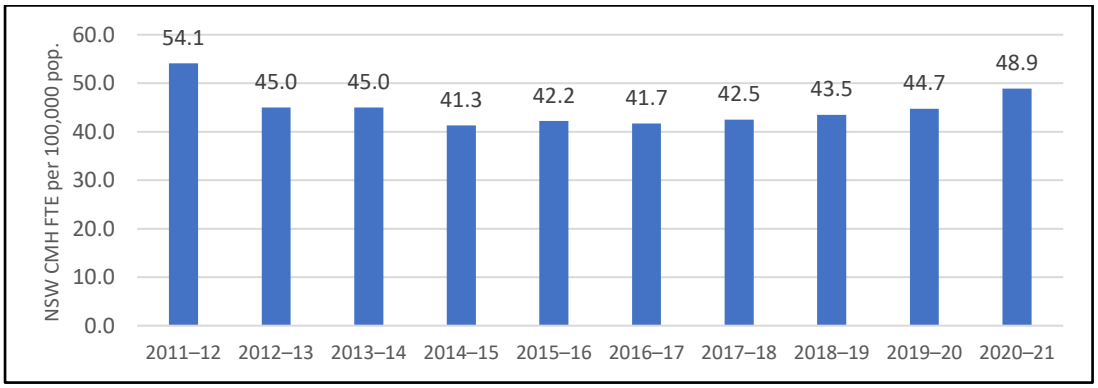


Source: AIHW Expenditure on mental health related services tables, Table EXP. 3 (2020-21)

Community Mental Health FTE per 100,000 population has decreased over time

CMH staff FTE per 100,000 population decreased in the past 10 years – from 54.1 community mental health staff per 100,00 population in 2011-12 to 48.9 in 2020-21. However, staff FTE per 100,000 population has been on the rise since 2017-18.

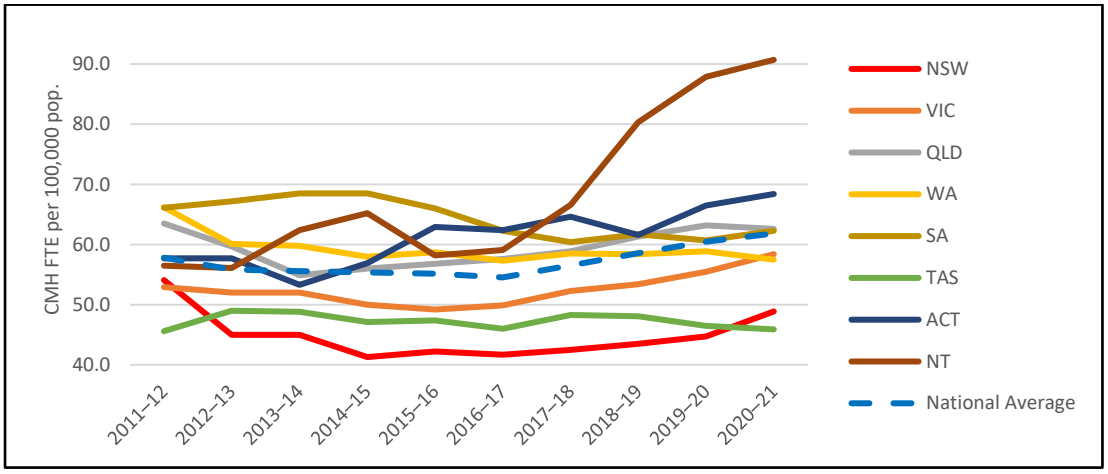
Figure 12 - NSW CMH FTE per 100,000 population - past 10 years



Source: AIHW Specialised mental health care facilities, Table FAC. 40 (2020-21)

NSW had the lowest CMH staff FTE per 100,000 population from 2012-13 to 2019-20. In 2020-21 staff FTE per 100,000 population increased, and is now the second lowest of all states and territories (behind Tasmania).

