# Clinical Services Plan to 2022 for SESLHD's Mental Health Services

Version 2.0 as at 7 October 2020

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# Abbreviations

| Abbreviation | Full name |
|---|---|
| AAGR | Average Annual Growth Rate |
| ACAT | Aged Care Assessment Team |
| ABS | Australian Bureau of Statistics |
| AIHW | Australian Institute of Health and Welfare |
| ALoS | Average Length of Stay |
| BPSD | Behavioural and psychological symptoms of dementia |
| CAFÉ | Child & Family East |
| CALD | Culturally and Linguistically Diverse |
| CAMHS | Child and Adolescent Mental Health Service |
| CASPAR | Comprehensive Assessment Service for Psychosis and At Risk |
| CESPHN | Central and Eastern Sydney Primary Health Network |
| CLS | Community Living Supports |
| CMO | Community Managed Organisation |
| CNC | Clinical Nurse Consultant |
| COPMI | Children of Parents with a Mental Illness |
| CRUfAD | Clinical Research Unit for Anxiety and Depression |
| ECT | Electroconvulsive therapy |
| ED | Emergency Department |
| eMR | Electronic Medical Record |
| FCMHP | Family and Carer Mental Health Program |
| GotIT | Getting On Track in Time Program |
| GP | General Practitioner |
| HASI | Housing and Accommodation Support Initiative |
| HETI | Health Education and Training Institute |
| KBIM | Keeping the Body In Mind |
| LGA | Local Government Area |
| LGBTI | Lesbian, gay, bisexual, trans and intersex |
| LHD | Local Health District |
| LHN | Local Health Network |
| MHICU | Mental Health Intensive Care Unit |
| MHPSP | Mental Health Patient Safety Program |
| MHS | Mental Health Service |
| NDIS | National Disability Insurance Scheme |
| NeuRA | Neuroscience Research Australia |
| NWAU | National Weighted Activity Unit |
| PACER | Police, Ambulance and Clinical Early Response Programme |
| PCLI | Pathways to Community Living Initiative |

| | |
|---|---|
| PECC | Psychiatric Emergency Care Centre |
| PEIPOD | Program for Early Intervention & Prevention of Disability |
| PEM | Public Equivalent Model |
| PHIDU | Public Health Information Development Unit |
| PICH | Primary, Integrated and Community Health |
| PIMHS | Perinatal & Infant Mental Health Service |
| POWH | Prince of Wales Hospital |
| SESLHD | South Eastern Sydney Local Health District |
| SGH | St George Hospital |
| SMHTAL | State Mental Health Telephone Access Line |
| SPHERE | Sydney Partnership for Health, Education, Research and Enterprise (Maridulu Budyari Gumal) |
| SRG | Service Related Group |
| TSH | The Sutherland Hospital |
| YPOP | Younger Persons Outreach Program |

# Prologue

The SESLHD MHS Clinical Services Plan was developed at a moment in time prior to NSW's worst bushfire season on record and first coronavirus disease (COVID-19) pandemic.

COVID-19 is currently the top priority for Australia's healthcare system. While there is still uncertainty about how the pandemic will unfold, the implications for the health care system broadly and our Mental Health Service locally will be long-felt.

It is with heartfelt gratitude that I extend my appreciation to our health leaders, mental health professionals and support staff for all they have done in 2020. There have been colossal efforts put in across the Service both in supporting bushfire-affected communities and during the pandemic with many positive actions and innovative solutions evidenced in trying times.

Mental Health Service efforts taken against COVID-19 so far include establishing and rapidly activating clear protocols and pandemic response teams; mobilising telehealth; fast-tracking increases in capacity of the workforce, connectivity and community partnerships; and many more.

It is likely that it will take some time post-pandemic to return to what could be considered 'business as usual'. While there is a natural desire to 'get back to how things were', it will be important to use the experience of this pandemic to best prepare our Mental Health Service for the next one, to reflect on positive transformations made to service delivery and critically evaluate our collective priorities in the new context.

As Australia transitions through the post-peak and post-pandemic periods in coming months, some planned activities will be put on hold whilst efforts are diverted to the management and treatment of COVID-19 and the required models of mental health care delivery. I acknowledge that this has impacted on the trajectory of our Clinical Service Planning activities and commitments as developed in 2019.

In response, SESLHD MHS will move to an annual business planning process that continues to hold onto the values and strategic directions that underpin the SESLHD MHS Clinical Services Plan whilst taking the current context into account when planning and prioritising activities.

Hopefully it will not be long before Australia enters a post-peak period and the plans, services and connections that we have established or modified across our service to better govern, manage and deliver during the pandemic will serve our community well into the future..

Angela Karooz
General Manager, Mental Health
South Eastern Sydney Local Health District

20th August 2020

# Executive Summary

This Clinical Services Plan aims to guide South Eastern Sydney Local Health District's (SESLHD) Mental Health Service (MHS) to best support people living with mental illness at times when acute intervention is required, remain well in their community and lead their own recovery.

In recent years there has been the ongoing development of consumer-focussed care across the MHS with new initiatives and services supporting this change. Yet based on data analysis, literature reviews, meetings and workshops as well as extensive consultation with consumers, members of the Consumer Advisory Committee and Peer Workers it is evident the MHS and our residents living with mental illness continue to face multiple vulnerabilities.

There is recognition the MHS needs to continue building strong partnerships to be able to provide care across the broad spectrum of our community's need.

The future directions and key actions are summarised overleaf, the changes we want to see are significant:

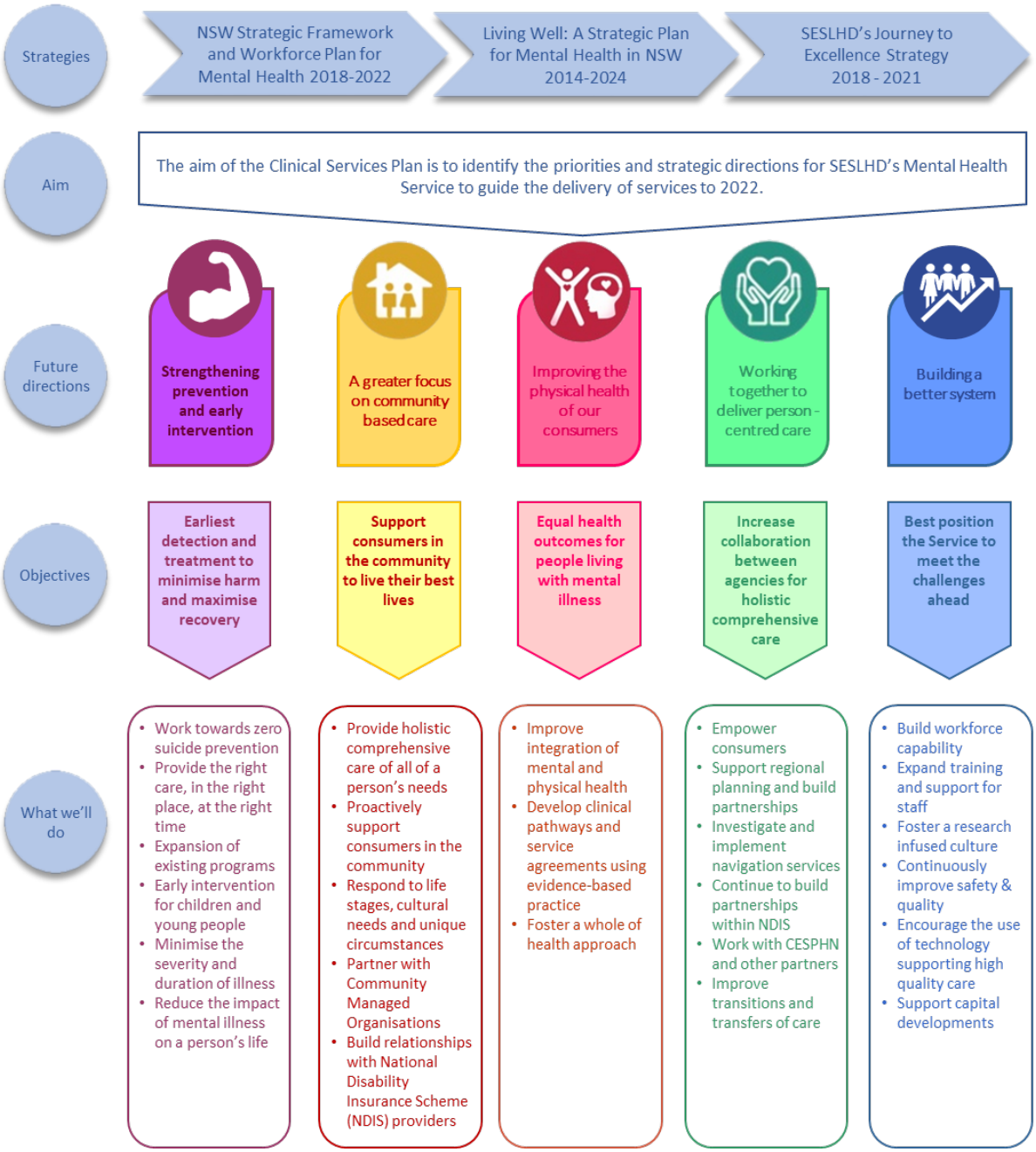
- Aiming for a broad perspective of prevention and early intervention – one which considers prevention and early intervention across all ages, throughout the course of illness, in ambulatory and inpatient settings, from primary, secondary and tertiary prevention perspectives and in collaboration with consumers, family, carers, primary care providers and other partners
- Widespread acceptance by consumers, the broader community and primary health and social service providers that ambulatory care is the preferred setting for delivering the vast majority services to people living with mental illness
- People living with mental illness will have the same physical health outcomes as those in the broader community
- Widespread acceptance that the best way to stabilise someone's mental health is by providing holistic comprehensive care of all of a person's needs.

Delivering these changes and the Plan's actions will require:

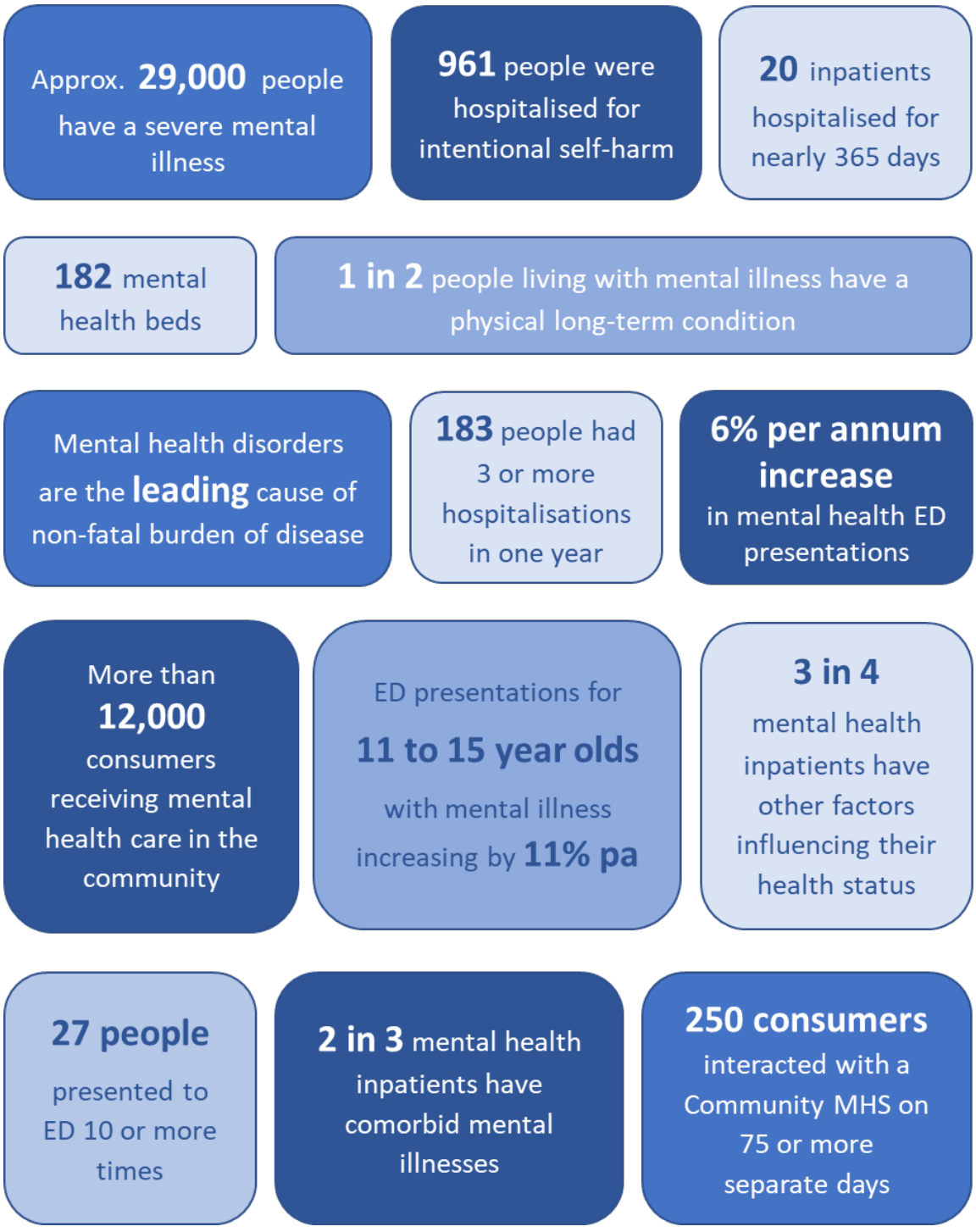
- Capable and compassionate staff
- A culture of delivering evidenced-informed best practice
- Continuous safety and quality improvement
- Fit-for-purpose infrastructure
- Harnessing technology and information systems to enhance care delivery.

To this end, this three year Plan is a starting point in a fundamental shift in the way care is delivered in a more externally focussed, recovery oriented approach.

# Summary of Clinical Services Plan



# Overview of SESLHD's residents living with mental illness and SESLHD service delivery 2018/19



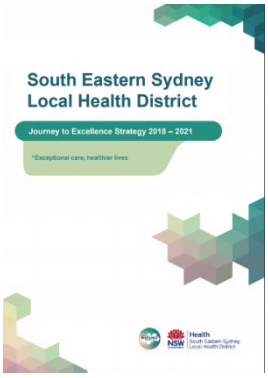

Data sources: refer to relevant sections in Plan

# 1. Introduction

## 1.1 Background

SESLHD is continuing to undertake a process of transformation radically changing its healthcare landscape.

SESLHD's vision for the next three years is 'exceptional care, healthier lives.' This vision acknowledges the responsibility to provide high quality, compassionate care when people need it. It also recognises SESLHD's role in enabling our community to stay healthy and well. Programs of work, aligned with the priorities set down in SESLHD's Journey to Excellence, aim to deliver optimal healthcare for our community now and in the future. These programs focus on:




- Safe, person-centred and integrated care.
- Workforce wellbeing.
- Better value.
- Community wellbeing and health equity.
- Foster research and innovation.

## 1.2 Aim of Clinical Services Plan

This Clinical Services Plan aims to:

- Summarise the strategic context in which the MHS operates
- Detail service demands
- Outline current services and future service needs
- Document future directions and actions to meet these objectives; including service developments, important strategies and resource investment

## 1.3 Plan's scope

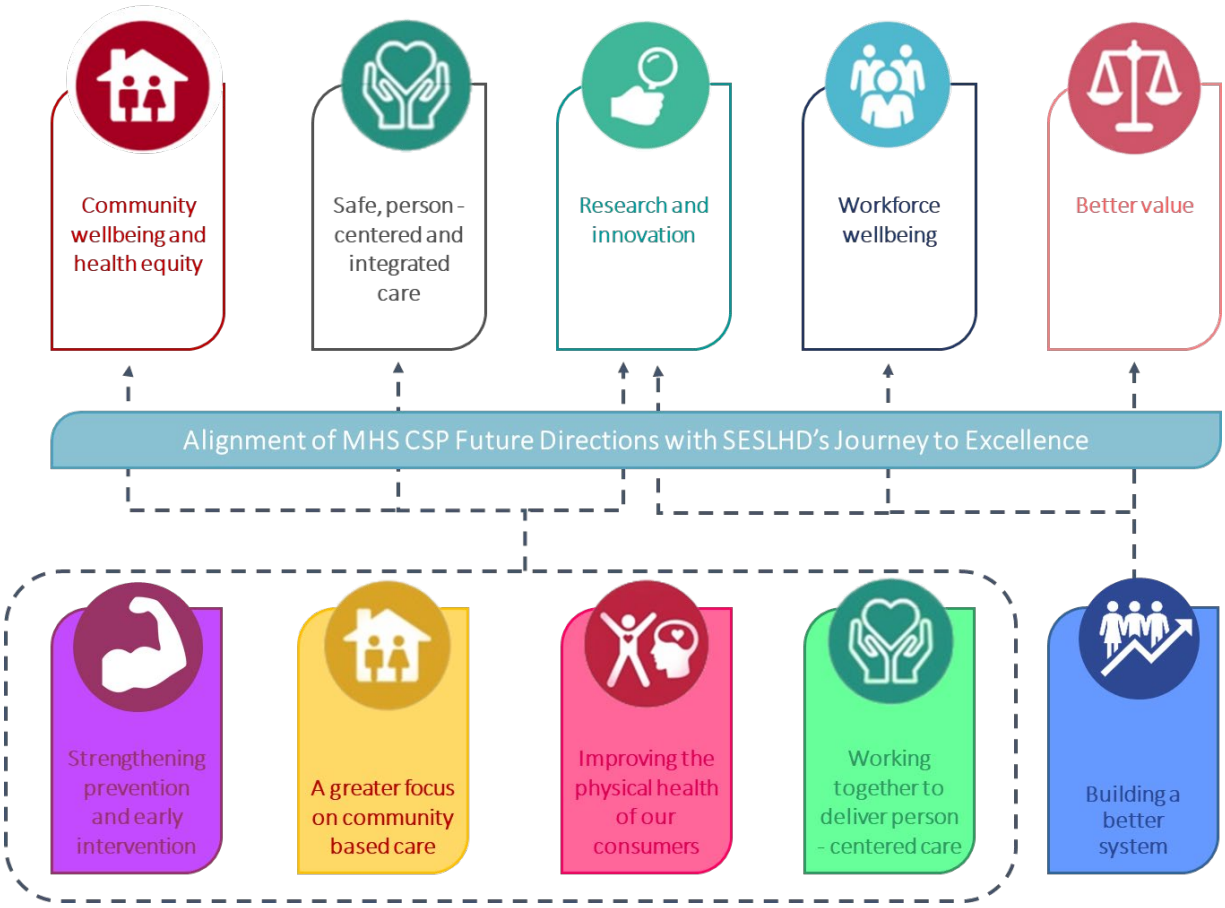
The Plan focuses on the future service delivery requirements of clinical services provided to people requiring specialist mental health care for moderate to severe mental illness and their families and carers. This incorporates tertiary ambulatory care and hospital-based services at distinct phases of illness and intensity of care e.g. acute, sub-acute, stable/recovery phase. As mental illness can occur at any stage of life, the scope includes children through to older adults. The Plan also considers relationships with other clinical services (e.g. emergency departments (ED), etc) as well as other health, social and care providers who are critical to supporting SESLHD's residents with mental illness.