Figure 13 - CMH FTE per 100,000 population - by state and territory - past 10 years



Source: AIHW Specialised mental health care facilities, Table FAC. 40 (2020-21)

Community Mental Health Experience ratings

Although the data suggests services are underfunded and staff have high workloads, the overall experience of services reported by consumer and carer is very positive. This is demonstrated through the national Your Experience of Service (YES) – a survey of mental health consumers about their experiences. In 2021-22, consumers generally report an overall positive experience, with nearly 80% of consumers rating the care they have received as excellent or very good.[59]

Similarly, for carers the Carers Experience of Services (CES) gathers feedback on carer's experiences of mental health services. In 2021-22, 69% of community CES returns reporting an excellent or very good experience. Carers in metropolitan areas reported a more positive experience than in regional areas. [60]

Appendix F Community Mental Health Services

Community programs*

Service/Initiative/Program	Description	Total budget/ Funding	District/Network
Family and Carer Mental Health Program	The purpose of the Program is to improve the wellbeing of families and carers of people with mental health conditions. Local health districts enhance the skills of mental health services staff to work with families and carers as partners in care. 5 community managed organisations provide training and education, one to one support, group support and advocacy services for families and carers of people with a mental illness.	$7.5million annually to community managed organisations. Funded to June 2026.	15 districts in partnership with 5 community managed organisations and Justice Health and Forensic Mental Health Network.
Housing and Accommodation Support Initiative (HASI) and Community Living Supports (CLS)	HASI and CLS are statewide community-based psychosocial support programs that help people with severe mental illness to live and participate in the community the way they want to. The programs are delivered by 8 community managed organisations in partnership with local health districts.	More than $76 million per annum.	All districts and Albury.
National Disability Insurance Scheme Mental Health Officer Program	The overarching objective of the Program is to improve access to, and the experience of, the NDIS for people with psychosocial disability in NSW.	$2.8 million annually. Funded to October 2023.	NSW engaged Flourish Australia to provide an Officer in each District/Network.
Housing and Accommodation Support Initiative Plus (HASI Plus)	HASI Plus is a statewide program for people with severe mental illness and significant difficulties managing day to day living. The program is community-based, transitional, rehabilitation and recovery-oriented. It integrates clinical and intensive psychosocial support that is available up to 16 or 24 hours per day, 7 days per week, with stable, community-based accommodation. There are currently 70 HASI Plus places across 8 accommodation sites hosted in 4 districts.	$12 million per annum	Hunter New England, Northern Sydney, Western Sydney and Mid North Coast 70 packages - 39 are statewide.
Mental Health – Community Living Supports for Refugees (MH-CLSR). Part of the suite of NSW Mental Health Community Living Programs.	The MH-CLSR is a first-of-its-kind program for refugees and asylum seekers who are experiencing psychological distress, mental ill health and impaired functioning. It aims to provide trauma-informed, recovery-oriented, culturally safe and responsive psychosocial supports	Commenced in 2019. Recurrent annual funding of $5.2million.	7 Districts where the concentration of refugees was highest at the time of commencement of the program: Sydney, South-Western Sydney, Western Sydney, Illawarra Shoalhaven, Mid-North Coast, Hunter New England and Murrumbidgee.

Service/Initiative/Program	Description	Total budget/ Funding	District/Network
	to enable participants to recover and transition to a quality life in the community. Delivered by 4 community managed organisations.		
Universal Aftercare	Under the Bilateral Schedule to the Mental Health and Suicide Prevention Agreement, universal aftercare support will be available across NSW following a suicide attempt and/or suicidal crisis. The program provides up to 3 months of psychosocial, non-clinical support in the community to support people in their recovery from suicide or significant suicidal crisis. Positions will also be funded within each District and Network, including a dedicated position for Albury-Wodonga, to support the integration of aftercare services within EDs and the broader NSW mental health system.	$121.3 million in joint NSW/Commonwealth funding over 4 years from 2022-23.	All District and Network geographical areas. District Coordinator positions will be funded in all Districts and Networks, with a dedicated position in Albury-Wodonga.
Post Suicide Support	Under the Bilateral Schedule to the Mental Health and Suicide Prevention Agreement, postvention support services will be available for those bereaved or impacted by suicide across NSW.	$14.7 million in joint NSW/Commonwealth funding over 4years from 2022-23.	All District and Networks.
Youth Community Living Support Service	The service provides community-based psychosocial support services to young people aged 15-24 years with severe and complex mental illness and their families/carers. The service works with District services to provide wrap around care that supports the young person in areas of their life where they would like to make positive change. The service is currently delivered by one community managed organisation.	$11.3 million over 5 years from 2021 to 2025	5 Districts - Hunter New England, Nepean Blue Mountains, Norther NSW, South-Western Sydney and Western Sydney.