The timeframe for the Plan is three years from 2019/20 to 2022/23. However, the actions were proposed with a view to continuing change beyond this period.

## 1.4 Structure of the Plan

The future directions outlined in this plan are aligned to five focus areas. The focus areas were chosen for their alignment with both the NSW Mental Health Reform 2014-2024 and the strategic themes identified in SESLHD's Journey to Excellence Strategy 2018-2021.

*Figure 1: Alignment of SESLHD MHS future directions with SESLHD's Journey to Excellence Strategy 2018 – 2021*



# 1.5 Development of the Plan

## 1.5.1 Development process

This document was based on publicly available data and information, service activity data analysis, and consultation. This initial review used information from SESLHD MHS, Commonwealth and NSW strategies, policies and guidelines as well as information from other entities.

Data was sourced through various channels including:

- Population based data from NSW HealthStats, NSW Mental Health Commission and Public Health Information Development Unit (PHIDU).
- Activity data provided by SESLHD MHS.
- Benchmark prevalence and service delivery data provided by SESLHD's Strategy and Planning Unit using the National Mental Health Service Planning Framework.

Consultation included:

- Raising awareness of the Plan's development by SESLHD MHS through regular meetings.
- Workshops held with Eastern Suburbs and St George/Sutherland MHS's and the MHS Clinical Council.
- Meetings held with MHS Executive.
- Review of the early iterations of the draft Plan by MHS staff and Executive.
- Extensive consultation with consumers, members of the Consumer Advisory Committee and Peer Workers of the MHS.
- Request for feedback from a broad range of stakeholders including other SESLHD staff and agencies (see Appendix).

> *"… we have an absolute powerhouse of lived experience across SESLHD, and an immense amount of passion and energy for bettering our service"*

Feedback was collated and used to refine the Plan prior to finalising it for approval.

# 2. Planning context

## 2.1 SESLHD's Mental Health Clinical Services Plan 2013-2018

In 2013 SESLHD MHS Directorate with input from a wide range of stakeholders developed the SESLHD's Mental Health Clinical Services Plan 2013-2018[1]. The Plan:

- Identified the scope and breadth of the community and those needing to access mental health services.
- Presented an outline of current services and strategic priorities for the MHS.
- Supplied an overview of the MHS reflecting the diversity and complexity of clinical need.
- Noted key external service partners.


In 2016 an update of the Plan informed the Greater Randwick Integrated Health Services Plan[2].

Reviews of the Plan identified that the MHS delivered on many of its key initiatives and recommendations. Of note and fundamental to the delivery of services, has been the ongoing development of consumer-focussed care, and keeping people living with mental illness well in the community through prevention, early intervention and assertive community care in or close to their home.

## 2.2 New services and initiatives of SESLHD MHS

In recent years, SESLHD MHS has implemented new and innovative models of care and services that have enhanced the care we provide to our community. Specifically, new services and initiatives developed since the previous Plan commenced in 2013 include:

- Keeping the Body in Mind (KBIM).
- South Eastern Sydney Recovery and Wellbeing College[3] .
- headspace Bondi Junction.
- Comprehensive Assessment Service for Psychosis and At Risk (CASPAR).
- Perinatal Infant Mental Health Service (PIMHS).
- y-QUIT a SESLHD-wide smoking cessation program.
- Police, Ambulance and Clinical Early Response (PACER) program.
- Getting On Track In Time (GOT It) program.
- Eating Disorders Service.

[1] SESLHD, 2013

[2] SESLHD, 2016

[3] Sommer, Gill & Stein-Parbury (2018) 'Walking side-by-side: Recovery Colleges revolutionising mental health care', Mental Health and Social Inclusion, Vol. 22 Issue: 1, pp.18-26

- Management structures for the Peer Workforce including reviewing models of care across both inpatient and community.
- Enhanced workplace capabilities shifting the MHS to contemporary training and education aligned with themes of recovery oriented practice, person-centred care, trauma informed care and strengths model of practice.
- Embedded Recovery and Strengths as overriding approaches in all clinical work.

For further detail on these services and initiatives refer to Section 4.1. Mental Health Services.

## 2.3 Commonwealth, State and SESLHD strategic directions

Over the past three decades, Australian and State governments have committed to reforming the mental health system through what has come to be known as the National Mental Health Strategy. The Strategy is articulated in a suite of planning documents, priorities, policies and guidelines to realise a vision of ensuring that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community. The latest national document is the Fifth National Mental Health and Suicide Prevention Plan published in 2018. [4]

During this period, reforms have sought to reduce the reliance on institutionalised care in favour of community-based care alternatives and episodic acute inpatient care in public hospitals. In addition, there has been greater emphasis on mental health promotion and mental illness prevention, coordination of service delivery, quality services and person-centred, recovery-oriented care.

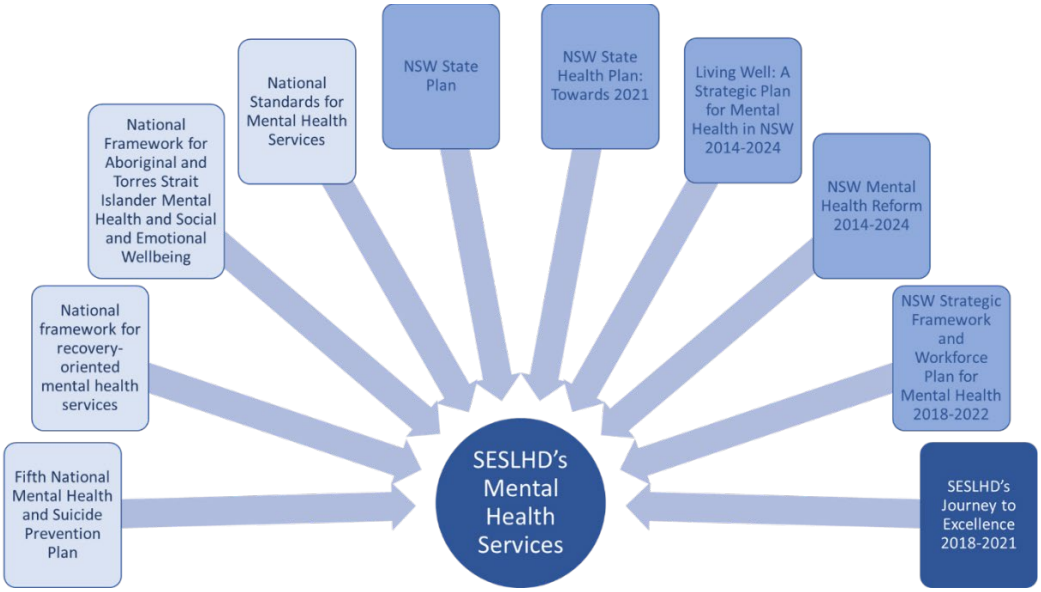
In NSW, the 'Living Well' report and accompanying plan were developed by the Mental Health Commission of NSW following a two-year consultation with the community.[5] The NSW Government responded to these documents by implementing the *NSW Mental Health Reform 2014-2024* and the *NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022: A Framework and Workforce Plan for NSW Health Services.*

The MHS was informed by the following documents in the development of the Clinical Services Plan. For a complete list of key documents, refer to Appendix and References.

[4] Council of Australian Governments Health Council, 2018.

[5] NSW Mental Health Commission, 2014, Living Well: Putting People at the Centre of Mental Health Reform in NSW: A report, and Living Well: A Strategic Plan for Mental Health in NSW 2014- 2024.

*Figure 2: Overview of some key strategic documents informing SESLHD MHS*




Note: for a detailed list of key documents refer to Appendix and References.

## 2.4 Mental Health and Suicide Prevention Regional Plan, Central and Eastern Sydney

The Mental Health and Suicide Prevention Regional Plan, Central and Eastern Sydney (2019-2022), commits the Central and Eastern Sydney PHN, Sydney Local Health District, South Eastern Sydney Local Health District, St Vincent's Health Network and the Sydney Children's Hospital to work together to achieve integration in planning and service delivery. Joining this consortium as signatories are the peak bodies for people with lived experience (Being NSW), for carers (NSW Mental Health Carers), and community managed organisations (the Mental Health Coordinating Council).

The Regional Plan establishes a platform for the partners to engage with other key agencies and stakeholders, to work together and combine resources in the pursuit of shared priorities identified by the community. It outlines solutions to address current problems such as "fragmentation of services and pathways, gaps, duplication and inefficiencies in service provision, and a lack of person-centred care" and seeks to ensure resources are targeted to best respond to local mental health and suicide prevention needs.

The Regional Plan's priorities are:

- Access and equity
- Improving the mental health of priority population groups.
- Improving the physical health of people with mental illness
- Improving Aboriginal mental health and suicide prevention
- Suicide prevention
- Integrated services
- Workforce.

In addition to identifying specific priorities and an implementation plan, core actions are identified and include (but not limited to) joint commissioning of services, 'no wrong door' approach, shared clinical governance mechanisms and quality processes.

## 2.5 Other organisations' strategic directions

The Plan considered strategies and planning of other organisations including:

- Central and Eastern Sydney Primary Health Network (CESPHN) Strategic Plan 2019-2021[6].
- Being | Mental Health and Wellbeing Consumer Advisory Group[7].
- Mindgardens Neuroscience Network.
- Sydney Children's Hospital Randwick[8].
- St Vincent's Hospital Sydney[9].
- NSW Government[10].

## 2.5 Quality standards for mental health care

The National Standards for Mental Health Services aim to assist the development and implementation of appropriate practices and guide continuous quality improvement in mental health services[11]. They are:

- Standard 1. Rights and responsibilities.
- Standard 2. Safety.
- Standard 3. Consumer and carer participation.
- Standard 4. Diversity responsiveness.
- Standard 5. Promotion and prevention.
- Standard 6. Consumers.
- Standard 7. Carers.
- Standard 8. Governance, leadership and management.
- Standard 9. Integration.
- Standard 10. Delivery of care.

The Standards also include six Recovery Principles to ensure the provision of mental health care supports the recovery of individuals living with mental illness:

- Uniqueness of the individual
- Real choices
- Attitudes and rights
- Dignity and respect
- Partnership and communication
- Evaluating recovery.

[6] CESPHN, 2018, Strategic Plan 2019-2021

[7] Being, 2015, Being Strategic Plan 2015 - 2018

[8] Sydney Children's Hospital Network (SCHN), 2017, Strategic Plan 2017 - 2022

[9] St Vincent's Health Australia, 2017, St Vincent's Integrated Healthcare Campus Darlinghurst Clinical Services Strategy – 2027

[10] Their Futures Matter a whole-of-government reform to deliver improved outcomes for vulnerable children and families.

[11] Australian Commission on Safety and Quality in Health Care, 2010, National Standards for Mental Health Services

It is also noted that the National Standards for all health service organisations (not just mental health services) embeds person-centred care and particularly supports improvements in the delivery of health care to people living with mental illness. Underpinning this change is that caring for a person's mental and physical health are integrated processes, that person-centred care meets all the person's health needs[12].

SESLHD MHS was surveyed against the National Safety and Quality Health Service Standards in November 2018, and was awarded accreditation for the period January 2019 through to 2022.

## 2.6 Approaches guiding mental health services

Central to many of these strategic documents is delivering high quality mental health care with some common themes appearing:


In addition, there are a range of principles and approaches guiding the delivery of mental health services. These include:

- Recovery-oriented practice
- Trauma-informed care
- Integrated care
- Lived experience
- Strengths based approach
- Co-production with consumers and carers
- Suicide prevention
- Reduction of restrictive practices
- Shifting care into the community
- Evidence-based care
- Physical Health in Mental Health.

For more detail about each of these, refer to Appendix.

[12] Australian Commission on Safety and Quality in Health Care, 2017, National Safety and Quality Health Service Standards Second Edition

# 3. Mental illness

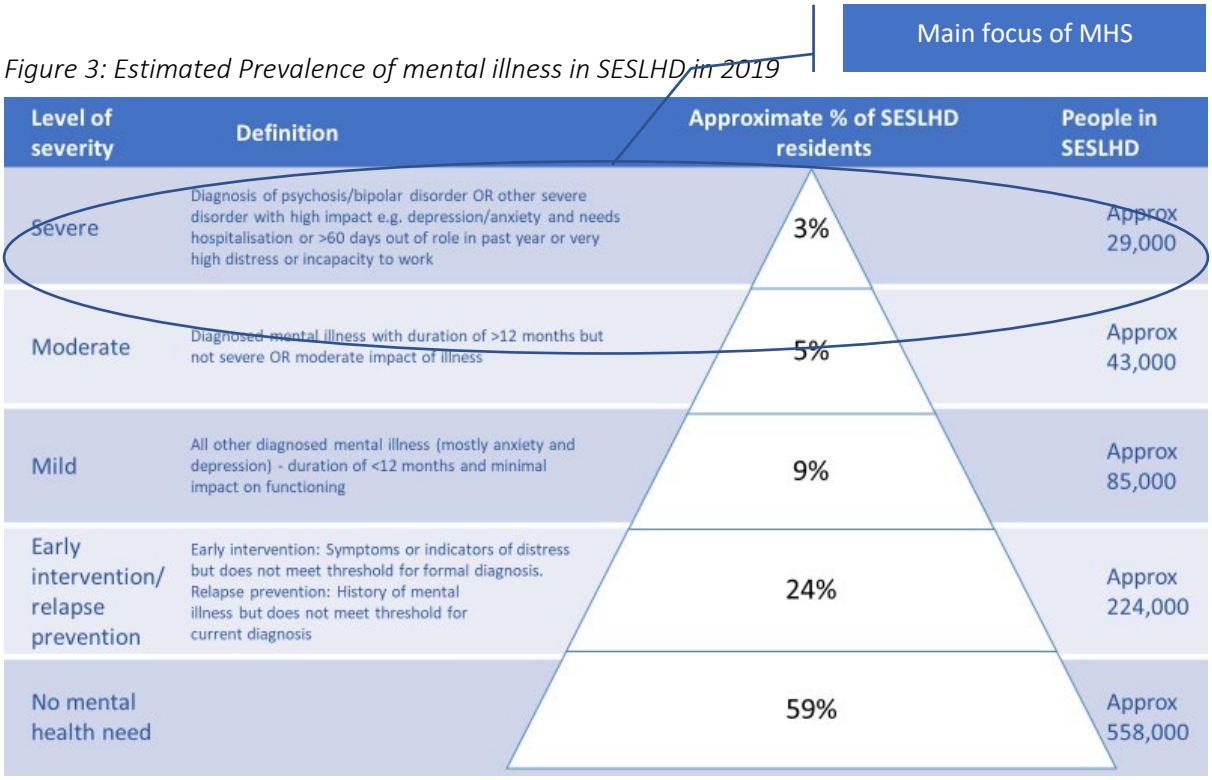
## 3.1 Prevalence of mental illness in SESLHD

It is estimated that of SESLHD's 940,000 residents, approximately 157,000 will experience mental illness requiring treatment in 2019[13].

For most people their level of disability will be mild to moderate, while approximately 29,000 people are estimated to be living with severe mental illness.

However, this estimated prevalence does not take account of socio-demographic variability and/or clustering of higher needs groups. For example, SESLHD has an overrepresentation of living in boarding houses and culturally diverse populations, who generally experience higher prevalence of severe and complex mental illnesses.

*Figure 3: Estimated Prevalence of mental illness in SESLHD in 2019*




Source: Adapted from Living Well: A Strategic Plan for Mental Health in NSW using rounded data from National Mental Health Service Planning Framework tool[14]

[13] University of Queensland, 2016, National Mental Health Service Planning Framework v2.1. Refer to Appendix for detailed data

[14] For detailed data refer to Appendix. NSW Mental Health Commission, 2014, Living Well: A Strategic Plan for Mental Health in NSW

## 3.2 Changing population will increase numbers of people with mental illness in SESLHD

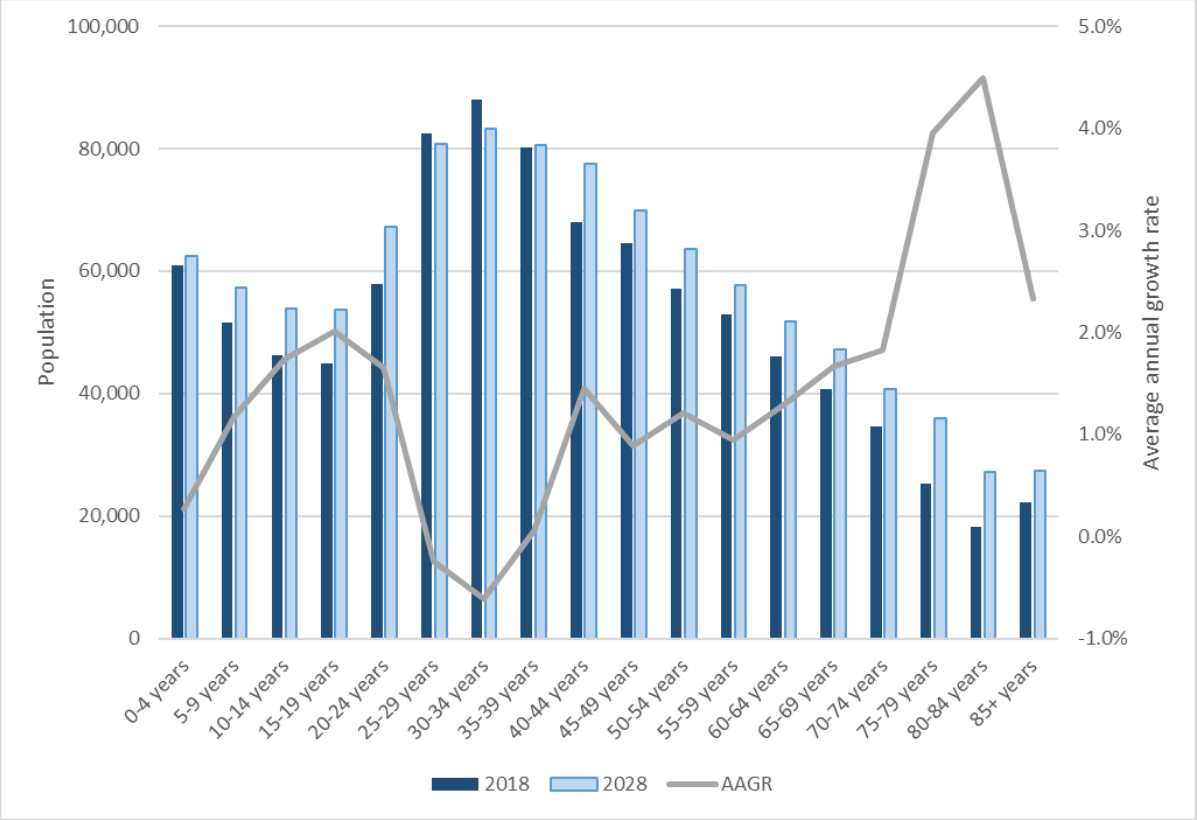
SESLHD's population is projected to grow and age (Figure 4). By 2028 the number of residents is expected to increase by 60,000 to more than 1 million people:

- Groups with most people continue to be those aged between 25 and 49 years.
- There will be a very high rate of growth[15] for SESLHD's older residents. Those aged between
  - 80 and 84 years increasing by 4.5% (compared to 0.9% growth for all other age groups),
  - 75 to 79 years by 4.0% and
  - 85 years and older by 2.3%.

This creates inter-related problems for mental health services:

- More residents mean a larger number of people living with mental illness
- This will increase demand for all mental health services, particularly proportionately for older people
- The health professional workforce needed to meet health service demand is also ageing. An undersupply of skilled professionals may weaken service delivery capacity.

*Figure 4: Growth and changing age structure of SESLHD's population, 2018 to 2028*




Source: NSW Health, Centre for Epidemiology and Evidence, 2018

[15] Annual average growth rate

## 3.3 Impact of diverse experiences on mental illness in SESLHD

While the population of SESLHD as a whole compares favourably with the NSW population, there is marked variation between various sub-populations resident across SESLHD in terms of risk factors and their outcomes.

The SESLHD Equity Strategy[16] identifies people with moderate to severe mental illnesses as a group more likely to experience inequities in health and wellbeing. The life expectancy of people with serious mental illness is typically between 10 and 32 years shorter than the general population. Around 80% of this higher mortality rate can be attributed to the much higher rates of physical illnesses, such as cardiovascular diseases, respiratory illnesses, diabetes and cancer. Many of these causes of premature death are due to preventable illnesses caused by increased high risk behaviours such as smoking, substance abuse, and exposure to communicable diseases such as hepatitis C. Further, some medications prescribed for people with mental illness are associated with weight gain, obesity and new onset diabetes. Mental illness also affects a person's ability to manage chronic illnesses, which may result in multiple illness complications. People living with mental illness are also more at risk of experiencing a range of adverse social, economic and health outcomes, such as homelessness, social isolation, and unemployment which may exacerbate mental illness symptoms.

A number of vulnerable groups in SESLHD are recognised as having higher rates of mental illnesses and associated risk factors than their peers. Groups at elevated risk and/or facing unique challenges are identified as:

- Children and young people
- Parents experiencing perinatal mental health issues
- Older people
- Aboriginal people
- People from Culturally and Linguistically Diverse (CALD) backgrounds
- People who are homeless
- Lesbian, gay, bisexual, trans, queer and intersex (LGBTQI) people
- People with an intellectual disability
- People living with complex mental health and co-existing complex physical health needs
- People with co-existing drug and alcohol issues
- Family and carers of people experiencing mental illness.

SESLHD MHS is committed to prioritising inclusive and responsive service delivery, targeted initiatives and developing partnerships for groups and sub-populations where additional and/or complex needs are not necessarily met in routine service delivery.

[16] SESLHD, 2015, South Eastern Sydney Local Health District Equity Strategy

### 3.3.1 Children and young people

Childhood, through adolescence to young adulthood is a period of notable change. In infancy, physical and emotional development may be compromised by exposure to ongoing violence, abuse and neglect, whether they are the target of the violence[17]. For young people, peer pressure, increasing responsibilities, disengagement, greater likelihood of risk taking and experimentation, concerns about school or study, coping with stress, sexuality, gender identity and body image can adversely affect mental health and self-esteem[18]. In addition, the context and type of family relationships have a huge impact on children and adolescent's mental health. Families may provide support and protective factors however situations such as divorce, separation, family conflict, and out of home care all impact mental health and may place a young person at increased risk for difficulties that continue into their adult life[19][20].

> *Approximately 16,000 young people living in SESLHD had a mental disorder in the previous 12 months*

This phase of life is the most common time for onset of mental illness. Three quarters of severe and enduring mental illnesses emerge before the age of 24. It is estimated that almost one in seven children and adolescents aged 4–17 years were assessed as having a mental illness in a 12-month period, which equates to 16,000 young people living in SESLHD.[21] Young people aged 16-24 years is the age group with the highest prevalence rates of mental illness, with more than one in four (26%) experiencing a mental illness in the past 12 months[22].

### 3.3.2 Older people living with mental illness

While many people's mental health improves as they get older, this is not true for all. There are some older people whose long term mental illnesses continue into old age, and others may develop mental illness due to the impact of grief, loss of identity, loneliness, social isolation and/or their mental illness may be associated with physical long term conditions, dementia, etc[23]. For some older people their living arrangements may compound their mental illness, with those living in residential care facilities having higher rates of mental illness than those living in their own home[24]. Men aged 85 years and older have the highest age-specific suicide rate[25]. Older people

> *Older people in SESLHD with a diagnosable mental illness is nearly 16,000*

[17] NSW Health, 2019, The Case for Change: Integrated prevention and response to violence, abuse and neglect in NSW Health

[18] NSW Mental Health Commission, 2014, Living Well: A Strategic Plan for Mental Health in NSW

[19] NSW Health, 2019, The First 2000 Days Framework

[20] Felitti, Vincent J et al, 1998, The Adverse Childhood Experiences (ACE) Study

[21] Assumptions: Estimated resident population of children and adolescents aged 4–17 in 2017 (PHIDU, 2019b) and 12.6% children and adolescents aged 4–17 living in a greater capital city had a mental disorder in the previous 12 months (Australian Institute of Health and Welfare, 2016)

[22] Australian Institute of Health and Welfare 2011. Young Australians: their health and wellbeing 2011. URL: https://www.aihw.gov.au/getmedia/14eed34e-2e0f-441d-88cb-ef376196f587/12750.pdf.aspx?inline=true

[23] NSW Health, 2017, NSW Older People's Mental Health Services Service Plan 2017-2027

[24] URL: https://nswmentalhealthcommission.com.au/sites/default/files/documents/living_well_in_later_life_-_the_case_for_change.pdf

[25] ABS, 2017, Catalogue number: 3303.0 - Causes of Death, Australia, 2017

presenting with mental illness are more likely to have atypical presentations, other physical health conditions, complex care needs, different responses to medication and a slower clinical recovery. Across NSW there is recognition of the need to ensure a plan is in place for the growing number of older people with complex and challenging mental health and comorbid physical health presentations.

For residents of SESLHD, the number of older people with a diagnosable mental illness is estimated to be nearly 16,000 in 2019[26] with this number rising as SESLHD's population increases and ages.

### 3.3.3 Aboriginal people

Aboriginal people may have protective factors such as a strong cultural identity and connections to country, family and community, yet they continue to be at greater risk of mental illness than non-Aboriginal people[27] [28]. This difference in mental health has been associated with many contributing factors; including dispossession, intergenerational trauma, separation policies through to discrimination, racism, isolation, unemployment, poverty, incarceration and alcohol and substance abuse[29].

*Approximately 2,400 Aboriginal adults residing in SESLHD live with a diagnosed mental illness*

It is estimated one in three, or approximately 2,400 Aboriginal adults in SESLHD, live with a diagnosed mental illness[30].

### 3.3.4 People from Culturally and Linguistically Diverse (CALD) backgrounds

For people of CALD backgrounds, mental health and wellbeing can involve extra challenges. For some people, their experience prior to arriving in Australia may have involved war, torture, trauma, loss and/or a complex travel and resettlement. Once living in Australia there may be language barriers, cultural differences, isolation and unemployment, all potentially placing some people at greater risk of mental illness[31]. In addition, adjustment to culture/psychosocial differences or bi-cultural issues can create extra challenges for children and young people from CALD backgrounds within our mental health systems.

Understanding the role of culture and the socioeconomic, religious, political, linguistic and familial frameworks of individuals and their communities is essential to the effective assessment, diagnosis and treatment of mental illness. Processes and services recognising diversity are critical to achieving equitable access and outcomes.

The percent of the population with CALD backgrounds is higher in SESLHD than NSW. In 2016, 28% of SESLHD's population (approximately 250,000 people) were born in a predominantly non-English speaking

[26] Refer to Appendix Table 6: Benchmarked prevalence and treated population by age group, SESLHD

[27] Australian Bureau of Statistics, 2016, Catalogue Nos 4714.0 - National Aboriginal and Torres Strait Islander Social Survey, 2014-15

[28] NSW Health, Centre for Epidemiology and Evidence, 2012, The health of Aboriginal people of NSW: Report of the Chief Health Officer

[29] Dudgeon P, 2014, Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people. Issues paper no. 12

[30] Assumptions: Usual place of residence for Aboriginal people aged 15 years and older in 2016 (PHIDU, 2019a), 33.1% of Aboriginal and Torres Strait Islander people aged 15 years and over living in non-remote Australia reported a diagnosed mental health condition (Australian Bureau of Statistics, 2016).

[31] NSW Mental Health Commission, 2014, Living Well: A Strategic Plan for Mental Health in NSW

country, the majority were residents of Georges River, Rockdale and Randwick LGAs[32] with people born in China making up the largest population from a non-English speaking country, followed by Indonesia, Greece and Hong Kong. One-third of SESLHD residents (approximately 300,000 people) speak a language other than English at home, the most common languages being Mandarin, Cantonese, Greek and Arabic.

### 3.3.5 Homeless people

People who are homeless have a higher prevalence of mental illness. Homelessness can both exacerbate existing mental health issues and contribute to the onset of new mental health illnesses. This is compounded by being amongst the most socially and economically disadvantaged people, and their homelessness both harming their health and making it more difficult to access the right health care at the right time[33].

*Nearly 4,000 homeless men, women, children and young people living in SESLHD have a mental health issue*

It is estimated more than half of SESLHD's homeless people have a mental health issue (nearly 4,000 homeless men, women, children and young people)[34].

### 3.3.6 Lesbian, gay, bisexual, trans, queer and intersex (LGBTQI) people

LGBTQI people are at risk of higher rates of some mental illnesses or suicidal feelings than the broader community. This is predominantly due to the stigma, discrimination and marginalisation they experience. The National LGBTI Health Alliance reports that:

- At least 36% of trans and 24% of gay, lesbian and bisexual Australians met the criteria for experiencing a major depressive episode (compared with 6.8% of the general population).
- [LGBTI people] are twice as likely to have a high/very high level of psychological distress as their heterosexual peers (18% compared with 9%).
- More than twice as many {LGBTI] Australians experience anxiety disorders as heterosexual people (31% compared with14%) and over three times as many experience affective disorders (19% compared with 6%).
- Up to 80% of same-sex attracted and gender-questioning young Australians experience public insult, 20% explicit threats, 18% physical abuse and 26% 'other' forms of homophobia (80% of this abuse occurs at school).
- Homophobic abuse and rejecting reactions are associated with feelings of shame, isolation and low self esteem, and may contribute to higher rates of self-harm, depressed mood and suicidal behaviour[35].

[32] Public Health Information Development Unit (PHIDU). Social Health Atlas of NSW & ACT: Data by LGA (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data. Accessed 23 September 2018

[33] Costello, Thomson, & Jones, 2013, Mental Health and Homelessness: Final Report

[34] Assumptions: Number of homeless people living in SESLHD and '… 53% of participants in the most recent Homelessness NSW Registry Week reported a mental health issue' (SESLHD, 2018)

[35] Rosenstreich, G. (2013) LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance. Sydney At https://www.beyondblue.org.au/docs/default-source/default-document-library/bw0258-lgbti-mental-health-and-suicide-2013-2nd-edition.pdf?sfvrsn=2 Accessed 7 August 2019

Around 10% of people across Australia experience same-sex attraction[36] with growing numbers of young people identifying as transgender or gender diverse. LGBTQI young people are twice as likely to be diagnosed with a mental illness, six times more likely to have suicidal thoughts and five times more likely to make an attempt on their life than their heterosexual peers[37].

### 3.3.7 People with an intellectual disability

People with an intellectual disability experience significantly poorer mental health and lower rates of treatment than the broader community. This may be due to several interacting factors including intellectual deficits affecting a person's ability to cope with routine tasks limiting their ability to communicate, leading to limited social networks and/or the person may have a history of physical or sexual abuse. Access to services may be compromised by their complex presentation, the need for interagency coordination and health professionals lacking training and expertise in supporting a person with an intellectual disability and poor mental health[38].

*3,000 people with an intellectual disability living in SESLHD have experienced a mental illness*

It is estimated four out of every ten people with an intellectual disability have experienced a mental illness, equating to around 3,000 people living in SESLHD[39].

### 3.3.8 People with a history of complex trauma

Although trauma is a part of everyday life not all people experience significant disability from the stress it creates. It seems how trauma impacts a person depends on the '*… type or severity of the trauma, the frequency of the trauma, the age we are when it occurs, and the supports we have around us at the time of the trauma and for the years after the event'*[40]. However, some groups of people are at greater risk of experiencing complex trauma including people who have experienced:

*It is estimated 94,000 people living in SESLHD will experience significant disability from the stress of a traumatic event at some time*

- Sustained discrimination and abuse such as refugees, people whose first language is not English, Aboriginal and Torres Strait Islander people as well as lesbian, gay, bisexual, transgender and intersex people.
- War (e.g. war veterans), torture (e.g. refugees) and crime (e.g. 'first responder' police and ambulance).

[36] Morris, S, 2016, Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People and Communities. URL: https://lgbtihealth.org.au/wp-content/uploads/2016/07/SNAPSHOT-Mental-Health-and-Suicide-Prevention-Outcomes-for-LGBTI-people-and-communities.pdf

[37] Robinson, K. et al, 2014, Growing Up Queer: Issues Facing Young Australians Who Are Gender Variant and Sexuality Diverse. URL: https://www.glhv.org.au/sites/default/files/Growing_Up_Queer2014.pdf

[38] NSW Mental Health Commission, 2014, Living Well: A Strategic Plan for Mental Health in NSW

[39] Assumptions: number of people living with intellectual disability (SESLHD, 2013), 40% of people with an intellectual disability have experienced a mental health disorder (NSW Mental Health Commission, 2014)

[40] Victorian Department of Health and Human Services, Trauma and mental health: 10-year mental health plan technical paper

- Impact of family violence and/or sexual assault.
- Childhood sexual abuse.
- Intergenerational trauma.
- Developmental trauma affecting cognitive development and brain structures for children and adolescents[41].

For people living in SESLHD, it is estimated 94,000 (1 in 10 people) will experience significant disability from the stress of a traumatic event at some time[42].

### 3.3.9 People living with severe and enduring mental illness

Some people have severe and enduring mental illness with a very complex range of co-occurring needs and issues. These may include substance misuse, intellectual disability or poor cognitive function, being at risk to others or themselves, childhood trauma and significant stigma and discrimination. For some of these people, hospitalisations can be lengthy due to the complexity of their health and social problems.

> *In SESLHD approximately 29,000 people live with a severe mental illness*

In SESLHD there are approximately 29,000 people with a severe mental illness. And at the time of this Plan's development, there were 20 patients with a combined length of stay of more than 6,000 bed days (i.e. nearly one year for each of these inpatients), their discharge postponed by lack of access to supported accommodation.

### 3.3.10 People living with complex mental health and co-existing complex physical health needs

Some people with complex mental illnesses are also living with complex physical health conditions, such as heart and/or kidney disease. It is important to note that mental illness and its treatment may predispose an individual to physical health conditions.

People living with complex mental and physical health needs are likely to require treatment and care from multiple specialists, services and primary care providers as well as care and support from carers, family and other service providers. Navigating, planning and managing their health care can be challenging and must be tailored to individual needs which are likely to change over time[43].

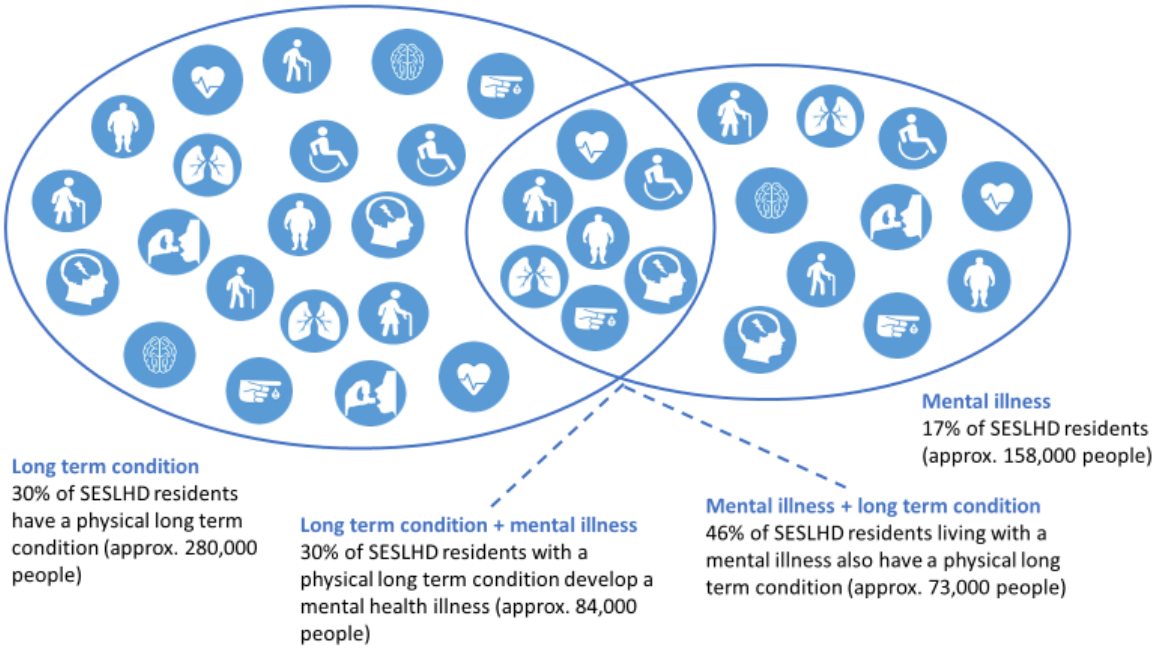
> *There are approximately 73,000 people living in SESLHD with both mental illness and physical long-term condition(s).*

[41] NSW Health, 2019, The First 2000 Days Framework

[42] Douglas, 2016, Trauma-related stress in Australia

[43] UK National Institute for Health Research, 2019, Making care safer for adults with complex health needs

*Figure 5: Mental illness and physical comorbidities, SESLHD*




Source: Adapted using percentages sourced from King's Fund (UK)[44] and data from National Mental Health Services Planning Framework

### 3.3.11 People with co-existing drug dependence

People living with a mental illness are more likely to use non-prescribed drugs and/or alcohol at far higher rates than the general community. They may use drugs and/or alcohol to make their symptoms feel better in the short-term. People who use drugs may trigger the first symptoms of mental illness. Over time, combined mental illness and substance use can 'perpetuate and exacerbate each other',[45] making the symptoms of mental illnesses worse and treatment more complicated and/or less effective.

> *7 of every 10 people who receive support from a mental health service also have a difficulty with drug and/or alcohol use*

It is estimated up to seven out of ten people who receive support from a mental health service also have difficulty with drug and/or alcohol use[46].

[44] Naylor CP et al, 2012, Long-term conditions and mental health: The cost of co-morbidities

[45] NSW Mental Health Commission, 2014, Living Well: A Strategic Plan for Mental Health in NSW

[46] Assumptions: '… 71% of people who receive support from a mental health service also have a difficulty with drug and alcohol use' (NSW Mental Health Commission, 2014)

### 3.3.12 People with eating disorders

Eating disorders are a group of mental illnesses which can adversely impact, or permanently impair physical and mental health, growth and development. They have very high rates of comorbidity of medical conditions and the highest mortality rate of any psychiatric illness.

Most people with an eating disorder who receive evidence-based treatment in a timely manner make a full recovery. However, this treatment requires a range of interventions, can be challenging and may require prolonged treatment. Yet, provision of care over extended periods can minimise deterioration in physical and psychosocial functioning, contain escalation and moderate demand on the broader health system.