* Programs are Ministry of Health funded and delivered by the Districts/Networks.

Statewide programs*

Service/Initiative/Program	Description	Total budget/ Funding	District/Network
Aboriginal Mental Health Care Navigators and Aboriginal Mental Health & Wellbeing Peer Workers	18 FTE Aboriginal Mental Health Care Navigators are responsible for connecting Aboriginal families to appropriate services in and around the District/Network. The role ensures systems, services and processes are established between mental health and non-government, primary care, social support, justice and drug and alcohol services to ensure collaboration, connectivity, reduce service duplication and ensure appropriate support at transitional points in care for Aboriginal people. 18 FTE Aboriginal Mental Health & Wellbeing Peer Workers who use their lived experiences to support the delivery of culturally safe services for Aboriginal consumers accessing District Emergency Department, inpatient and community mental health services.	Total funding $21 million over 4 years from 2021 to 2025.	All Districts and Networks.
Aboriginal Mental Health Clinical Leader Program	This role supports the implementation of the Aboriginal Mental Health Workforce Program in the Districts, including provision of leadership and general support of Aboriginal Mental Health Trainees and the supervisors and mentors directly supporting the traineeship positions.	Total annual funding approx. $1.75 million.	All Districts and Networks except Sydney Children's Hospitals Network, St Vincent's Health Network and Murrumbidgee.
Aboriginal Mental Health Workforce Program	The program helps increase a clinically and culturally skilled Aboriginal Mental Health Professional Workforce.	Total funding annually approx. $1.6 million	All Districts and Networks except Sydney Children's Hospitals Network, St Vincent's Health Network and Murrumbidgee.
Consumer Peer Workforce	The Ministry of Health works with Districts and BEING to provide the annual Consumer Peer Workers Forum.	-	-
Disaster Recovery Clinician	Work on the ground to provide support at recovery centres and in the community to ensure people are linked to mental health and practical support as quickly as possible.	$9 million annually from 2021-22. Funded to June 2023.	Mid North Coast, Nepean Blue Mountains, Murrumbidgee, Southern NSW, Hunter New England, Northern NSW, Western NSW, Far West, Central Coast, Illawarra Shoalhaven and South Western Sydney.
Eating Disorder	The program supports public funded mental health services to deliver evidence-based assessment and treatment. Eating Disorders Coordinators link people to community-based care on discharge from hospital or facilitates transfer to specialist eating disorders services when required. They also help teams develop	$12 million annually from 2021-22.	All Districts and Networks.

Service/Initiative/Program	Description	Total budget/ Funding	District/Network
	guidelines and care pathways to support the person with an eating disorder and their families.		
Farm Gate Counsellor and Drought Peer Support Program	Provide support and links to information and care and promotes mental health through local community events. 27 FTE positions are based in 8 rural and regional Districts.	$18.2 million over 4 years from 202-22.	Far West, Mid-North Coast, Nepean Blue Mountains, Murrumbidgee, Southern NSW, Hunter New England, Norther NSW, Western NSW.
Safeguards	25 community-based Safeguard child and adolescent mental health response teams. This new dedicated resource provides innovative and best practice care to children and adolescents aged 0-17 years experiencing acute mental distress, and their support network.	$109.5 million over 4 years from 2021-22.	**Tranche 1** (funded in 2021-22): Central Coast, Hunter New England, Illawarra Shoalhaven, Mid-North Coast, Murrumbidgee, Northern NSW, Northern Sydney, South Eastern Sydney, South Western Sydney, Western NSW, Western Sydney. **Tranche 2** (funded in 2022-23): Justice Health and Forensic Mental Health Network, Nepean Blue Mountains, Sydney, Sydney Childrens Hospitals Network, Southern NSW, with Hunter New England and South Western Sydney getting additional teams in Tranche 2. **Tranche 3** (due 2024-25): To be determined.
Getting On Track In Time (Got It!)	The program provides school based social and emotional learning, universal screening, teacher training and targeted interventions for children aged 5 to 8 years old with early behavioural, social and emotional concerns and emerging conduct disorder and their families. It reduces the emergence of conduct disorders for this cohort in 100 primary schools a year.	$11.2 million annually.	All Districts and Justice Health and Forensic Mental Health Network.
Pathways to Community Living Initiative (PCLI)	Integrated clinical hospital and community program with a new complex care workforce (over 74 FTE) working with patients with Severe and Persistent Mental Illness to move them more rapidly through hospital care to the community. Specialist residential aged care services for older people with complex mental health needs, operated by aged care providers in partnership with specialist clinical older people's mental health services.	$15 million in 2022-23 (including specialist residential aged care services within Sydney, Western Sydney, Western NSW, Nepean Blue Mountains, Northern Sydney, and Hunter New England. ($8 million annualised and $4.9 million per year for 4 years from	All Districts and St Vincent's Health Network and Justice and Forensic Mental Health Network.