*There are more than 30,000 people living in SESLHD with a clinically significant eating disorder*

It is estimated that 4% of the population is affected by an eating disorder to clinically significant levels[47]. This equates to more than 30,000 individuals (aged 15 or over) living in SESLHD with a clinically significant eating disorder (Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder or Eating Disorder Not Otherwise Specified).

### 3.3.13 Families and carers of people experiencing mental illness

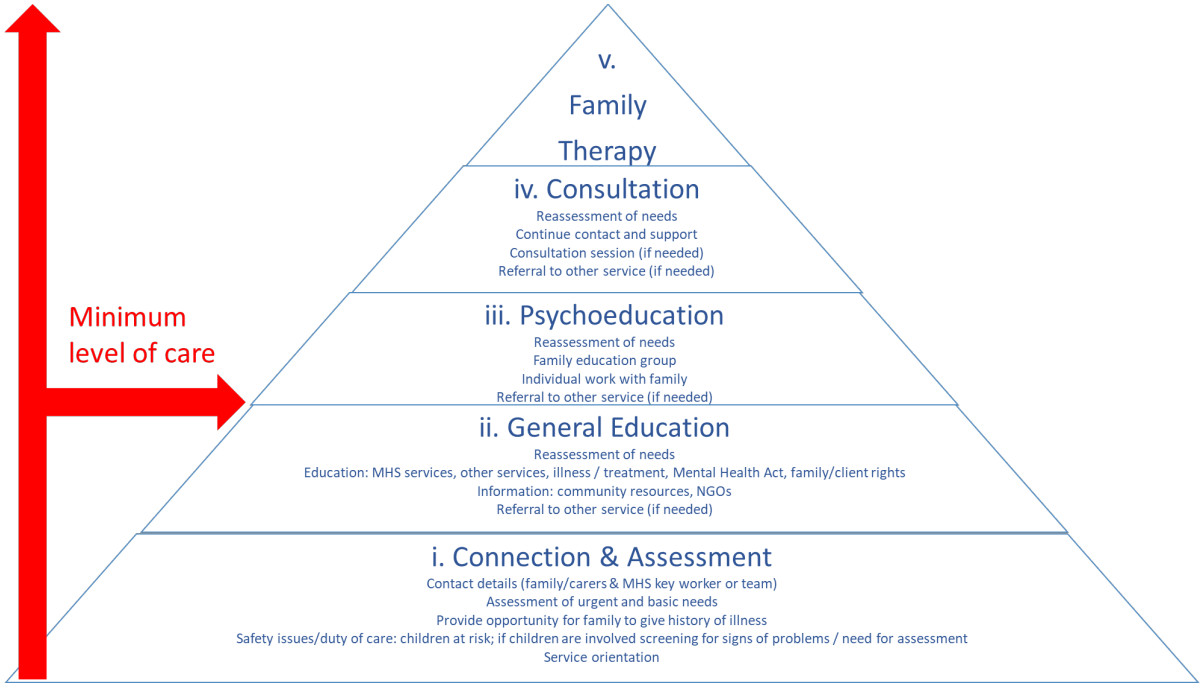
SESLHD recognises the valuable contribution families and carers play in supporting consumer recovery. Often, but not always, carers are spouses, parents, adult children or younger children of a person needing support. Some people are caring for more than one person. Carers may assist with activities of daily living, being a key person for transport, social support, medical appointment support or providing emotional support and assisting with decision making. They may care for a few hours a week or all day, every day, seven days a week. Not all those who provide care to another would call themselves carers. Due to cultural expectations, language, or because their relationship to the person being cared for has always included an element of "loving care" for example spouses or parents. Carers often struggle navigating their way through the health system and advocating for their loved ones.

In SESLHD, 10% of the population over the age of 15 years are carers (nearly 80,000 people) with 60% of the carer population being women. Most carers are aged between 50 and 69 years (70%). The St George area (Georges River LGA and Rockdale LGA) has the highest percentage of carers by population across SESLHD (28% of SESLHD's population; 32% of the total carer population).

*There are nearly 80,000 carers living in SESLHD*

[47] Deloitte Access Economics, 2012, Economic and social costs of eating disorders in Australia. URL: https://thebutterflyfoundation.org.au/assets/Uploads/Butterfly-report-Paying-the-Price-Executive-Summary.pdf

*Figure 6: Pyramid of family care*




## 3.3.14 Other factors

Other factors which may affect SESLHD resident's mental health include:

**Socioeconomic context**

- 12,000 people are long-term unemployed
- 17,000 adults experienced a barrier to accessing healthcare when needed it in the last 12 months, with the main reason being cost of service
- 18,000 children live in low income families
- 95,000 are pensioners (aged, disability, sole parents)

**Social and physical environment**

- 29,000 adults often have difficulty or cannot get to places needed with transport, including people who are housebound
- 33,000 low income households have financial stress from mortgage or rent
- 56,000 adults could not raise $2,000 within a week
- 225,000 adults supply support to relatives living outside the household

**Vulnerability**

- 36,000 residents have a profound or severe disability
- 37,000 residents do not speak English well or at all
- 67,000 adults report high levels of psychological distress
- 81,000 adults are not able to get support in times of crisis from people outside the household

**Health measures and consequences**

- 510,000 adults have one of four risk factors (current smokers, high risk alcohol, obese, no or low exercise in the previous week)
- 88,000 adults with fair or poor self-assessed health
- 7,400 adults die prematurely each year
- 3,500 adults die from avoidable causes each year

Source: Public Health Information Development Unit (PHIDU) accessed 27 February 2019

# 4. SESLHD's Mental Health Services

Within SESLHD, specialist clinical services are delivered by ambulatory teams supplying assessment and crisis responses, clinical management, monitoring and rehabilitation services.

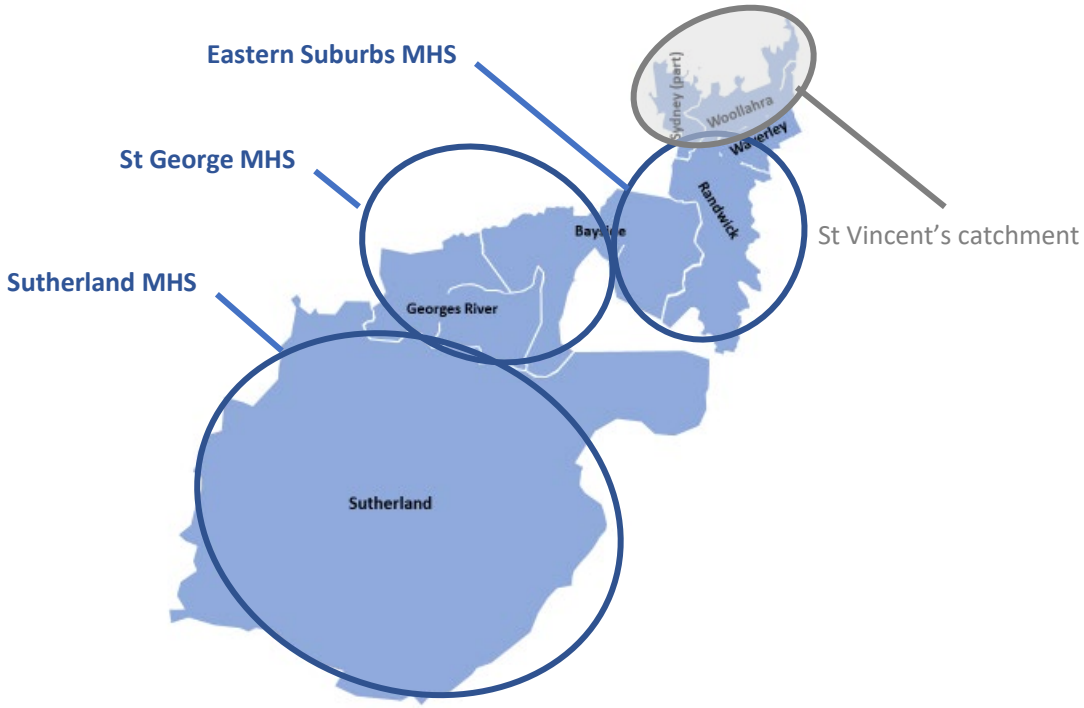
Hospital-based services include acute, non-acute, emergency and intensive care inpatient beds and accommodates both voluntary and involuntary admissions.

## 4.1 Mental Health Services

The catchment for SESLHD MHS is divided geographically.

- Eastern Suburbs MHS includes consumers from Local Government Areas (LGA) of Randwick and Waverley, eastern parts of Woollahra and the former Botany Bay LGA (now amalgamated with Rockdale LGA to form the LGA of Bayside).
- The St George MHS includes the former Rockdale LGA (now amalgamated with Botany Bay to form Bayside LGA) and the Georges River LGA (formerly Kogarah and Hurstville LGA's).
- While Sutherland MHS encompasses residents of Sutherland LGA.

It should be noted, people living in Sydney and western parts of Woollahra LGAs are in a separate catchment managed by St Vincent's Hospital Sydney (part of St Vincent's Health Network) (refer to Section 5.3.1 Other public hospitals).



### 4.1.1 Adult Mental Health Services

<table>
<tr><th>Eastern Suburbs MHS</th><th>St George MHS</th><th>Sutherland MHS</th></tr>
<tr><td colspan="3">Acute Care Team (ACT)<br>The Community MHS conducts urgent community-based assessment and short-term treatment interventions for people with a mental illness in crisis. They also provide intensive support for people with prolonged and severe mental illness and associated high-level disability, non-urgent and continuing-care services for people with a mental illness and their families or carers in the community.</td></tr>
<tr><td colspan="3">Acute Adult Mental Health Inpatient Service<br>The Service provides a variety of interventions and therapies for consumers who are experiencing acute symptoms of their mental illness and requires care within an inpatient setting. A person admitted to a unit can either be voluntary or involuntary under the NSW Mental Health Act (2007). A mental health clinician authorised by a consultant psychiatrist will conduct an assessment to determine whether an admission is the best option.</td></tr>
<tr><td colspan="3">Adult Community MHS<br>Community MHSs are distinct from inpatient mental health services and play a vital role in supporting people between 18 to 65 years old with a severe mental illness and psychiatric disability throughout the recovery process.<br>Community MHSs support people with psychiatric disability to manage their self-care, improve social and relationship skills and achieve broader quality of life via physical health, social connectedness, housing, education and employment.</td></tr>
<tr><td>Mental Health Inpatient Rehabilitation Service<br>The Rehabilitation Inpatient Unit promotes recovery and prevents relapse of mental illness through best practice multidisciplinary and integrated care, incorporating innovative rehabilitation assessment, treatment and consultation.</td><td>Referrals to Sutherland's Mental Health Inpatient Rehabilitation Service</td><td>Mental Health Inpatient Rehabilitation Service<br>The Rehabilitation Inpatient Unit promotes recovery and prevents relapse of mental illness through best practice multidisciplinary and integrated care, incorporating innovative rehabilitation assessment, treatment and consultation.</td></tr>
<tr><td>Mental Health Intensive Care Unit<br>The Mental Health Intensive Care Unit (MHICU) offers a therapeutic approach for the most complex persons referred by other mental health inpatient units. The MHICU team provides specialist, intensive multidisciplinary care to people with high levels of clinical complexity and risk that cannot be safely and effectively managed in a standard acute mental health inpatient unit.</td><td>Referrals to ESMHS's MHICU</td><td>Referrals to ESMHS's MHICU</td></tr>
</table>

| Eastern Suburbs MHS | St George MHS | Sutherland MHS |
|---|---|---|
| | Co-location Employment Program<br>The Co-location Employment Program aims to improve employment outcomes for consumers with a mental illness by co-locating an employment consultant from a local disability employment service in the community mental health teams. The Program is available to consumers of St George MHS who are motivated to work, able to work 8 hours or more and an active participant in the job seeking process. | |
| Perinatal & Infant Mental Health Service (PIMHS)<br>Works in partnership with mothers and families with diagnosed mental health problems during the perinatal period to optimise mental, social and physical health. PIMHS has a holistic approach to care delivery to help women and families affected by severe and complex mental illness. The teams offer consultation liaison, in reach to acute inpatient units and intensive hospital in the home. | Referral to PIMHS | Referral to PIMHS |
| Psychiatric Emergency Care Centre (PECC)<br>Offers short term care to consumers who requires urgent mental health care and intervention. The multidisciplinary teams help the consumer, their family and carers during the 24-72 hours of admission to the PECC. | | Referral to SGH's PECC |
| South Eastern Sydney Recovery and Wellbeing College<br>The Recovery and Wellbeing College provides education that promotes healing, wellbeing and recovery. The aim is for people to become experts in their recovery, emotional wellbeing and achieve their goals and aspirations (also refer to Section 4.1.5). | | |

## 4.1.2 Child, Adolescent and Youth Mental Health Services

<table>
<tr><th>Eastern Suburbs MHS</th><th>St George MHS</th><th>Sutherland MHS</th></tr>
<tr><td colspan="3">Child and Adolescent Mental Health Service (CAMHS)<br>CAMHS is a specialist mental health service for consumers under 18 years old or consumers who are currently enrolled in secondary school. They provide comprehensive assessment, individual and family based therapeutic intervention and short to medium term therapy to infants, children and adolescents experiencing emotional, behavioural and social difficulties. CAMHS use both individually tailored and family focused interventions to the improve the wellbeing of the consumer, their family and carers. Interventions range from behaviour management, cognitive based therapy, family therapy to medication where appropriate.</td></tr>
<tr><td colspan="2">headspace, Bondi Junction<br>headspace is a free, confidential service for people aged 12 to 25 years old. The team supports young people experiencing a tough time, or who are concerned for their mental, physical or sexual wellbeing, or those worried about their drug and alcohol use.<br>headspace is designed to make it as easy as possible for a young person and their family to get the help they need for problems affecting their wellbeing.</td><td>Note: headspace at Hurstville and Miranda is operated by Aftercare</td></tr>
<tr><td colspan="3">Comprehensive Assessment Service for Psychosis and At Risk (CASPAR)<br>The CASPAR is a District wide youth mental health service aimed at delivering improved access to comprehensive, cohesive and coordinated care to young people (aged 12 to 25 years) with an emerging mental illness who are appropriate for management in a headspace setting.<br>CASPAR delivers in-reach into the Bondi Junction, Hurstville and Miranda headspace centres to provide early identification, care coordination, assertive outreach and targeted interventions to the 'missing middle' youth population – those young people who have needs greater than what can be met by headspace alone but do not meet the criteria for traditional public mental health services.</td></tr>
<tr><td colspan="2">Early Psychosis Programme<br>The Programme provides support to young people aged 14 to 25 years old who are experiencing a first episode psychosis, or who are identified as being at ultra-high risk of experiencing a first episode psychosis.</td><td>Youth Mental Health and Early Psychosis<br>The service provides specialist assessment and mental health care to young people who are experiencing first episode psychosis or who are assessed as being at risk of developing psychosis. These community based multidisciplinary teams work with the young person and their family and carers to minimise the impact of illness and promote recovery.</td></tr>
</table>

## 4.1.3 Older Adult Mental Health Services

<table>
<tr><th>Eastern Suburbs MHS</th><th>St George MHS</th><th>Sutherland MHS</th></tr>
<tr><td>Older Persons' MHS<br>The Older Persons MHS (formerly known as the Aged Care Psychiatry Service) is a specialist clinical multidisciplinary team that provides assessments, management and care of people aged 65 years and older and 50 years and over for Aboriginal people who are at risk of or who are experiencing a psychological disorder or mental illness; and provide support to their family members and carers.<br><br>The service is guided by the principles of recovery, consumer-led care and partnering with consumers, family/carers, GPs and other key services and supports. They provide clinical assessment, treatment and management for inpatients and older people in domiciliary and residential accommodation.</td><td>See below</td><td>See below</td></tr>
<tr><td>See above</td><td>Older Persons Inpatient MHS<br>Provides a variety of interventions and therapies for older persons who are experiencing acute symptoms of their mental illness and requires care within an inpatient setting. A person admitted to the unit can either be voluntary or involuntary under the NSW Mental Health Act (2007). Consumer care is provided by a multidisciplinary team which includes, psychiatrists, registrars, nurses, social worker, psychologist, occupational therapist and peer worker.<br>A mental health clinician authorised by a consultant psychiatrist will conduct an assessment to determine whether an admission is the best option.</td><td>Referral to SGH's Older Persons Inpatient MHS</td></tr>
<tr><td>See above</td><td colspan="2">Older Persons' Community MHS<br>Provides mental health assessment, treatment, care and support to consumers over 65 years and older and 50 years and over for Aboriginal people. They work as a multidisciplinary team in a range of settings including residential aged care facilities, in the community or in the person's home.</td></tr>
</table>

## 4.1.4 Other Mental Health Services and Programs

| Eastern Suburbs MHS | St George MHS | Sutherland MHS |
|---|---|---|

### Children of Parents with a Mental Illness (COPMI)

COPMI provides support to families where a parent has a mental illness and there are children 0-17 years. The program promotes the wellbeing and reduces the risks associated with mental illness for infants, children, adolescents and their parents/carers and families.

### Eating Disorders and Mental Health

The Eating Disorder Coordinator supports the roll out of the NSW Statewide Service Plan for People with Eating Disorders and implementation of the SESLHD Local Service Plan for Eating Disorders. This role encompasses service and workforce development, as well as clinical consultation and support to health professionals and teams treating people with eating disorders in SESLHD.

### Family and Carer Mental Health Program (FCMHP)

The FCMHP improves consumer health outcomes by acknowledging the significant role of families and carers, reducing barriers within the service and promoting collaboration between clinicians, consumers, families and carers.

### Intellectual Disability and Mental Health

The Clinical Coordinator for Intellectual Disability and Mental Health provides information and support to people with intellectual disability and their families who want to access mental health services.

### Got It! Program (Getting On Track in Time)

A SESLHD-wide program in collaboration with the Department of Education providing in-reach for mental health services into infant schools. It includes conducting assessments and facilitating groups for children (and their teachers and parents) who display behavioural concerns and/or emerging conduct problems.

### Keeping the Body In Mind (KBIM)

KBIM is a program for consumers of the MHS developed to prevent and address cardiometabolic health issues. The teams consist of a nurse, exercise physiologist, dietitian and peer support worker.

The KBIM team work with consumers to develop health goals and work towards supporting lifestyle changes that are achievable, measurable and sustainable.

### Peer Support Workers

Peer Support Workers work across inpatient and ambulatory settings. The aim of the Peer Workers is to support the consumer through their mental health service journey by providing individual consultations, education and group interventions aimed at facilitating recovery principles of hope, choice, self-determination and social connectedness.

### SESLHD Mental Health Patient Safety Program (MHPSP)

SESLHD MHS strives to improve the quality of care delivered to its consumers. Continuous Quality Improvement is a process of perpetually striving for excellence in care delivery in all patient safety and clinical quality domains.

The SESLHD MHPSP is a collaborative program empowering leadership, staff, consumers and carers from across the service to test and implement processes to improve patient safety, reduce risk to consumers and staff and foster the best possible care experience for all.

In 2019, SESLHD MHS joined the Clinical Excellence Commission's implementation plan for the NSW MHPSP and the state-wide Mental Health Improvement Collaborative.

### Consultation Liaison Psychiatry Service

The Consultation Liaison Psychiatry Service addresses the mental health needs of people who are being treated primarily for physical health problems or symptoms in the general hospital setting. The prevalence of mental illness is particularly high in the general hospital setting, where almost half of all inpatients live with a mental illness such as depression, anxiety, dementia or delirium. Mental health comorbidities complicate the treatment of physical conditions, such as diabetes and lung disease and lead to increased length of hospital stay.

### Mental Health Telephone Access Line (MHTAL)

The MHTAL is a NSW Health initiative that provides the community with a single access point to government funded mental health services and information.

## 4.1.5 Teaching and education

### South Eastern Sydney Recovery and Wellbeing College

The Recovery and Wellbeing College offers the opportunity to learn about recovery, wellbeing and inspire people to lead hopeful and meaningful lives. The aim is for people to become experts in their recovery, emotional wellbeing and achieve their goals and aspirations.

It is open to people 18 years of age and older who experience mental health concerns and/or drug and alcohol service users, families, carers and staff of SESLHD.

Many of its courses address concerns for minority groups and aim to enhance staff members skills in working with these communities e.g. LGBTI Mental Health and Social Justice, Journeys in Gender, Sex and Sexuality: From Thriving to Surviving, Exploring Intellectual Disability and Mental Health, Introduction to Mindfulness and Making Mindfulness Your Own in community languages, etc.

### Workforce Capabilities Team

The education and training framework at SESLHD MHS is centred with the Workplace Capabilities Team. The Workplace Capabilities Team is:

- Built around kind, compassionate, person centred care.
- Values the opportunity for shared learning and teaching within the MHS.
- Ensures innovative and comprehensive education and training programs are co-designed and co-delivered by consumers with a lived experience of mental illness.
- Has a strong focus on supporting our workforce to flourish.

The team brings together a range of recovery-oriented approaches and

- Place a high value on active consumer, carer and community participation at all levels of our service to ensure meaningful and shared decision making.
- Recognise trauma informed care as an integral part of recovery orientated practice
- Ensure all SESLHD mental health clinicians are trained in the recovery and strengths methodology.
- Coordinate two mental health specific transition to professional practice programs for both Registered and Enrolled Nurses
- Coordinate the mandatory training program and the mental health services' clinical supervision program.

The measured outcomes are the attraction and retention of staff, excellence in service delivery and improved consumer outcomes.

### South Eastern Sydney Psychiatry Training Network

South Eastern Sydney Psychiatry Training Network is the largest psychiatry training network in NSW. We provide a complete Royal Australian and New Zealand College of Psychiatrists accredited program from Basic through to Proficient and completion of Advanced Training.

Trainees rotate through mandatory terms in adult, child and adolescent and consultation-liaison psychiatry and have a choice of a broad range of additional placements including subspecialties as diverse as Old Age Psychiatry, Youth and Early Intervention, Forensic Psychiatry, Emergency Psychiatry, Addiction Psychiatry, Private Hospitals, Peri-Natal Psychiatry and Intellectual Disability Mental Health.

There are internationally respected professorial units to which registrars can be allocated, with specific terms available at the Black Dog Institute (mood disorders), the Clinical Research Unit for Anxiety and Depression (CRUfAD) and in Neuropsychiatry.

### The Neuropsychiatric Institute

The Neuropsychiatric Institute is a tertiary referral unit, a University of NSW teaching hospital which provides specialised services including:

- Drug-Induced Movement Disorders Clinic.
- Inpatient assessment of neuropsychiatric disorders.
- Outpatient neuropsychiatric assessments.
- Neuropsychology Clinic, Epilepsy and Psychiatry Clinic.
- Tourette's Syndrome Clinic.
- Treatment of refractory psychiatric disorders using physical treatments.

## 4.2 Physical configuration of services

Eastern Suburbs MHS has:

- Community based services located at:
  - Maroubra Centre.
  - headspace at Bondi Junction.
  - Randwick Health Campus Ambulatory Care Centre.
  - Bondi Junction Community Mental Health Centre.
- Inpatient services located on the Randwick Health Campus include:
  - Kiloh Observation Unit 16 beds.
  - Kiloh General Acute 30 beds.
  - Mental Health Intensive Care Unit 12 beds.
  - Psychiatric Emergency Care Centre 4 beds (with a proposed increase to 6 beds).
  - Euroa Centre Aged Care inpatient 6 beds.
  - Euroa Centre Neuropsychiatric inpatient 2 beds.
  - Euroa Centre Mental Health Rehabilitation Unit 14 beds.

St George MHS has:

- Community based services across the age spectrum located in Kogarah.
- Inpatient services located on the SGH campus include:
  - Inpatient Unit 28 beds.
  - Psychiatric Emergency Care Centre 6 beds.
  - Sub-acute older person unit 16 beds.

Sutherland MHS has:

- Community based services located on the Sutherland Hospital (TSH) campus.
- Inpatient services include:
  - Acute ward 28 beds.
  - Rehabilitation unit 20 beds.

## 4.3 Integration with other clinical services in SESLHD

The MHS has a long history of clinical collaboration within SESLHD hospitals (e.g. ED, acute care, etc.) and other Directorates (e.g. Primary, Integrated and Community Health (PICH) and Planning, Population Health and Equity) due to their shared consumers, location on hospital campus, professional collegiality and the historical development of services.

Examples of integration include:

- Documenting collegial arrangements between MHS and Aged Care Assessment Team (ACAT) for older people living with mental illness requiring residential care and Home Care Packages.
- Service agreements between:
  - MHS and ED.
  - CAMHS and paediatrics and Child, Youth and Family Services in PICH.
  - Medical wards (e.g. POWH Nephrology, TSH Warada) and the MHS for the management of eating disorder inpatients.
  - Older Persons Mental Health and geriatrics.

    - PIMHS and maternity services plus Child, Youth and Family Services in PICH.
- Joint meetings and 'ways of working' document with Drug and Alcohol Service.
- Joint meetings at TSH for NUMs including those from MHS.
- Work provided by the Consultation and Liaison Services.
- Partnership between the MHS and Dietetics for the management of eating disorder inpatients.

## 4.4 Clinical networking

Clinical networking across SESLHD is based on role delineation and a sound understanding that maximising patient outcomes with finite resources requires a coordinated system where clinicians, patients, carers and families work together to provide high quality and appropriate services.

The various clinical networking arrangements for people living with mental illness in SESLHD are summarised below:

- Most consumers are treated locally.
- Within SESLHD all consumers requiring MHICU input are treated on the Randwick Health Campus.
- Clinical Networking to other LHD/LHNs and health care providers (for details refer to Section 5: Other Service Providers):
    - St Vincent's Hospital.
    - Sydney Children's Hospital.
    - Private hospitals.
    - Primary health care (general practitioners, private specialists, allied health providers, etc.).

# 5. Current activity and projections

## 5.1 Benchmarks for service delivery

The National Mental Health Service Planning Framework provides benchmarking for optimal service delivery for a comprehensive mental health system. The benchmarks cover the full spectrum of mental health services from promotion and prevention services through to primary and specialist mental health care (detailed data tables for benchmarking for optimal service delivery in SESLHD are in the Appendix).

However, these benchmarks need to be treated with caution. The Framework's documentation[48] states a key assumption is '… all elements of the mental health and other health and social service systems are operating in an adequate manner to support people with mental illness' noting '… gaps in one area may have flow on effects for the resources required in other sectors'. It suggested the Framework be used '… to identify areas of relative underinvestment and priority areas for development'.

Benchmarks for the population of SESLHD highlight significant gaps in services mainly related to lack of:

- Residential alternatives to hospitalisation in the community (e.g. crisis homes and high intensity rehabilitation support homes).
- Day care (both health related and social day care).
- Residential support homes and residences with integrated care provision[49].

These gaps have a flow-on effect for the MHS.

## 5.2 Non-admitted activity

### 5.2.1 Current non-admitted activity

In 2018, across the MHS there were more than 12,000 individuals receiving non-admitted services, with nearly 180,000 Service Contact Dates[50] and within those more than 940,000 activities (e.g. care planning, care management, documentation and report writing, clinical review, etc)[51].

Most people (18%) had a single Service Contact Date, a further 9% of people had two Service Contact Dates, with a decreasing number of consumers attending on multiple days. However, 2% of consumers (250 people) had 75 or more Service Contact Dates with the MHS.

Analysis of consumers indicates:

- Most people were aged 16 to 25 years (19%), followed closely by 26 to 35 year olds (18%) and 36 to 45 year age group (18%). Children aged 0 to 15 years accounted for 3% of consumers, while people aged 66 years and older accounted for 15% of consumers.

[48] National Mental Health Service Planning Framework, 2019, Introduction to NMHSPF: Population planning for mental health

[49] For a detailed inventory of available services specifically targeted for people with a lived experience of mental illness within the geographic catchment, refer to Furst et al, 2016, The Integrated Mental Health Atlas of the Central and Eastern Sydney PHN. Annex 2: South Eastern Sydney Local Health District

[50] Service Contact Dates: Any activity related to a consumer occurring on a single day

[51] Source: HIE data set provided by SESLHD's MHS

- Aboriginal and/or Torres Strait Islander people accounted for 3.6% of all client contacts.
- Most consumers (83%) were residents of SESLHD.

### 5.2.2 Projected non admitted activity

In recent years there has been a strong focus on improving the recording of non-admitted activity. While the 2018 data is considered a reasonably accurate reflection of activity, prior years' data is not as robust and so is unreliable for trend analysis. It is envisaged data recording will continue to improve enabling more detailed trend analysis to be conducted in future years.

In the interim, projected activity has been based on applying population growth rate to current activity. By 2028 there will be a projected increase of approximately 1,200 extra individuals accessing non-admitted services, more than 18,000 additional Service Contact Dates and within these nearly 100,000 additional activities.

## 5.3 Emergency department activity

### 5.3.1 Recent emergency department activity

In 2018 SESLHD's EDs had nearly 8,000 presentations allocated a mental health flag.[52]

Most people (79%) had a single presentation to an ED in 2018, a further 13% of people two ED presentations, with a decreasing number of consumers presenting on multiple occasions. However, there were 27 consumers who had ten or more ED presentations.

Recent activity between 2015 and 2018 indicate presentations have been trending up (see table below). The annual average growth rate (6%) is significantly higher than the population growth rate (1.8%) and inpatient separations over a similar period (Section 6.4: Inpatient activity).

Of concern are the increasing number and significant growth rate of 11-15 years old presenting to EDs.

*Table 1: Trends by age group in SESLHD ED presentations with mental health flag, 2015 to 2018*

| Patients Age | 2015 | 2016 | 2017 | 2018 | Trend | Change | AAGR |
|---|---|---|---|---|---|---|---|
| 0 - 10 years | 41 | 22 | 26 | 29 | | -12 | -11% |
| 11 - 15 years | 181 | 182 | 226 | 246 | | 65 | 11% |
| 16 - 25 years | 1,486 | 1,629 | 1,716 | 1,819 | | 333 | 7% |
| 26 - 35 years | 1,354 | 1,494 | 1,586 | 1,789 | | 435 | 10% |
| 36 - 45 years | 1,262 | 1,375 | 1,375 | 1,446 | | 184 | 5% |
| 46 - 65 years | 1,552 | 1,596 | 1,659 | 1,813 | | 261 | 5% |
| 66 years + | 625 | 626 | 601 | 644 | | 19 | 1% |
| **Total** | **6,501** | **6,924** | **7,189** | **7,786** | | **1,285** | **6%** |

Source: HIE data set provided by SESLHD MHS
Inclusions: Mental health flag

[52] Mental Health Flag: NSW Health classification assigned to anyone with a primary or secondary mental health diagnosis in EDs. This includes consumers seeking help for exacerbations of symptoms relating to mental illness; however it should be noted that this flag may be allocated to consumers with cognitive issues or behavioural disturbances but treated under a different specialty, e.g. dementia, delirium, anxiety relating to a physical health concern. Approximately 10% of consumers allocated a mental health flag did not have a mental health consult requested in the ED.

Of people presenting to emergency in 2018 allocated a mental health flag:

- Age group: Most people presenting were aged 16 to 25 years (23%) and 26 to 35 years (23%), followed by 36 to 45 year age group (19%). Children aged 0 to 15 years accounted for 4% of presentations, with people aged 66 years and older 8% of presentations (see Table1).
- Interpreter: Of those presenting 2% required an interpreter.
- Aboriginal and/or Torres Strait Islander: 5% of people presenting identified as being of Aboriginal and/or Torres Strait Islander origin.
- Mode of arrival: Most people arrived by ambulance 51% with a further 42% via private vehicle.
- Time of arrival: Only 38% of people arrived between 9am to 6pm Monday to Friday (see Table 2).
- Triage category:
    - Triage Category 3 had the highest proportion of presentations at 63% and more than one third of these presentations were subsequently admitted.
    - Triage Category 4 represents 27% of total presentations with more than one in five people being admitted.
    - Although small in number there has been a significant growth in demand in the highest acuity Triage Category 1 (26% growth rate), followed by Triage Category 3 (8% but with more than 1,000 additional presentations between 2015 and 2018) (see Table 3).
- Diagnosis: The top 15 diagnosis description (SNOMED) made up 75% of all presentations: with Mental health problem (finding) 16%, Suicidal thoughts (finding) 12%, Anxiety (finding) 11% (see Figure 7).
- Length of stay: Most patients stayed in emergency less than 4 hours (53%) accounting for 39% of all admissions from emergency. However, for those patients staying longer than 4 hours there was a greater likelihood they would be admitted (61%).
- Mode of separation: Most people were discharged from ED with their treatment completed (nearly 60%), with 32% being admitted and 6% classified as discharged (left at their own risk).

*Table 2: SESLHD ED presentations with mental health flag, by day and time of presentation, 2018*

| Arrival time | Mon | Tue | Wed | Thu | Fri | Sat | Sun | Total |
|---|---|---|---|---|---|---|---|---|
| 00:01 to 03:00 | 105 | 70 | 102 | 103 | 84 | 108 | 125 | 697 |
| 03:01 to 06:00 | 50 | 49 | 56 | 44 | 55 | 53 | 63 | 370 |
| 06:01 to 09:00 | 49 | 58 | 45 | 48 | 42 | 53 | 59 | 354 |
| 09:01 to 12:00 | 195 | 153 | 171 | 157 | 151 | 129 | 138 | 1,094 |
| 12:01 to 15:00 | 248 | 209 | 230 | 208 | 203 | 165 | 185 | 1,448 |
| 15:01 to 18:00 | 227 | 201 | 215 | 214 | 202 | 133 | 161 | 1,353 |
| 18:01 to 21:00 | 228 | 193 | 189 | 191 | 174 | 183 | 181 | 1,339 |
| 21:01 to 24:00 | 168 | 174 | 166 | 144 | 146 | 157 | 176 | 1,131 |
| **Total** | **1,270** | **1,107** | **1,174** | **1,109** | **1,057** | **981** | **1,088** | **7,786** |

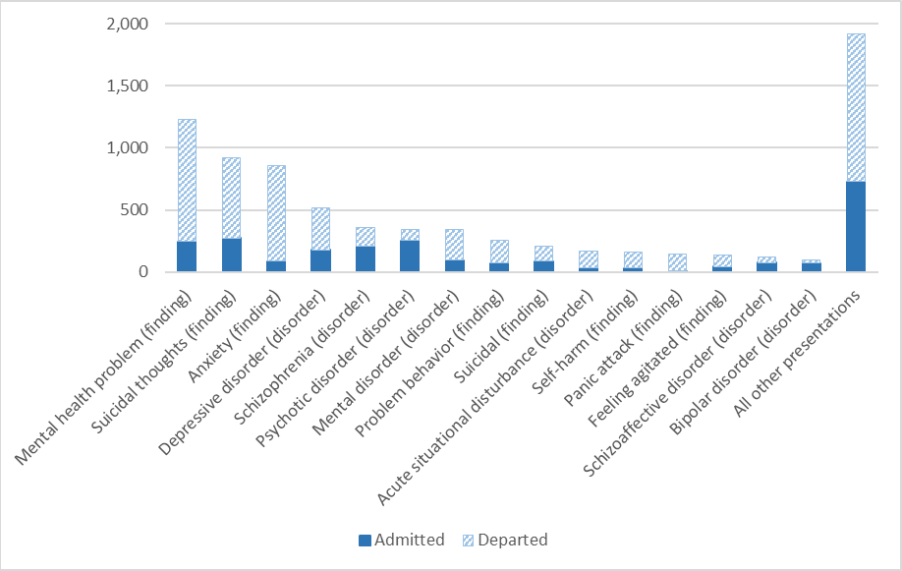
Source: HIE data set provided by SESLHD MHS
Inclusions: Mental health flag

*Table 3: Trends by Triage Category in SESLHD ED presentations with mental health flag, 2015 to 2018*

| Triage Category | 2015 | 2016 | 2017 | 2018 | Trend | Change | AAGR |
|---|---|---|---|---|---|---|---|
| Cat 1 | 24 | 39 | 33 | 48 | | 24 | 26% |
| Cat 2 | 519 | 523 | 436 | 549 | | 30 | 2% |
| Cat 3 | 3,872 | 4,173 | 4,500 | 4,912 | | 1,040 | 8% |
| Cat 4 | 1,874 | 1,981 | 2,064 | 2,110 | | 236 | 4% |
| Cat 5 | 212 | 208 | 156 | 167 | | -45 | -8% |
| **Total** | **6,501** | **6,924** | **7,189** | **7,786** | | **1,285** | **6%** |

Source: HIE data set provided by SESLHD MHS
Inclusions: Mental health flag

*Figure 7: SESLHD ED presentations with mental health flag, by diagnosis description (SNOMED) and admission status, 2018*




Source: HIE data set provided by SESLHD MHS
Inclusions: Mental health flag

### 5.3.2 Projected emergency department activity

Applying the 6% annual average growth rate of recent years to the current number of ED presentations results in more than 13,000 ED presentations allocated a mental health flag by 2028.

This level of growth is unsustainable and for some patients, not in their best interests and/or clinically inappropriate. There is a compelling case for diversion of some of this activity to more appropriate settings and/or providing more clinical and social support to people in the community.

## 5.4 Inpatient activity

### 5.4.1 Inpatients with a Psychiatric Service Related Group[53]

In 2017/18 activity for consumers allocated a psychiatric Service Related Group (SRG) (Table 4) showed:

- More than 3,500 hospital stays.
- Nearly 55,000 bed days in a designated mental health unit with an average length of stay in the unit of 15 days.
- Nearly 80,000 bed days for their total hospitalisation with an average length of stay of 21 days, meaning many patients with a psychiatric SRG are cared for in both a designated mental health unit as well as a medical and/or surgical ward and have a comparatively long length of stay in these wards.
- An average National Weighted Activity Unit (NWAU)[54] 3.51 and an average Public Equivalent Model (PEM)[55] 3.69 reflecting a relatively high cost and complexity of patients in relation to many of SESLHD's medical and surgical patients.

For activity by hospital refer to Appendix.