Service/Initiative/Program	Description	Total budget/ Funding	District/Network
		Jan 2022 to be annualised after that).	
Peer Supported Transfer of Care (Peer-STOC)	Designed to provide additional person-centered and recovery focused supports to individuals with complex mental health needs during transition to home or community after an inpatient admission.	$2.7 million annually.	All Districts and Networks.
Rural Adversity Mental Health Program (RAMHP) Coordinators	A mental health promotion program focused on prevention and early intervention. There are 19.5 FTE Coordinators based in rural and regional Districts. Coordinators aim to provide information and link people to services and resources, provide mental health training, and partner with stakeholders to create pathways to care. Grand Pacific Health provides coordination and management services for the program.	Maximum reimbursement of $15.6 million for Districts from 2021-26. Total of $5.5 million to Grand Pacific Health from 2021-2026.	Far West, Hunter New England, Illawarra Shoalhaven, Mid-North Coast, Murrumbidgee, Nepean Blue Mountains, Northern NSW, Southern NSW and Western NSW.
School-Link Coordinators	Links schools with specialist mental health services to provide coordinated care to students needing mental health support. There are 23 Coordinators statewide.	$3 million annually.	All District and Sydney Children's Hospitals Network and Justice Health and Forensic Mental Health Network.
Towards Zero Suicides (TZS) - Safe Havens	Provides non-clinical alternatives to emergency departments for people seeking support for suicidal thoughts or distress. Safe Havens have been co-designed and are led by people with a lived experience of suicide and recovery. Visitors have access to a safe, quiet and welcoming spaces with opportunity to use music, sensory equipment and conversations with suicide prevention peer workers who are uniquely placed to understand their experience.	$45.7 million over 2022 to 2026.	All Districts, Sydney Children's Hospitals Network and St Vincent's Health Network.

Service/Initiative/Program	Description	Total budget/ Funding	District/Network
Towards Zero Suicides (TZS) - Suicide Prevention Outreach Teams (SPOTs)	The initiative ensures assertive, outreach-based care to people experiencing suicidal thoughts or distress by engaging with people where they live or where they are comfortable accessing support. These teams are co-designed and co-staffed by suicide prevention peer workers and mental health clinicians to link people with support services and care pathways to address the causes of their suicidal distress. This contributes to reducing the time people spend in emergency departments.	$41.9 million over 2022 to 2026.	All Districts, Sydney Children's Hospitals Network and St Vincent's Health Network.
Towards Zero Suicides (TZS) - Rural Counsellors	The initiative funds 15 FTE across 9 rural and regional Districts, recognising the disproportionate suicide rates in rural areas and challenges to accessible mental health support. Rural Counsellors support people experiencing psychosocial hardship, suicidal distress, or recovering from a suicide attempt. They support people who are experiencing suicidal crisis, including Aboriginal people, farmers, people released from custody, and those who live on remote properties.	$9.6 million over 2022 to 2026.	Illawarra Shoalhaven, Far West, Hunter New England, Murrumbidgee, Mid-North Coast, Nepean Blue Mountains, Northern NSW, Southern NSW, Western NSW.
Towards Zero Suicides (TZS) - Zero Suicides in Care (ZSiC)	A systematic, continuous change management and quality improvement initiative to reduce suicides of individuals in contact with NSW public mental health care settings. ZSiC promotes strong service leadership to enhance a just and restorative safety culture. ZSiC underpins changes to NSW Health policies and models of care, such as the development of Suicide Care Pathways and improved safety planning processes. ZSiC also supports staff in the mental health system to improve their suicide prevention skills to support people in inpatient and community based mental health services.	$20.2 million over 2022 to 2026.	All Districts and Networks.
Whole of Family Team	Provides specialist in-home and community-based interventions for children and families with complex mental health and/or drug and alcohol issues where the children have been identified as at risk of significant harm (ROSH). Referrals from Department of Communities and Justice are prioritised. Multi-disciplinary Teams with approximately 10 FTE.	$13,735 million per annum (funding approved to June 2025). $1.9 million per team per annum.	Norther NSW, Central Coast, Hunter New England, South Western Sydney, Western Sydney, Nepean Blue Mountains, Illawarra Shoalhaven.