Recent trends indicate between 2013/14 and 2017/18:

- Separations have remained relatively stable.
- Bed days have remained relatively stable.
- Average length of stay has been variable. It is important to note, routinely the average length of stay is not used as a measure for analysing mental health activity as some very long stay patients skew the average.
- Average NWAU and PEM, reflecting the comparative cost and complexity of patients, has been steadily increasing.
- It is noted that the average length of stay differs between hospitals and these differences have remained relatively constant in recent years. In 2017/18 SGH had the lowest (17 days), followed by TSH (22 days), then Prince of Wales (24 days). However, caution should be used when

[53] Service Related Groups are used nationally to categorises admitted patient episodes into groups representing clinical divisions of hospital activity, based on aggregations of the patient's diagnosis on discharge.
[54] An NWAU is a measure of health service activity expressed as a common unit, against which the national efficient price is paid. It provides a way of comparing and valuing each public hospital service (whether it is an admission, emergency department presentation or outpatient episode), by weighting it for its clinical complexity. The average hospital service is worth one NWAU – the most intensive and expensive activities are worth multiple NWAUs, the simplest and least expensive are worth fractions of an NWAU.
[55] PEM is Public Equivalent Model, it is a NWAU without the application of private patient status discounts, therefore is a more accurate measure of cost and complexity of care than NWAU

considering these variances due to the number of complex consumers and classification of beds (acute, rehabilitation, MHICU, etc.) on each site. Further detail is contained in Appendix.

*Table 4: Trends in mental health inpatient activity for the MHS, 2013/14 to 2017/18*

| | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | Trend | Change | AAGR |
|---|---|---|---|---|---|---|---|---|
| Hospital stays | 3,860 | 3,983 | 3,825 | 4,088 | 3,654 | | -206 | -1.4% |
| Days in Designated Pysch Unit | 55,757 | 55,697 | 58,347 | 60,657 | 54,697 | | -1,060 | -0.5% |
| Total beddays | 81,178 | 80,816 | 84,843 | 99,723 | 78,213 | | -2,965 | -0.9% |
| ALoS in designated psych unit | 14 | 14 | 15 | 15 | 15 | | 1 | 0.9% |
| ALoS for hospital stay | 21 | 20 | 22 | 24 | 21 | | 0 | 0.4% |
| NWAU (v18) | 10,974 | 10,667 | 11,384 | 11,816 | 12,836 | | 1,862 | 4.0% |
| Average NWAU (v18) | 2.84 | 2.68 | 2.98 | 2.89 | 3.51 | | 0.67 | 5.4% |
| PEM | 11,307 | 11,032 | 11,830 | 12,471 | 13,499 | | 2,192 | 4.5% |
| Average PEM | 2.93 | 2.77 | 3.09 | 3.05 | 3.69 | | 0.77 | 6.0% |

Source: HIE data set provided by SESLHD MHS
Inclusions: 82 Psychiatry - Acute, 83 Psychiatry - Non Acute, 85 Psychogeriatric Care

More detailed analysis of MHS consumers who were an inpatient with a Psychiatry SRG in 2017/18 indicates (refer Appendix):

- Age: patients aged between 16 and 45 accounted for 54% of separations, 44% of bed days.
- Country of birth: most patients were born in Australia (68%), of people born in non-English speaking countries most were from China (excluding Taiwan), Greece and the Former Yugoslav Republic of Macedonia.
- LGA: most consumers accessed care from their local hospital (approximately 70%), with 16% travelling from LGAs bordering SESLHD.
- Source of referral: most inpatients were admitted from ED (77%).
- Days in a designated mental health unit: 81% of inpatients spent time in a designated unit, with 12% of consumers having a care type of psychogeriatric, and the remaining consumers having an acute (medical or surgical) care type.
- Legal Status: most patients were voluntary (61%).
- Number of admissions: most consumers had a single admission (80%), with a further 14% consumers having two admissions. The remaining 8% of consumers (182 people) had three or more admissions.
- Diagnosis Related Group: The top 10, accounting for nearly 70% of all activity, were:
    - Schizophrenia Disorders, Minor Complexity.
    - Schizophrenia Disorders, Major Complexity.
    - Major Affective Disorders, Minor Complexity.
    - Personality Disorders and Acute Reactions, Minor Complexity.
    - Major Affective Disorders, Major Complexity.
    - Drug Intoxication and Withdrawal, Major Complexity.
    - Paranoia and Acute Psychotic Disorders, Minor Complexity.
    - Mental Health Treatment W/O ECT, Sameday.
    - Dementia and Other Chronic Disturbances of Cerebral Function, Major Complexity.
    - Personality Disorders and Acute Reactions, Major Complexity.

- Multi-morbidities: Analysis of SESLHD's mental health inpatients by their primary and other diagnosis[56, 57] compared to NSW population demonstrates:
    - Nearly two of every three inpatients had comorbid mental illnesses.
    - Just over half the inpatients had a physical disease (e.g. endocrine, digestive, infectious, etc)[58] with 12% being diabetic (compared with 5% for the NSW population).
    - Three-quarters of inpatients had other 'Factors influencing health status and contact with health services' e.g.:
        - 34% tobacco use (compared with smoking rate among NSW adults of 14%).
        - 34% had a disorder due to illegal drug use (compared with 12% of the NSW adult population reporting use of illegal drugs).
        - 25% personal history of noncompliance with medical treatment and regimen.
        - 7% homelessness (compared with 0.5% of the NSW population)[59].

*Table 5: Multimorbidity of SESLHD inpatients with psychiatric SRG, 2017/18*

| Primary or other diagnosis (ICD10 codes) | SESLHD MH Inpatients | NSW population (self reported) [60, 61] |
|---|---|---|
| **Mental, Behavioural and Neurodevelopmental disorders (F01–F99)** | | |
| • Two or more mental disorder diagnosis (F10-F19) | 62% | Not available |
| **Physical diseases** | | |
| • Diabetes (E10-E14) | 12% | 5% |
| • COPD (J40-J44, U83.2) | 2.7% | 2.7% |
| • Cardiovascular disease (I00-I99, U82.1-U82.3) | 18% | 22% |
| **Other factors influencing health** | | |
| • Personal history noncompliance with medical treatment & regimen (Z91.1) | 25% | Not available |
| • Obesity (E66 (exc'g E66.3) + U78.1) | 11% | 31% |
| • Tobacco use, current (Z72.0) | 34% | 14% |
| • Alcohol related disorders (F10) & Alcohol use (X65, Z72.1, Z86.41) | 19% | 17% |
| • Disorders due to psychoactive substance use (excluding alcohol) (F11-F19) & Drug use (Z72.2, Z86.42) | 34% | 12% |
| • Homelessness (Z59.0) | 6.7% | 0.5% |

Source: HIE data set provided by SESLHD MHS
Inclusions: Year: 2017/18; SRGs: 82 Psychiatry - Acute, 83 Psychiatry - Non Acute, 85 Psychogeriatric Care

### 5.4.2 Inpatients with a Psychiatric SRG cared for in a ward other than a designated mental health unit

Nearly 400 inpatients allocated a psychiatric SRG were admitted to a speciality unit other than a designated mental health unit, predominantly:

- Aged care/geriatric wards.

[56] Other diagnosis are coexisting conditions at the time of admission or develop subsequently, and affect patient care during their admission
[57] Data source: HIE data set provided by SESLHD's Mental Health Service. Inclusions: 2017/18; SRGs: 82 Psychiatry - Acute, 83 Psychiatry - Non Acute, 85 Psychogeriatric Care:,
[58] ICD10 Blocks A00-E89 and G00-N99 have been equated to physical diseases
[59] ABS, 2018, Catalogue number: 2049.0 - Census of Population and Housing: Estimating homelessness, 2016
[60] ABS, 2018, 4364.0.55.001 - National Health Survey: First Results, 2017-18
[61] ABS, 2018, Catalogue number: 4364.0.55.001 - National Health Survey: First Results, 2017-18

- Neurology unit.
- Other medical units.
- Paediatric wards.

These patients differed from those with a stay in a designated mental health unit in that they:

- Averaged a shorter length of stay (16 days).
- Had a lower NWAU and PEM and (1.65 and 1.84 respectively).
- Had a differing mix of diagnosis, the top five being:
    - Anxiety Disorders, Minor Complexity.
    - Anxiety Disorders, Major Complexity.
    - Personality Disorders and Acute Reactions, Major Complexity.
    - Personality Disorders and Acute Reactions, Minor Complexity.
    - Major Affective Disorders, Major Complexity.

It is noted that although relatively small numbers, inpatient separations for Eating and Obsessive-Compulsive Disorders (43 separations in 2017/18) have a long average length of stay (34 days) and a very high average NWAU and PEM (7.33 and 8.84 respectively).

### 5.4.3 Inpatient flows to SESLHD

Whilst most SESLHD patients live in SESLHD, in 2017/18 there were more than 550 hospital stays for inflows, that is, consumers living outside of SESLHD but travelling to a SESLHD hospital to be treated.

These inflows accounted for more than 15% of all mental health inpatient hospital stays (see Table 6 below). Activity showed these consumers (in comparison to SESLHD residents) had a shorter length of stay for both days in a designated mental health unit and overall stay in hospital, and had a lower average PEM reflecting their lower cost and complexity.

*Table 6: Comparison of mental health inpatient activity by inflows, 2017/18*

| Values | SESLHD | LHD's surrounding SESLHD | All other LHD's and interstate | Total |
|---|---|---|---|---|
| Hospital stay | 3,088 | 246 | 320 | 3,654 |
| Days in designated mental health unit | 48,683 | 2,482 | 3,532 | 54,697 |
| Total bed days for hospitalisation | 69,846 | 3,280 | 5,087 | 78,213 |
| ALoS in designated mental health unit | 16 | 10 | 11 | 15 |
| ALoS for hospitalisation | 23 | 13 | 16 | 21 |
| NWAU | 11,199 | 696 | 941 | 12,836 |
| Av NWAU | 3.63 | 2.83 | 2.94 | 3.51 |
| PEM | 11,826 | 704 | 970 | 13,499 |
| Av PEM | 3.83 | 2.86 | 3.03 | 3.69 |

Source: Data set provided by SESLHD MHS
Inclusions: 82 Psychiatry - Acute, 83 Psychiatry - Non Acute, 85 Psychogeriatric Care

### 5.4.4 Projected inpatient bed requirements

Projected inpatient bed requirements have been considered using two different methods:

- Method 1: Benchmarked service delivery:

  - NMSPF calculates the resources required to deliver adequate mental health services to a nominal population of 100,000 people by age group and for a selected geographic area[62].
  - In the SESLHD geographic catchment in 2018/19 there were 231 public hospital designated mental health beds (182 beds in SESLHD, 33 beds at St Vincent's Hospital and 8 beds at Sydney Children's Hospital Randwick)
  - Using NMHSPF benchmarks suggests by 2021 there is a total requirement of 192 hospital beds within the geographic area of SESLHD (including St Vincent's and Sydney Children's Hospital Randwick)[63].
- Method 2: Extrapolation of bed days in designated mental health unit: applying a linear trendline from 2013/14 through to 2021/22 shows a requirement for 190 beds for SESLHD[64].

Both these methods suggest there are enough beds within SESLHD for the life of this Plan. However, the analysis does not take account of the configuration of beds (e.g. split between acute, rehabilitation, quaternary services, etc), bed and ward configuration including flexibility of spaces to accommodate a range of consumer needs, statewide service delivery, and assumes the existing infrastructure is fit-for-purpose. In addition, Method 1 assumes there are no gaps in other health and social systems, while Method 2 assumes recent activity has not been constrained by the number of beds available.

In summary, it is projected the number of inpatient separations will remain stable, constrained by the number of beds; unless models of care are changed, the average length of stay is decreased and/or gaps in the number of residential support home beds are addressed.

Moving forward with a stable bed base, the focus is to be on better utilisation of beds for consumers requiring inpatient care to support resolution of acute psychiatric symptoms. To achieve this, it will be vital to work with our partners to deliver a comprehensive 'stepped' system of care across the region to ensure support is available that matches consumers' treatment, residential and/or psychosocial needs at any given time, in the most appropriate setting.

[62] National Mental Health Service Planning Framework, 2019, Introduction to NMHSPF: Population planning for mental health. URL: https://nmhspf.org.au/wp-content/uploads/2019/01/Introduction-to-the-National-Mental-Health-Service-Planning-Framework_2019.pdf

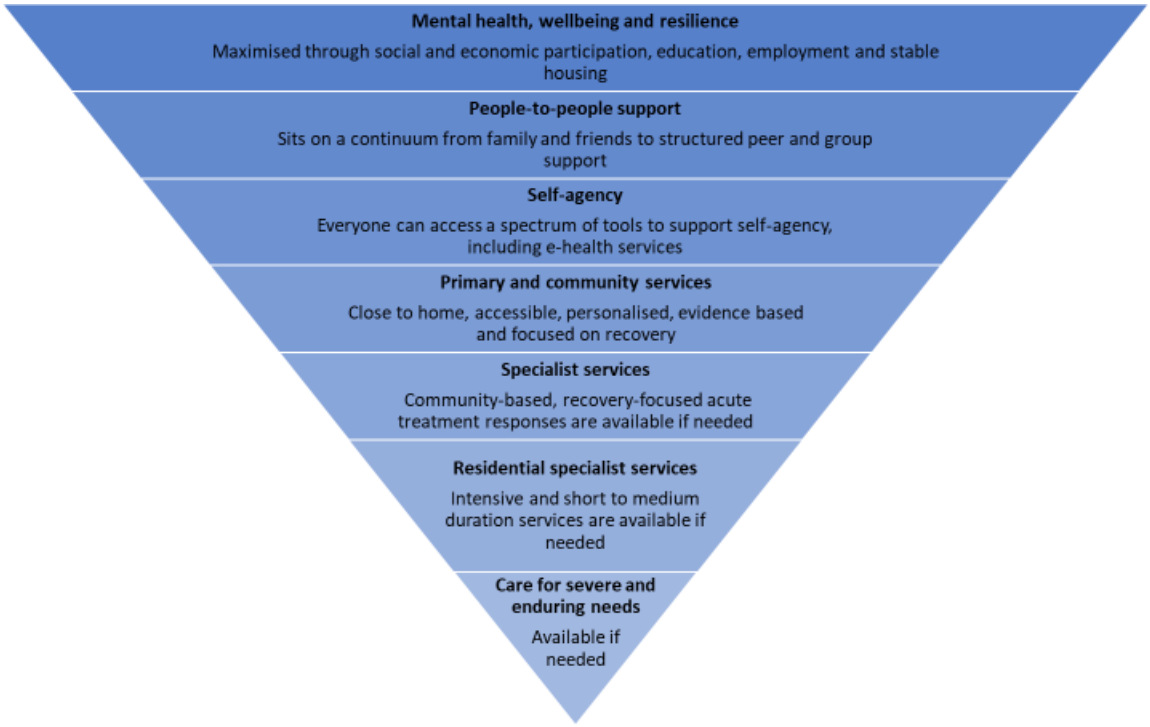
[63] This requirement is premised on assumptions detailed in Section 6.1 Benchmarks for service delivery

[64] Calculation of beds required based on bed days in designated mental health unit divided by 365 days divided by 85% occupancy

# 6. Other service providers

While SESLHD MHS mainly provides tertiary clinical services for people with moderate to severe mental illness there is a range of other providers supporting consumers. These other service providers support to MHS consumers, as well as people living with mild and moderate mental illness.

*Figure 8: Delivering mental health and wellbeing*




Source: adapted from NSW Mental Health Commission, 2014, Living Well: A Strategic Plan for mental health in NSW

## 6.1 Primary health care providers

Most people living with mental illness access care through primary health care providers; including general practitioners, psychologists, psychiatrists, other allied health professionals (e.g. occupational therapists, social workers, etc.) or other specialists (e.g. gerontologists and paediatricians)[65].

[65]For detailed data and information related to mental health services across the system refer to Furst et al, 2016, The Integrated Mental Health Atlas of the Central and Eastern Sydney PHN. Annex 2: South Eastern Sydney Local Health District

### 6.1.1 Central and Eastern Sydney Primary Health Network

The CESPHN is a not–for-profit regionally-based organisation funded by the Commonwealth to strengthen primary care by redirecting frontline health services to improve health outcomes of the community.

CESPHN holds responsibility for identifying health needs in the region and procuring services from external providers to address those needs. Primary mental health services commissioned by CESPHN follow a stepped care approach to support people matching services to their needs and recovery goals[66].

Examples of mental health services commissioned by CESPHN include:

- headspace for people aged 12 to 25 years.
- Psychological Support Services for people who are unable to access psychological treatment under the Better Access Scheme.
- Primary Integrated Care Supports for people experiencing severe mental illness who require care coordination to support their recovery.

There are also commissioned mental health services integrated with SESLHD MHS, such as suicide prevention care coordination and the shared care mental health nurse program.

## 6.2 Community Managed Organisations

Community Managed Organisations (CMOs)[67] provide supportive psychosocial care, predominantly of a non-clinical nature.

There are numerous organisations providing diverse services including:

- Subacute care, non-acute care (medium to long term residential care).
- Social support services such as crisis residential support, psychosocial support and rehabilitation, personal, vocational and educational support, respite and other carer support services and peer support.
- Information and referral, cultural support and care coordination specialists (e.g. Butterfly Foundation).
- Specialist programs such as those targeting refugees, specific cultural groups or other special needs groups[68].

SESLHD MHS has formal partnership agreements with CMOs providing the Housing and Support Initiative (HASI) and Community Living Supports programs.

In addition, SESLHD administers grants to some CMOs with the aim of improving the health and well-being of people in the community. In 2018/19 the CMOs funded for mental health programs were:

- Aftercare (FACES) is a partnership with SESLHD's FCMHP provide support and care for families and friends who care for people living with mental illness to sustain their own emotional

[66] Further information on the services CESPHN commissions and Stepped Care Principles can be found at: https://www.cesphn.org.au/general-practice/help-my-patients-with/mentalhealth

[67] The community managed sector is predominantly made up of not-for-profit organisations providing community-based support services that help keep people well

[68] For a detailed discussion of various NGOs refer to Integrated Mental Health Atlas of SESLHD

wellbeing. This support includes information, assistance with self–care, basic education on mental health and resources, basic counselling and advocacy.

- Independent Community Living Australia Ltd: offers services that are targeted at supporting individuals to achieve their personal goals, increase their confidence, independence and opportunity for social and community connection. These services can be provided in an individual's home or in accommodation sites within Sydney's eastern suburbs.
- RichmondPRA (Flourish Australia): provides community psychosocial support programs co-located with the MHS, including the Young Peoples Outreach Program (YPOP) that works across the region.

## 6.3 Other hospitals

### 6.3.1 Other public hospitals

SESLHD is unique in having two public hospitals which are managed by other organisations within its geographic boundary with mental health services:

- St Vincent's Hospital Sydney (part of the St Vincent's Health Network) has a catchment including people living in Sydney and western parts of Woollahra LGAs. It has a range of mental health services including:
    - Specialty services: Psychogeriatric/Old Age Psychiatry Service, Consultation Liaison Psychiatry Service, Program for Early Intervention and Prevention of Disability (PEIPOD) and The Anxiety Disorders Unit.
    - Inpatient services: Caritas High Dependency Unit (6 beds), Acute Unit (21 beds) and the PECC (6 beds)[69].
    - Community services: Triage, ACT, continuing care, rehabilitation, early intervention and a Day Clinic.
    - Research units: CRUfAD and Research Unit for Schizophrenia Epidemiology.
- Sydney Children's Hospital Randwick (part of the Sydney Children's Hospitals Network) supports the positive mental health of children and young people and cares for those who experience problems associated with mental illness. Its services include:
    - Adolescent medicine: The adolescent services clinic helps teenagers and their families manage difficulties and adapt to changes in their lives. Adolescent inpatients receiving acute mental health treatment in the hospital are housed in an 8 bed ward[70].
    - Eating Disorders Inpatient Program for children and adolescents 16 years and under.

A number of statewide services provide treatment for consumers requiring specialised mental health care in centralised locations. SESLHD residents may be referred to these facilities outside of area if clinically indicated, e.g. mother baby unit at St John of God Burwood, child and adolescent inpatient care, eating disorders admissions.

[69] Bed numbers sourced from Furst, et al., 2016
[70] ibid

### 6.3.2 Private hospitals

There are private hospitals licensed to provide mental health care[71] within the geographical boundary of SESLHD including:

- The Sydney Clinic located in Bronte providing inpatient (44 beds) and day programs.
- Wesley Hospital Kogarah has a 30 bed facility providing both inpatient and day programs.
- St Vincent's Private Hospital has established USpace a private mental health service targeted to the needs of young adults aged 16–30 promoting the recovery and psychological wellbeing of young adults with severe and emerging mental health problems with a 20 bed inpatient unit[72].

## 6.4 Other providers, organisations and government agencies

Leading a collaborative approach is the NSW Mental Health Commission working with government and the community with a vision that people:

> *'… have the best opportunity for good mental health and wellbeing and to live well in the community, on their own terms, having the services and supports they need to live a full life'*[73].

SESLHD MHS fosters collaboration with a range of other government agencies who provide public health services (e.g. drug and alcohol services, dental services, Child and Family Services, antenatal services, etc.) and social services (e.g. public housing, policing and justice, welfare and child protection services).

### 6.4.1 National Disability Insurance Scheme (NDIS)

NDIS is a relatively new provider of services for people aged younger than 65 years with a psychosocial disability. Their funding remit is to provide:

> *'… disability supports that are not clinical in nature and that focus on a person's functional ability, including supports that enable a person with a mental illness or psychiatric condition to undertake activities of daily living and participate in the community and social and economic life.'*[74] .

## 6.5 Other teaching, education and research

NSW Health recognises research plays a vital role in generating solutions for mental health care. The Office for Health and Medical Research has a key priority to support translational research through collaborative research hubs[75].

[71] NSW Health, n.d., Licensed private health facilities offering overnight accommodation

[72] St Vincent's Hospital, URL: https://www.svphs.org.au/uspace/overview. Accessed 20 March 2019

[73] Mental Health Commission of NSW, 2018, Key Directions 2018-2023

[74] National Disability Insurance Agency, URL: https://www.ndis.gov.au/understanding/ndis-and-other-government-services/mental-health. Accessed 20 March 2019

[75] NSW Health, 2012, NSW Health and Medical Research Strategic Review

SESLHD is a partner of Maridulu Budyari Gumal, the Sydney Partnership for Health, Education, Research and Enterprise (SPHERE) recognised by the National Health and Medical Research Council as an Advanced Health Research Translational Centre.

### 6.5.1 Mindgardens Neuroscience Network

The recently established Mindgardens Neuroscience Network located on the Randwick Health Campus is an alliance between SESLHD, Neuroscience Research Australia (NeuRA), Black Dog Institute and University of NSW supporting a research-infused culture within MHS' clinical services.

The Mindgardens Neuroscience Network's vision is '… *to bring together clinicians, scientists, consumers and the public to collaborate, develop and implement innovative solutions and new models of care'*[76]. It is focused on research-led and clinically tested solutions driven by patient and community involvement.

A recent research paper noted the Mindgardens Neuroscience Network '… emphasis on collaboration removes abilities of the partners to operate in isolation and provides opportunities to:

- Support the delivery of world's best practice in the diagnosis, treatment and prevention of mental health … disorders
- Create a link between research partners and the [LHD] connecting clinicians to best practice research and treatment
- Implement evidence-based models of care including apex clinics and integrated community hubs
- Create opportunities for consumers, researchers and the clinical workforce to share expertise and build awareness.'[77]

[76] Mindgardens Neuroscience Network, URL: https://www.mindgardens.org.au/. Accessed 19 March 2019

[77] Mindgardens Neuroscience Network, 2019, Review of the burden of disease for neurological, mental health and substance use disorders in Australia

# 7. Future directions

In recent years, SESLHD MHS has made important and positive changes. This has been due in part to the:

- Ongoing development of consumer-focussed care – improving the health and wellbeing of people living with mental illness and
- MHS, SESLHD, other government agencies and CMOs working together to enable people living with mental illness to remain well in their community through prevention, early intervention and assertive community care.

Yet based on data analysis, literature reviews, meetings and workshops it is evident the MHS and our residents living with mental illness continue to face multiple vulnerabilities:

- An increasing population leading to an increasing demand for mental health services
- A significant increase in mental health presentations to emergency departments particularly for 11 to 15 year old people
- Inpatient activity constrained by some patients having very long length of stay
- A need to adhere to a raft of policies and guidelines and meet Key Performance Indicators
- Changing community expectations of mental health services
- Fragmentation of the mental health service landscape
- Limited resources including gaps in some health and social support services
- The need for all service providers to deliver sustainable services
- Ongoing stigma and discrimination faced by people living with mental illness.

There is recognition the MHS needs to continue building strong partnerships to be able to provide care across the broad spectrum of our community's need. To this end, this three year Plan is a starting point in a fundamental shift in the way care is delivered in a more externally-focussed, recovery-oriented approach.

# 7.1 Strengthening prevention and early intervention

## Why it's important

Strengthening prevention and early intervention of mental illness has benefits for our consumers, our community, the MHS, SESLHD and other agencies:

- Reducing the impact of mental illness on individuals' lives allows them to contribute more fully to society
- Identifying and intervening early in each episode of illness significantly enhances sustainable recovery and reduces cost
- Investing in prevention can lead to more efficient use of mental health resources
- A flow-on effect for a range of services including general health care, drug and alcohol services, education, child and family services and the justice system.

- 961 people hospitalised in SESLHD for self-harm (2018/19)
- 11% annual increase of 11 – 15 year-olds with mental health ED presentations (2015 to 2018)
- 6% annual increase in mental health ED presentation for all ages (2015 to 2018)

## What is the change we want to see?

SESLHD MHS will work towards prevention and early intervention rather than a crisis-driven approach. While recent policies and guidelines emphasised early intervention for children and young people as well as suicide prevention, SESLHD MHS is aiming for a broader perspective – one which considers prevention and early intervention:

- Across all ages
- Throughout the course of illness
- In ambulatory and inpatient settings
- From primary, secondary and tertiary prevention perspectives
- In collaboration with consumers, family, carers, primary care providers and other partners.

This broader approach fosters early detection and treatment to:

- Prevent exacerbation of a consumer's mental illness
- Reduce the development, duration and/or severity of illness and multi-morbidities
- Enable more timely and targeted referrals to specialist services
- Improve confidence and engagement of primary care providers
- Support Regional, State and Commonwealth initiatives.

# 7.2 A greater focus on community-based care

## Why it's important

It is well recognised that most people living with mental illness want their care provided clos
They do not want to be hospitalised, particularly not repeatedly, for lengthy periods and/or when social issues are driving their distress. Yet for some consumers, hospitals are the only option when timely and accessible services and supports are not available to keep them well in the community.

This leads to sub-optimal care for people who could benefit from community-based care as well as those requiring hospitalisation.

- 27 consumers had 10 or more ED presentations (2018/19)
- 182 people had 3 or more inpatient admissions (2018/19)
- 20 inpatients with an average length of stay of nearly 1 year (May 2019)

## What is the change we want to see?

There is widespread acceptance by consumers, the broader community, clinicians and primary health and social service providers that hospitals are not the preferred setting for delivering the vast majority of services to people living with mental illness. Alternate models have the potential to provide interventions that are less intensive and intrusive for consumers.

A stronger outward community focus will enable better prioritisation of hospitals and emergency department resources for critical mental health care that is clinically appropriate. Specialised community based services can reduce the reliance on acute inpatient beds and ensure that people with higher acuity conditions and complex behaviours have access to appropriate care in a more therapeutic setting.

For people with enduring or episodic needs, this would ensure they are provided with stronger support, particularly following a crisis. Flexible service delivery models in the community would better recognise that people's needs change over time.

To make this change happen requires acceptance that stabilising someone's mental health requires holistic comprehensive care of all a person's needs. This, in turn, is dependent on an increase in funding community services not only for public mental health but also residential care, psychosocial rehabilitation and support services to help people to build their individual ability for self-care, self-management and self-determination.

# 7.3 Improving the physical health of our consumers

## Why it's important

Consumers of MHS are living with complex needs and multi-morbidities. Analysis of SESLHD MHS' inpatients by their primary and other diagnoses[78] [79]:

- Nearly two of every three inpatients have comorbid mental illnesses.
- Just over half the inpatients have a physical disease (e.g. endocrine, digestive, infectious, etc)[80]with 12% being diabetic (compared with 5% of the NSW population).
- Three quarters of inpatients have other 'factors influencing health status and contact with health services' e.g.
    - 34% tobacco use (compared with a smoking rate among NSW adults of 14%).
    - 34% have a disorder due to illegal drug use (compared with 12% of the NSW adult population reporting use of illegal drugs).
    - 25% personal history of noncompliance with medical treatment and regimen.
    - 7% homelessness (compared with 0.5% of the NSW population[81]).

Taking a 'whole of person' approach to physical and mental health requires focus on:

- Minimising treatment-related physical illness and premature mortality, and
- Supporting better chronic disease management

Many of the consumers cared for in the community are likely to have similarly complex needs.

Yet it is known

> *'… effective mental health care, in conjunction with quality physical health care provided early, improves life expectancy and quality of life for consumers and reduces the pressure on the health system'*[82].

## What is the change we want to see?

People living with mental illness will have the same physical health outcomes as those in the broader community. This is despite some multi-morbidities being the result of prescribed medication, some associated with modifiable risk factors (e.g. smoking, drug and alcohol misuse, poor diet, lack of exercise,

[78] Data source: HIE data set provided by SESLHD's Mental Health Service. Inclusions: 2017/18; SRGs: 82 Psychiatry - Acute, 83 Psychiatry - Non Acute, 85 Psychogeriatric Care

[79] Other diagnosis are coexisting conditions at the time of admission or develop subsequently, and affect patient care during their admission

[80] ICD10 Blocks A00-E89 and G00-N99 have been equated to physical diseases

[81] ABS, 2018, Catalogue number: 2049.0 - Census of Population and Housing: Estimating Homelessness, 2016

[82] The Fifth National Mental Health and Suicide Prevention Plan URL: http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf

etc) while other conditions are exacerbated by a person's social, employment, housing, etc circumstances.

Achieving equal health outcomes will be a complex and long-term strategy requiring:

- People living with mental illness being involved and making decisions in relation to their care based on informed consent.
- Health professionals being willing and able to take a 'whole person' perspective, having the necessary skills to do so and in challenging discrimination.
- The MHS continuing to develop clinical pathways based on evidence-based practice.
- From an organisational perspective enabling integrated care from within the MHS, across SESLHD and with other organisations and agencies (also see Section 7.4) to ensure services deliver the best possible care.

# 7.4 Working together to deliver person-centred care

## Why it's important

Given the complex needs and multi-morbidities our consumers' experience, it is inevitable they will access support, care and treatment services from numerous people, organisations and agencies throughout the course of their illness.

For too many consumers, their care and support is fragmented and difficult to navigate, limiting their ability to fully and effectively participate in society.

Their voice needs to be '… heard as wealth of experience whether or not they hold degrees'.

A person living with severe mental illness may interact with

- Several agencies
- Multiple health professionals
- Numerous care providers.

With so many people involved the consumer must be recognised as the expert in their needs and supported to be active participants in their care and treatment

## What is the change we want to see?

There is widespread acceptance that to better support people experiencing or at risk of severe mental illness is to provide holistic comprehensive care of all a person's needs. This approach continues to move away from a medical model where health professionals 'fix a problem', toward recovery oriented practice:

> *'… a holistic approach to illness that addresses all aspects of a person's life, including psychological and physical needs, as well as social, economic, education, employment, housing and other needs …, whilst maximising the ability to live in the community independently. The focus is on the individual and their needs first and on the illness, which is only one part of the person, second*'.[83]

It is dependent on the MHS having an outward focus and building partnerships where multiple providers have sound information, so they can work together to meet the needs of each consumer.

There must also be recognition of:

> *"… [t]he importance of transitioning out of care and into 'normal' life. Although it can be harsh, telling consumers that they are too well for a service can have its benefits … [not least] promoting true independence. [Timing that discussion] I believe lies between the time it takes someone to take back control of their life through therapy and when that therapy becomes an enabling force for learned helplessness"* (Consumer).

[83] Mental Health Coordinating Council, 2015, Mental Health Rights Manual: An online guide to the legal and human rights of people navigating the mental health and human service systems in NSW (4th Edition) http://mhrm.mhcc.org.au/home/

# 7.5 Building a better system

## Why it's important

SESLHD MHS endeavours to best support people with mental illness at times when acute intervention is required, to remain well in the community, and to lead their own recovery.

In recent years, the Service has undergone numerous redesigns, developments and innovations and demonstrated progressive improvements in the safety, experience and effectiveness of care delivered.

For the MHS to build on the improvements made to date and best position itself to meet the challenges ahead requires investment in our current and future workforce, effective quality and safety improvement mindset and processes, guiding practice with evidence, fit-for-purpose infrastructure, and making best use of technological developments and information systems.

Providing consistently high quality mental health care will require prioritisation of:

- Capable and compassionate staff
- A culture of delivering evidence-informed best practice
- Continuous safety and quality improvement
- Fit-for-purpose infrastructure
- Harnessing technology and information systems to enhance care delivery

## What is the change we want to see?

To provide services that deliver safe, efficient, effective, and consistent care into the future, the MHS is committed to applying the principles of quality improvement in all aspects of clinical care and service management. All MHS staff, consumers and carers have a role to play in the continuous improvement of services. Intrinsic to this approach is the centrality of the consumer and ensuring all changes in practice ultimately result in better and safer consumer experiences and outcomes.

Service delivery is dependent on workforce. Focusing on educating and upskilling to deliver contemporary care, and attracting and retaining staff that share the organisation's values, are key to securing the Service's capacity and capability to provide high quality services.

The Service will facilitate a culture of research and evaluation that promotes and implements evidence-based practice. Importantly, it will operate within a cycle that systematically reviews its own practice, identifies evidence based care, and tests and implements models to produce measurable improvements for consumers, carers and families. Opportunities will be sought to work with tertiary education partners to pilot and review new ways of working.

The physical environment is also critical to the effective delivery of evidence-informed service models. Many of the Service's physical assets are in very poor condition and operate out of repurposed buildings. There are opportunities to draw on international leading practice for more contemporary and therapeutic clinical environments that reinforce recovery-oriented treatment goals, and for greater colocation of mental health services and with service delivery partners.

Partnerships ---responsibility as a partner in the Regional Plan… Invest in systems that improve the timeliness and relevance of communication between hospitals, LHDs/ LHNs, GPs, specialists, and CMOs to improve the quality of care experienced by consumers who access multiple services. 6.18 In collaboration with each LHD/LHN, the NSW Ministry of Health, GPs, specialists and CMOs (where appropriate), develop strategies for improving clinical handover processes.

Technology ?

# 8. Monitoring and review

## 8.1 Monitoring

Monitoring is a regular assessment providing information on the achievement of actions. It identifies if activities are occurring, meeting the required standard and having the desired results.

Monitoring:

- Provides information on achievements.
- Allows early identification of problems achieving actions.
- Enables accountability.

The MHS Clinical Council will monitor achievement of actions identified in Section 7, and may delegate to other Committees as required.

## 8.2 Annual business plan

Each year this Plan will be formally reviewed and progress monitored. The Mental Health Service will develop and publish an Annual Business Plan to site alongside the Clinical Services Plan to guide implementation of agreed actions as well as ongoing operational commitments.

Recognising that the Plan was published at a point in time in 2019 prior to the COVID-19 pandemic, ongoing review will be required to:

- Ensure the Plan and its actions remain relevant and appropriate.
- Consider new and emerging issues and current context.

# Appendices

## Additional information

### Key Commonwealth, State and SESLHD publications

#### Commonwealth

Future planning of MHSs needs to align with the following key national clinical reform publications:

- The Fifth National Mental Health and Suicide Prevention Plan, 2017.
- A national framework for recovery-oriented mental health services: Guide for practitioners and providers, 2013.
- National Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2017.
- National Drug Strategy 2016-2025.
- National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014–2019.
- National Comorbidity Initiative: A review of data collections relating to people with coexisting substance use and mental health disorders.
- National Standards for Mental Health Services.
- Gayaa Dhuwi (Proud Spirit) Declaration.

#### NSW Government

Consideration needs to be given to NSW Government policy objectives in terms of mental health services as well as broader strategic plans including:

- NSW State Plan.
- NSW State Health Plan: Towards 2021.
- Living Well: A Strategic Plan for Mental Health in NSW 2014-2024.
- NSW Mental Health Reform 2014-2024.
- Strategic Framework for Suicide Prevention in NSW 2018-2023.
- NSW Health Drug Health Services Strategic Plan 2016–2021.
- NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings, 2009.
- NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022.
- The First 2000 Days Framework.
- NSW Service Plan for People with Eating Disorders (2019 – 2024) currently under review to be released in July 2019.
- Greater Sydney Commission, 2018, A Metropolis of Three Cities – the Greater Sydney Region Plan.
- Greater Sydney Commission, 2018, Eastern City and South District Plan.

### Regional

- Mental Health and Suicide Prevention Regional Plan, Central and Eastern Sydney 2019
- Intersectoral Homelessness Strategy 20
-

### South Eastern Sydney Local Health District

In addition, future MHS will need to align with the SESLHD's strategic documents and policies including:

- SESLHD's Journey to Excellence 2018-2021
- SESLHD's Asset Strategic Plan 2012-2017 (including annual updates from 2018)
- SESLHD's Drug and Alcohol Clinical Services Plan 2017-2027
- SESLHD's Integrated Care Strategy
- SESLHD's Integrated Oral Health Promotion Plan 2016-2020
- SESLHD's Community Partnerships Strategy
- SESLHD's Equity Strategy
- SESLHD's Research Strategy 2017-2021
- Greater Randwick Integrated Health Services Plan (2017)
- St George Hospital Integrated Health Services Plan (2018)
- Sutherland Hospital Integrated Health Services Plan (2019)
- Royal Hospital for Women Integrated Health Services Plan (2019)
- SESLHD Local Service Plan for Eating Disorders: 2019 – 2021.

## Key approaches to guiding mental health service delivery

### Recovery-oriented practice

Delivering recovery-oriented practice requires services to focus on achieving the best outcomes for people's mental health, physical health and wellbeing. It is respectful of the person's autonomy and engages the person in a therapeutic relationship which makes space for self-agency in all areas of a person's life.

### Trauma-informed care

The core components of trauma-informed care are safety, trustworthiness, choice, collaboration and empowerment, in parallel with the core tenets of a recovery-informed approach. It requires services to ensure staff have a well-developed understanding of how trauma affects the life of a person and accommodate sensitivities and vulnerabilities of trauma survivors. Most fundamentally, it represents a move away from a sole focus on diagnosis and towards the provision of holistic care based on lived experience and individual need.