Service/Initiative/Program	Description	Total budget/ Funding	District/Network
Closing the Gap: Model of Care	Supports knowledge sharing and connected care between Aboriginal health services, NSW Health and people and families accessing services. The initiative will ultimately improve service access and extend the number of access pathways for Aboriginal people and communities needing mental health and social and emotional wellbeing support.	$10.1 million over 4 years from 2022-23 to implement Aboriginal mental health models of care. The funding will provide 12 grants of $200,000 a year over 4 years to co-design and sustain culturally appropriate models of care.	All Districts, Sydney Children's Health Network and Aboriginal Community Controlled Health Services.
Perinatal and Infant Mental Health Service (PIMHS)	A statewide specialist mental health service for perinatal women (pregnancy up to 2 years post-birth) and their infants, who experience a severe, acute or complex mental illness. Clinicians provide time-limited, intensive support through direct patient care or consultation liaison. The service network includes a statewide telehealth consultation liaison outreach perinatal psychiatry service for rural areas.	$4.4 million per annum.	All Districts and Networks except Far West and Justice Health and Forensic Mental Health Network.

* Programs are Ministry of Health funded and delivered by the Districts/Networks.

Appendix G Examples of Service Planning and Simulation Tools

National Mental Health Services Planning Framework (NMHSPF)

The NMHSPF is a data tool which provides resource estimates for optimal mental health service delivery in Australia. Consecutive NMHSPF versions have markedly increased the resources and costs associated with optimal service delivery. Given that some assumptions underpinning the modelling do not align with NSW models of care, NSW Health advises that NMHSPF should be used indicatively. The NMHSPF is most useful in identifying areas where the difference between current and modelled services is the greatest – indicating the need for potentially increased or redirected investment.

Currently, LHD service planners are encouraged to use the NMHSPF as well as additional planning approaches (such as local demographics, expert knowledge, models of care, historical data and projections, strategic and local priorities, staffing, economics, risks and other planning tools) to ensure comprehensive and informed mental health planning. The NMHSPF administrators, the Australian Institute of Health and Welfare (AIHW) also acknowledge that estimates may require adjustments based on local population knowledge and service context.

Mental Health Investment Decision Tool (MhIND-T)

Action 15 of Living Well in Focus 2020 – 2024 assigns responsibility to the Mental Health Commission of NSW to develop a cross-sector tool to inform regional planning. In collaboration with the Sax Institute, the Commission has developed the Mental health Investment Decision Tool (MhIND-T). The tool includes NMHSPF epidemiology data, NSW Health data, and data from the Australian Institute of Health and Welfare.

Lumos Data

Lumos data is available to inform planning, monitoring, funding and evaluation of health services. This data provides insights into the patient journey through the NSW health system. De-identified data from general practices is linked with other health services data to provide a comprehensive view of patient pathways. A Secure Analytics Primary Health Environment (SAPHE) allows approved PHNs, LHDs, and Ministry of Health employees access to the deidentified data asset.

ESME & DESDE

Tools for consideration to inform a quantitative gap analysis are ESME (European Service Mapping Schedule) and the DESDE[61] (Description and Evaluation of Services and DirectoriEs) tool which is used to classify and describe (in a standard way), service availability in defined catchment areas.

Chapter 3 - Infographic Reference List

i. NSW Mental Health Commission. (2022). High psychological distress in adults and secondary students. Accessed 7/11/2023

ii. ABS (Australian Bureau of Statistics). (2020-2022). *National Survey of Mental Health and Wellbeing: summary of results*. ABS, Canberra

iii. NSW Ministry of Health. (2023). MH-TRACE, Indicators of NSW Mental Health service demand and care. Release date: 24 Nov 2023. Sydney. NSW. (Unpublished)

iv. AIHW (Australian Institute of Health and Welfare). (2023). Community mental health care services 2020-21 (Table CMHC. 2), AIHW, Canberra. Accessed 8/11/2023

v. AIHW (Australian Institute of Health and Welfare). (2023). Community mental health care services 2020-21 (Table CMHC. 2), AIHW, Canberra. Accessed 8/11/2023

vi. AIHW (Australian Institute of Health and Welfare). (2023). Community mental health care services 2020-21 (Table CMHC. 26), AIHW, Canberra. Accessed 8/11/2023

vii. AIHW (Australian Institute of Health and Welfare). (2023). Community mental health care services 2020-21 (Table CMHC. 2), AIHW, Canberra. Accessed 8/11/2023

viii. AIHW (Australian Institute of Health and Welfare). (2023). Community mental health care services 2020-21 (Table CMHC. 2), AIHW, Canberra. Accessed 8/11/2023

ix. AIHW (Australian Institute of Health and Welfare). (2023). Expenditure on mental health related services 2020-21 (Table EXP. 3), AIHW, Canberra. Accessed 8/11/2023

x. AIHW (Australian Institute of Health and Welfare). (2023). Expenditure on mental health related services 2020-21 (Table EXP. 4), AIHW, Canberra. Accessed 8/11/2023

xi. AIHW (Australian Institute of Health and Welfare). (2023). Expenditure on mental health related services 2020-21 (Table EXP. 3), AIHW, Canberra. Accessed 8/11/2023

xii. AIHW (Australian Institute of Health and Welfare). (2023). Specialised mental health care facilities 2020-21 (Table FAC. 40), AIHW, Canberra. Accessed 8/11/2023

Endnotes

[1] Keiller, E., Masood, S., Wong, B.H. et al. (2023) Intensive community care services for children and young people in psychiatric crisis: an expert opinion. BMC Med 21, 303. https://doi.org/10.1186/s12916-023-02986-5

[2] The Royal Australian & New Zealand College of Psychiatrists. (2023). The NSW mental healthcare system on the brink: Evidence from the frontline. Sydney. NSW

[3] Diminic, S., Page, I., Gossip, K., Pagliaro, C., Wright, E., John, J., Comben, C., & Whiteford, H. (2023). Epidemiology Flow Charts for the National Mental Health Service Planning Framework. Commissioned by the Australian Government Department of Health and Aged Care. Version AUS V4.3. The University of Queensland, Brisbane

[4] AIHW (Australian Institute of Health and Welfare). (2023). Community mental health care services 2020-21. AIHW, Canberra. Accessed 8/11/2023

[5] Omer S, Priebe S, Giacco D. (2015). Continuity across inpatient and outpatient mental health care or specialisation of teams? A systematic review. European Psychiatry. Feb;30(2):258-70. doi: 10.1016

[6] AIHW (Australian Institute of Health and Welfare). (2023). Specialised mental health care facilities tables AIHW, Canberra. Accessed 16/08/2023

[7] AIHW (Australian Institute of Health and Welfare). (2023). Community mental health care services 2020–21 tables. AIHW, Canberra. Accessed 16/08/2023

[8] Parliament of New South Wales, Parliamentary Research Service. (2023). Mental health: Mapping the current reform landscape. Sydney. NSW

[9] The Royal Australian & New Zealand College of Psychiatrists. (2023). The NSW mental healthcare system on the brink: Evidence from the frontline. Sydney. NSW

[10] The Royal Australian & New Zealand College of Psychiatrists. (2023). The NSW mental healthcare system on the brink: Evidence from the frontline. Sydney. NSW

[11] Being. (2023) Response to the Legislative Council Portfolio Committee No. 2 - Health. Woolloomooloo. Sydney.