### Integrated care

> '*Integrated care involves the provision of seamless, effective and efficient care that responds to all of a person's health needs, across physical and mental health, in partnership with the individual, their carers and family. It means developing a system of care and support that is based around the needs of the individual, provides the right care in the right place at the right time, and*

*makes sure dollars go to the most effective way of delivering health care for the people of NSW.'*[84]

## Lived experience

There continues to be emphasis on the importance of lived experience from people living with mental illness, their families and carers.

Combining people with lived experience (the experts on their lives and experiences) with mental health professionals (the experts on available treatments and services) '… offers opportunities for profound cultural change in the way it challenges traditional notions of professional power and expertise'[85].

## Strengths based approach

Focusing on strengths is a key domain of recovery-oriented practice and service delivery to support people to embrace their strengths, resilience and inherent capacity for living a full and meaningful life of their choosing.

## Co-production with consumers and carers

Co-production is 'Implementing, delivering and evaluating supports, systems and services, where consumers, carers and professionals work in an equal and reciprocal relationship, with shared power and responsibilities, to achieve positive change and improved outcomes'[86]

For example: co produced research with people with mental health lived experience ensures the correct research questions are being asked and the priorities of people accessing services are being addressed.

## Suicide prevention

Internationally, nationally and at a State level there is movement towards zero suicides.

Most recently the Strategic Framework for Suicide Prevention in NSW 2018–2023 set out the Government's vision '*everyone in NSW lives with hope, wellbeing and good health, with fewer lives lost through suicide*' [87]. The Framework represents the beginning of NSW's journey towards zero suicides.

One of the initiatives from this Framework is Zero Suicides in Care. The aim is, to strengthen practices within the mental health system with the aim of virtually eliminating suicides and suicide attempts by people in care.

## Reduction of restrictive practices

Another focus at the National and State level is the reduction and, where possible, elimination, of restrictive practices in mental health services.

[84] NSW Mental Health Commission, 2014, Living Well: A Strategic Plan for Mental Health in NSW

[85] Australian Health Ministers' Advisory Council, 2013, A national framework for recovery-oriented mental health services: Guide for practitioners and providers

[86] National Mental Health Consumer and Carer Forum, 2017, Advocacy brief: Co-design and co-production

[87] Mental Health Commission of NSW, 2018, Strategic framework for suicide prevention in NSW 2018 - 2023

The NSW Government has made a major commitment to preventing the use of seclusion and restraint in NSW Health acute mental health units and EDs[88].

The future direction of the MHS needs to look at restrictive practices in a broader sense (refer to Section 7.3).

## Shifting care into the community

Most consumers living with mental illness recover best through services that support them to live stable and fulfilling lives in their own homes or within their local community.

While for some people hospital care is required, it should be only be accessed when community care is not appropriate and patients should be discharged into community care when clinically appropriate.

In the meantime, early intervention, acute, emergency and specialist interventions as well as ongoing support are fundamental to providing effective community-based care.

NSW Health continues to support this shift in care through several programs including:

- *HASI - a state wide program which supports people with a severe mental illness to live and participate in the community in the way that they want to.*
- *Pathways to Community Living (PCLI) - this initiative supports people with enduring and serious mental illness, who have been in hospital for more than 12 months, to re-establish their lives in the community.*
- *Community Living Supports - a state wide program which supports people with a severe mental illness to live and participate in the community in the way they want to*[89].

In addition, at a federal level is the NDIS which can help support some people with a mental health illness (refer to Section 5.4: Other service providers and government agencies).

## Evidence-based care

Internationally, nationally, in NSW and across SESLHD clinical services are increasingly being informed by evidence-based care - integrating the best available research evidence with clinical expertise and patient values[90].

It involves translating evidence into practice, combining research, clinical experience, patient experience and information from the local context and ensuring that health practitioners, consumers, family and carers are aware of and use research evidence to inform their health and healthcare decision-making.

[88] NSW Health, 2018, Mental Health Safety and Quality in NSW: A plan to implement recommendations of the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities

[89] NSW Health URL: https://www.health.nsw.gov.au/mentalhealth/services/pages/programs-adults.aspx Retrieved 27 April 2019

[90] For example, guidance developed by UK's National Institute for Health and Care Excellence (NICE)

### Physical health in mental health

Physical Health Care within Mental Health Services[91] provides direction to mental health services in improving the provision of physical health to consumers.

Key principles of this policy are:

- Mental health consumers are entitled to quality, evidence-based education, care and treatment for all aspects of health, including physical health.
- Physical health for mental health consumers is considered by mental health services in planning, education, access, health promotion, screening and preventative activities.
- Physical health care for mental health consumers must:
    - Recognise consumers as critical partners in the care team.
    - Appropriately involve consumers, their families and carers.
    - Discuss with the consumer and be delivered in a respectful, non-judgemental and culturally sensitive way.
    - Support the consumer to make informed choices.
- Mental health services work collaboratively with other key health providers in providing quality physical health care for mental health consumers. GPs, Primary Health Networks and non-government organisations have a pivotal role in the provision of care.
- Physical health care is responsive to issues such as consumer preferences, gender, ethnicity, English proficiency and age.

## Mental health workforce

The NSW Mental Health Workforce Plan 2018-2022[92] notes providing care to people living with mental illness to improve their mental health and wellbeing requires a multitude of service providers and a large workforce.

It notes the mental health workforce includes those employed by public MHSs as well as many other staff in working in the public health system (e.g. EDs, drug and alcohol services, etc) through to partner organisations such as other government agencies (e.g. police, ambulance, etc), CMOs and private health providers.

It goes on to emphasise partnering with these workforces is essential to ensuring consumers experience a streamlined journey through care (also refer to Section 7.5).

### Aboriginal mental health workforce

The Workforce Plan also aims to improve the mental health and wellbeing of Aboriginal people by:

- '*… improving the cultural capability of the health workforce to better understand and respond to Aboriginal people with mental health and wellbeing problems and their family and carers. […and]*
- *to increase the number of Aboriginal people working in mental health*'.

[91] NSW Health, 2017, Physical Health Care within Mental Health Services (PD2017_033). URL: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_033.pdf
[92] NSW Health, 2018, URL: https://www.health.nsw.gov.au/mentalhealth/resources/Publications/mh-strategic-framework.pdf#page=45

### Peer workers

Formally recognising lived experience through the employment of peer workers is integral to mental health treatment and recovery.

*'Peer workers draw on their lived experience to play unique roles in encouraging and supporting the recovery of people experiencing mental health issues by:*

- *Offering hope and supporting consumers and carers to develop a recovery-oriented perspective.*
- *Supporting consumers and carers to develop important life skills.*
- *Supporting consumers and carers to move beyond being a patient or carer to develop a personal sense of empowerment.*
- *Empathising with consumers and carers from a position of experience' [93].*

In SESLHD peer support workers work across inpatient and community settings. The aim of the peer workers is to support the consumer through their mental health service journey by providing individual consultations, education and groups aimed at facilitating recovery principles of hope, choice, self-determination and social connectedness.

## Role delineation

Role delineation is a tool developed by NSW Health to provide a means to categorise the complexity of services required for the needs of the population (Level 6 is the most complex level of service, whereas Level 0 means the service is not available)[94]. It also recognises that for each level of clinical service provision, a corresponding level of clinical support services and staff profile are required to ensure services are delivered in a safe, efficient and appropriate manner.

It is noted that role delineation maps all services to hospitals resulting in the role delineation for SESLHD MHS being as follows:

Table 7: Role delineation for MHSs, SESLHD, 2017

| SPECIALTY | POWH | RHW | SSEH | WMH | GW | SGH | TSH | CHCK | GC |
|---|---|---|---|---|---|---|---|---|---|
| Adult Mental Health | 6 | NPS | NPS | NPS | NPS | 5 | 5 | NPS | NPS |
| Child and Youth Mental Health | 4 | NPS | NPS | NPS | NPS | 4 | 4 | NPS | NPS |
| Older Persons Mental Health | 6 | NPS | NPS | NPS | NPS | 6 | 4 | NPS | NPS |

Note: The Role Delineation Tool maps all services to hospitals rather than the Mental Health Service sites.
NPS = no planned service

[93] Australian Government, 2018, Peer workforce role in mental health and suicide prevention

[94] NSW Health, 2016, NSW Health Guide to Role Delineation

# Additional data

## Detailed inpatient data

*Table 8: Trended activity of Psychiatry SRG's, by hospital, 2013/14 to 2017/18*

| | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | Trend | Change | Annual Growth Rate |
|---|---|---|---|---|---|---|---|---|
| **Hospital stays** | | | | | | | | |
| Prince of Wales Hospital | 1,874 | 1,685 | 1,630 | 1,700 | 1,645 | | -229 | -3.2% |
| St George Hospital | 1,143 | 1,434 | 1,387 | 1,520 | 1,182 | | 39 | 0.8% |
| Sutherland Hospital | 843 | 864 | 808 | 868 | 827 | | -16 | -0.5% |
| **Total hospital stays** | **3,860** | **3,983** | **3,825** | **4,088** | **3,654** | | **-206** | **-1.4%** |
| **Days in Designated Pysch Unit** | | | | | | | | |
| Prince of Wales Hospital | 28,786 | 26,283 | 27,742 | 28,960 | 27,066 | | -1,720 | -1.5% |
| St George Hospital | 14,210 | 15,238 | 17,052 | 16,004 | 15,134 | | 924 | 1.6% |
| Sutherland Hospital | 12,761 | 14,176 | 13,553 | 15,693 | 12,497 | | -264 | -0.5% |
| **Total days in designated pysch unit** | **55,757** | **55,697** | **58,347** | **60,657** | **54,697** | | **-1,060** | **-0.5%** |
| **Total beddays** | | | | | | | | |
| Prince of Wales Hospital | 40,111 | 34,747 | 37,649 | 49,027 | 39,818 | | -293 | -0.2% |
| St George Hospital | 18,313 | 20,067 | 22,285 | 21,771 | 20,228 | | 1,915 | 2.5% |
| Sutherland Hospital | 22,754 | 26,002 | 24,909 | 28,925 | 18,167 | | -4,587 | -5.5% |
| **Total Beddays** | **81,178** | **80,816** | **84,843** | **99,723** | **78,213** | | **-2,965** | **-0.9%** |
| **Average Length of Stay in designated pysch unit** | | | | | | | | |
| Prince of Wales Hospital | 15 | 16 | 17 | 17 | 16 | | 1 | 1.7% |
| St George Hospital | 12 | 11 | 12 | 11 | 13 | | 0 | 0.7% |
| Sutherland Hospital | 15 | 16 | 17 | 18 | 15 | | 0 | 0.0% |
| **Total ALoS** | **14** | **14** | **15** | **15** | **15** | | **1** | **0.9%** |
| **Average Length of Stay** | | | | | | | | |
| Prince of Wales Hospital | 21 | 21 | 23 | 29 | 24 | | 3 | 3.1% |
| St George Hospital | 16 | 14 | 16 | 14 | 17 | | 1 | 1.7% |
| Sutherland Hospital | 27 | 30 | 31 | 33 | 22 | | -5 | -5.0% |
| **Total ALoS** | **21** | **20** | **22** | **24** | **21** | | **0** | **0.4%** |
| **NWAU (v18)** | | | | | | | | |
| Prince of Wales Hospital | 5,698 | 5,321 | 5,981 | 5,732 | 6,159 | | 461 | 2.0% |
| St George Hospital | 3,124 | 3,258 | 3,372 | 3,803 | 3,769 | | 645 | 4.8% |
| Sutherland Hospital | 2,152 | 2,088 | 2,031 | 2,281 | 2,908 | | 756 | 7.8% |
| **Total NWAU (v18)** | **10,974** | **10,667** | **11,384** | **11,816** | **12,836** | | **1,862** | **4.0%** |
| **Average NWAU (v18)** | | | | | | | | |
| Prince of Wales Hospital | 3.04 | 3.16 | 3.67 | 3.37 | 3.74 | | 0.70 | 5.3% |
| St George Hospital | 2.73 | 2.27 | 2.43 | 2.50 | 3.19 | | 0.46 | 3.9% |
| Sutherland Hospital | 2.55 | 2.42 | 2.51 | 2.63 | 3.52 | | 0.96 | 8.3% |
| **Total Average NWAU (v18)** | **2.84** | **2.68** | **2.98** | **2.89** | **3.51** | | **0.67** | **5.4%** |
| **PEM** | | | | | | | | |
| Prince of Wales Hospital | 5,801 | 5,467 | 6,156 | 6,033 | 6,467 | | 666 | 2.8% |
| St George Hospital | 3,251 | 3,366 | 3,484 | 3,990 | 3,978 | | 727 | 5.2% |
| Sutherland Hospital | 2,255 | 2,199 | 2,189 | 2,448 | 3,054 | | 799 | 7.9% |
| **Total PEM** | **11,307** | **11,032** | **11,830** | **12,471** | **13,499** | | **2,192** | **4.5%** |
| **Average PEM** | | | | | | | | |
| Prince of Wales Hospital | 3.10 | 3.24 | 3.78 | 3.55 | 3.93 | | 0.84 | 6.2% |
| St George Hospital | 2.84 | 2.35 | 2.51 | 2.63 | 3.37 | | 0.52 | 4.3% |
| Sutherland Hospital | 2.68 | 2.54 | 2.71 | 2.82 | 3.69 | | 1.02 | 8.4% |
| **Total Average PEM** | **2.93** | **2.77** | **3.09** | **3.05** | **3.69** | | **0.77** | **6.0%** |

Source: HIE data set provided by SESLHD MHS
Inclusions: 82 Psychiatry - Acute, 83 Psychiatry - Non Acute, 85 Psychogeriatric Care

*Table 9: Characteristics of consumers with a mental health SRG, by hospital, 2017/18*

| | POWH | STGH | TSH | Total |
|---|---|---|---|---|
| **Separations** | **1,645** | **1,182** | **827** | **3,654** |
| **Age Group** | | | | |
| 0 - 15 years | 0% | 2% | 1% | 1% |
| 16 - 25 years | 17% | 16% | 14% | 16% |
| 26 - 35 years | 20% | 21% | 22% | 21% |
| 36 - 45 years | 17% | 17% | 20% | 18% |
| 46 - 55 years | 16% | 14% | 15% | 15% |
| 56 - 65 years | 10% | 11% | 10% | 10% |
| 66 - 75 years | 7% | 12% | 7% | 9% |
| 76 - 85 years | 9% | 5% | 7% | 7% |
| 85 years and older | 4% | 2% | 4% | 3% |
| **Country of birth (excluding Australia)** | | | | |
| Australia | 64% | 64% | 81% | 68% |
| England | 12% | 11% | 12% | 11% |
| New Zealand | 8% | 6% | 12% | 8% |
| China (excluding Taiwan) | 5% | 10% | 3% | 7% |
| Greece | 3% | 8% | 5% | 5% |
| Former Yugoslav Republic of Macedonia | 1% | 11% | 4% | 5% |
| Lebanon | 2% | 7% | 3% | 4% |
| India | 4% | 2% | 4% | 3% |
| Egypt | 3% | 3% | 5% | 3% |
| Philippines | 3% | 3% | 2% | 3% |
| Sri Lanka | 4% | 0% | 1% | 3% |
| **Local Government Area** | | | | |
| **SESLHD** | **84%** | **83%** | **88%** | **84%** |
| Randwick (C) | 50% | 2% | 4% | 24% |
| Sutherland | 1% | 9% | 68% | 19% |
| Rockdale (C) | 1% | 33% | 7% | 13% |
| Hurstville (C) | 1% | 29% | 4% | 11% |
| Waverley (A) | 13% | 1% | 2% | 6% |
| Botany Bay (C) | 10% | 0% | 1% | 5% |
| Kogarah (C) | 0% | 8% | 1% | 3% |
| Woollahra (A) | 6% | 0% | 0% | 3% |
| Sydney (Inner & East SLAs) | 3% | 0% | 0% | 1% |
| All other LHD's & interstate | 16% | 17% | 12% | 16% |
| **Source of referral** | | | | |
| Emergency Department | 84% | 78% | 63% | 77% |
| Hospital in same Health Service | 1% | 6% | 23% | 8% |
| Medical Practitioner other than Private Psychiatric Practice | 0% | 12% | 4% | 5% |
| Community Health | 5% | 2% | 7% | 4% |
| Outpatients | 4% | 0% | 0% | 2% |
| All other referrals | 6% | 2% | 3% | 4% |
| **Legal status** | | | | |
| Involuntary | 31% | 43% | 48% | 39% |
| Voluntary | 69% | 57% | 52% | 61% |

Source: HIE data set provided by SESLHD MHS
Inclusions: 82 Psychiatry - Acute, 83 Psychiatry - Non Acute, 85 Psychogeriatric Care

# Contributors

The development of this Plan has been based on an opportunity to review the Plan and/or discussions held with MHSs staff or units and their Executive including:

## Eastern Suburbs MHS

Acute Care Team
Administration Manager
Adult Community Mental Health Teams
CAFÉ (Child and Family East)
Child and Adolescent Mental Health Service
Clinical Director
Clinical Operations Manager
Community Services Manager
headspace MHS
Inpatient Services Manager
Kiloh Centre General Unit
Kiloh Centre Observation Unit
Mental Health Intensive Care Unit (MHICU)
Mental Health Rehabilitation Unit
Older Persons Mental Health Unit
Patient Safety and Clinical Quality Manager
Perinatal Mental Health Service
Psychiatric Emergency Care Centre (PECC)
SAFE START Team Leader
Senior Staff Specialist
Service Director
State Mental Health Telephone Access Line
Clinical Coordinator Youth Mental Health

## SESLHD MHS

Acting Director (February – June 2019)
Clinical Coordinator Youth Mental Health
Clinical Director Youth Mental Health
Clinical Manager Older Persons' MHS
Clinical Partnership Coordinator
Clinical Risk Manager
Consumer Partnerships Coordinator
Director
Eating Disorder Coordinator
FCMHP District Program Manager
Grow Mental Health Coordinator
Mental Health Access and Service Integration
Manager Mental Health Improvement Advisor
Mental Health NDIS Project Officer
Nurse Educator
Partnerships Coordinator
Recovery & Wellbeing College Manager
Service Development Manager
Senior Executive Officer

## St George MHS

Acute Care Team
Adult Community Services Manager
Clinical Director
Clinical Operations Manager
Connections / Outlook Adult Community Health
Consultation Liaison Psychiatry
Directions Early Psychosis Programme
Inpatient Services Manager Acute Inpatient Unit
Older Persons Mental Health Unit
Psychiatric Emergency Care Centre (PECC)

## St George / Sutherland MHS

Acting District Rehabilitation Clinical Coordinator
CAMHS / YMH / Perinatal
Patient Safety and Clinical Quality Manager
Peer Support Manager
Service Manager CAMHS
Service Manager Older Adults
Service Coordinator Rehabilitation Services

## Sutherland MHS

Acute Care Team / Intake Team
Acute Inpatient Unit
Adult Community Services Manager
Clinical Director

Clinical Operations Manager
CONNECT Team
Consultation Liaison Psychiatry
Inpatient Services Manager
Mental Health Rehabilitation Unit
START Team

## Broader consultation

Broader consultation was sought from

Black Dog Institute
Central and Eastern Sydney Primary Health Network
Community Advisory Committee members
Consumers
Mindgardens Neuroscience Network
Neuroscience Research Australia (NeuRA)
SESLHD Clinical Streams
SESLHD Clinical Directorates

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