[12] New South Wales Legislative Council. (2022). Health outcomes and access to health and hospital services in rural. Sydney, NSW
[13] Mental Health Commission of NSW. (2021). Peer navigation: Desktop review. Sydney. NSW
[14] Parliament of New South Wales, Parliamentary Research Service. (2023) Mental health: Mapping the current reform landscape. Sydney. NSW
[15] Commonwealth of Australia. (2010). National Standards for Mental Health Services. Canberra. ACT.
[16] NSW Ministry of Health. (2021). Physical Health Care for People with Mental Health Issues. Sydney. NSW
[17] Sara, G,. Arumuganathan, M,. Chen, W,. et al. (2019). Cohort profile: Mental Health Living Longer: a population-wide data linkage to understand and reduce premature mortality in mental health service users in New South Wales, *Australia BMJ Open*, 2019;9:e033588. doi: 10.1136/bmjopen-2019-033588
[18] Commonwealth of Australia. (2023). The National Mental Health Workforce Strategy - 2022-2032. Canberra. ACT
[19] Workforce - Mental health - AIHW
[20] Commonwealth of Australia. (2020). Productivity Commission Inquiry Report Volume 1, No.95, 30 June 2020. Canberra, ACT
[21] Commonwealth of Australia. (2023). The National Mental Health Workforce Strategy - 2022-2032. Canberra. ACT
[22] Commonwealth of Australia (2017) Psychiatry Factsheet. Canberra. ACT
[23] Commonwealth of Australia. (2023). The National Mental Health Workforce Strategy - 2022-2032. Canberra. ACT
[24] The Royal Australian & New Zealand College of Psychiatrists. (2023). The NSW mental healthcare system on the brink: Evidence from the frontline. Sydney. NSW
[25] Diminic, S., Page, I., Gossip, K., Pagliaro, C., Wright, E., John, J., Comben, C., & Whiteford, H. (2023). Introduction to the NMHSPF. Commissioned by the Australian Government Department of Health and Aged Care. Version AUS V4.3. The University of Queensland, Brisbane
[26] Commonwealth of Australia. (2023). The National Mental Health Workforce Strategy - 2022-2032. Canberra. ACT
[27] NSW Ministry of Health. (2022). Future Health. Guiding the next decade of care in NSW 2022-2032 Report. NSW Ministry of Health, Sydney
[28] Byrne, L, Wang, L, Roennfeldt, H, Chapman, M, Darwin, L, Castles, C, Craze, L, Saunders, M. National Lived Experience (Peer) Workforce - Development Guidelines. Sydney. NSW
[29] Commonwealth of Australia. (2023). The National Mental Health Workforce Strategy - 2022-2032. Canberra. ACT
[30] Byrne, L, Wang, L, Roennfeldt, H, Chapman, M, Darwin, L, Castles, C, Craze, L, Saunders, M. National Lived Experience (Peer) Workforce - Development Guidelines. Sydney. NSW
[31] NSW Ministry of Health, System Information and Analytics Branch (2023). Health System Performance Report. Release date: 27 Nov 2023. Sydney. NSW. (Unpublished)
[32] AIHW (Australian Institute of Health and Welfare). (2023). 3.10 Access to mental health services. National Indigenous Australians Agency. Accessed on 7/11/2023
[33] Duggan. M., Harris. B., Chislett. W.K., & Calder. R., (2020). Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments. Mitchell Institute Commissioned Report, Victoria University.
[34] NSW Ministry of Health. (2018). Aboriginal Health Worker Guideline for NSW Health. Sydney. NSW
[35] NSW Ministry of Health (2021). NSW Health Psychiatry Workforce Plan 2020-2025. Sydney. NSW
[36] NSW Ministry of Health (2021). NSW Health Psychiatry Workforce Plan 2020-2025. Sydney. NSW
[37] Royal Australian &New Zealand Collage of Psychiatry. (2023). Investment needed to turn mental health workforce plan into reality, say psychiatrists. Media release 10 October 2023. Accessed 7/11/2023
[38] Commonwealth of Australia. (2021). House of Representatives Select Committee on Mental Health and Suicide Prevention. Mental Health and Suicide Prevention - Final Report. Canberra. ACT
[39] Agency for Clinical Innovation. (2022). Trauma-informed care in mental health services across NSW - A framework for change. Sydney. NSW
[40] Law Enforcement Conduct Commission (LECC). (2023) *Five Years (2017 – 2022) of Independent Monitoring of NSW Police Force Critical Incident Investigations*. Sydney. NSW
[41] NSW Legislation. (2016) *Law Enforcement Conduct Commission Act 2016*. Current version for 1 October 2023 to date (accessed 7 November 2023 at 21:58)
[42] Kruger. E., (2020) *Mental health and the policing context* Chapter 22 in Birch, P., Kennedy, M., and Kruger. E., (2020) *Australian Policing: Critical Issues in 21st Century Police Practice*. Taylor & Francis Group. London.
[43] Law Enforcement Conduct Commission (LECC). (2023) *Five Years (2017 – 2022) of Independent Monitoring of NSW Police Force Critical Incident Investigations*. Sydney. NSW

[44] NSW Mental Health Commission. (2022). Mental Health related emergency department presentations. Accessed 7/11/2023
[45] NSW Mental Health Commission. (2022). Mental Health related emergency department presentations. Accessed 7/11/2023
[46] Duggan. M., Harris. B., Chislett. W.K., & Calder. R., (2020). Nowhere else to go: Why Australia's health system results in people with mental illness getting 'stuck' in emergency departments. Mitchell Institute Commissioned Report, Victoria University
[47]The Royal Commission into Victoria's Mental Health System. (2021). Final Report, Summary and Recommendations. State of Victoria. Melbourne
[48]Anderson,. P. (2020) Review into Improvements to Security In Hospitals. Sydney. NSW
[49] Commonwealth of Australia. (2020). Productivity Commission Inquiry Report Volume 1, No.95, 30 June 2020. Canberra, ACT
[50] Purcal, C., O'Shea, P. Giuntoli, G., Zmudzki, F., Fisher, K.R. (2022). Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative. CLS-HASI Evaluation Report. Sydney: UNSW Social Policy Research Centre
[51] NSW Council for Social Services (NCOSS). (2022) *Aftershock: Addressing the Economic and Social Costs of the Pandemic and Natural Disasters Report One – Mental Health. Sydney. NSW*
[52] Purcal, C., O'Shea, P. Giuntoli, G., Zmudzki, F., Fisher, K.R. (2022). Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative. CLS-HASI Evaluation Report. Sydney: UNSW Social Policy Research Centre
[53] Purcal, C., O'Shea, P. Giuntoli, G., Zmudzki, F., Fisher, K.R. (2022). Evaluation of NSW Community-based Mental Health Programs: Community Living Supports and Housing and Accommodation Support Initiative. CLS-HASI Evaluation Report. Sydney: UNSW Social Policy Research Centre
[54] Ridoutt, L., Leary, J., Stanford, D., Lawson, K., Cowles, C. and Yousif, M. (2022). Evaluation of the NSW Mental Health – Community Living Supports for Refugees Program (2019-21): Final Report. NSW Ministry of Health. Sydney
[55] NSW Mental Health Commission. (2022). High psychological distress in adults and secondary students. Accessed 7/11/2023
[56] ABS (Australian Bureau of Statistics). (2020-2022). *National Survey of Mental Health and Wellbeing: summary of results*. ABS, Canberra
[57] NSW Ministry of Health. (2023). MH-TRACE, Indicators of NSW Mental Health service demand and care. Release date: 24 Nov 2023. Sydney. NSW. (Unpublished)
[58] AIHW (Australian Institute of Health and Welfare). (2023). Community mental health care services (Table CMHC. 26), AIHW, Canberra. Accessed 8/11/2023
[59] NSW Ministry of Health. (2022). Your Experience of Service: What consumers say about NSW Mental Health Services 2020–21. NSW Ministry of Health, Sydney
[60] NSW Ministry of Health. (2022). Mental Health Carer Experience Survey: What carers say about NSW Mental Health Services 2021–22. NSW Ministry of Health, Sydney
[61] University of Canberra. (2023). About ESMS/DESDE. Access on 7/11/2023