Updated Activity Work Plan 2016-2018:
Primary Mental Health Care Funding

Nepean Blue Mountains PHN
Overview

This Activity Work Plan is an update to the 2016-17 Activity Work Plan submitted to the Department in May 2016. However, activities can be proposed in the Plan beyond this period.

Mental Health Activity Work Plan 2016-2018

This Plan outlines activities against each and every one of the six priorities for mental health and suicide prevention. The Plan also lays the foundation for regional planning and implementation of a broader stepped care model in the PHN region. This Plan recognises that 2016-17 was a transition year and full flexibility in programme design and delivery will not occur until 2018-19.

The Plan will:

a) Provide an update on the planned mental health services to be commissioned from 1 July 2016, consistent with the grant funding guidelines.

b) Outline the approach to be undertaken by the PHN in leading the development with regional stakeholders including LHNs of a longer term, more substantial Regional Mental Health and Suicide Prevention plan (which is aligned with the Australian Government Response to the Review of Mental Health Programmes and Services (available on the Department’s website). This will include an outline of the approach to be undertaken by the PHN to seek agreement to the longer term regional mental health and suicide prevention plan from the relevant organisational signatories in the region, including LHNs.

c) Outline the approach to be taken to integrating and linking programmes transitioning to PHNs (such as headspace, and the Mental Health Nurse Incentive Programme services) into broader primary care activities, and to supporting links between mental health and drug and alcohol service delivery.

d) Have a particular focus on the approach to new or significantly reformed areas of activity – particularly Aboriginal and Torres Strait Islander mental health, suicide prevention activity, and early activity in relation to supporting young people presenting with severe mental illness.

In addition, PHNs will be expected to provide advice in their Mental Health Activity Work Plan on how they are going to approach the following specific areas of activity in 2016-18 to support these areas of activity:

- Develop and implement clinical governance and quality assurance arrangements to guide the primary mental health care activity undertaken by the PHN, in a way which is consistent with section 1.3 of the Primary Health Networks Grant Programme Guidelines available on the PHN website at [http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines](http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines), and which is consistent with the National Standards for Mental Health Services and National Practice Standards for the Mental Health Workforce.

- Ensure appropriate data collection and reporting systems are in place for all commissioned services to inform service planning and facilitate ongoing performance monitoring and evaluation at the regional and national level, utilising existing infrastructure where possible and appropriate.

- Develop and implement systems to support sharing of consumer clinical information between service providers and consumers, with appropriate consent and building on the foundation provided by myHealth Record.

- Establish and maintain appropriate consumer feedback procedures, including complaint handling procedures, in relation to services commissioned under the activity.

Value for money in relation to the cost and outcomes of commissioned services needs to be considered within this planning process.
1. (a) Strategic Vision

The overall long term vision of NBMPHN is to play a crucial part in delivering joined up consumer centred mental health services across the acute, primary care and community sector in a stepped care model.

During 2017-18 NBMPHN will continue its mental health reform tasks to support the implementation of a regional stepped care model in line with its needs assessment. In 2016-17 systems were put in place to ensure ongoing targeted engagement with stakeholders is embedded in any work undertaken in the six mental health priority areas by NBMPHN. This included the establishment of several advisory bodies: the Mental Health Advisory Committee which has a cross representative each on the NBMPHN Clinical Council and on the NBMPHN GP Advisory Committee; the Joint NBM PHN/LHD Aboriginal Advisory Committee for Drug &Alcohol and Mental Health with Aboriginal community representatives and Aboriginal health worker representatives from all four LGAs within the region; the Mental Health Consumer/Carer Advisory Committee which has three cross representatives on the Mental Health Advisory Committee and the Regional Suicide Prevention Working Group which also includes a consumer representative. These advisory bodies meet regularly to provide input into the reform tasks. In addition broader consultation with key stakeholder will be undertaken particularly for the redesign of psychological therapy services for hard to reach/underserviced groups and services for people with severe mental illness.

The stepped care model will be further developed during 2017-18. Initially, currently commissioned services will continue and will be augmented by new services under the low intensity, suicide prevention, Aboriginal specific and severe mental illness priorities. A staged rollout of the stepped care model will be implemented with the intention to fully transition to the new regional stepped care model by July 2018.

The stepped care model will be underpinned by the re-designed intake system which will play a pivotal part in providing coherent referral pathways for mental health and suicide prevention services in the primary care sector.

During 2017-18 NBMPHN will continue to engage with stakeholders including the LHD to create an overarching strategic longer term regional mental health and suicide prevention plan addressing the vision of joined up consumer centred mental health care across the acute, primary care and community sector.
1. (b) Planned activities funded under the Primary Mental Health Care Schedule – Template 1

Note 1: For Priority Area 1, 2, and 5-8 use Template 1 below.
Note 2: For Priority Areas 3 and 4, please use Template 2 on page 9.

<table>
<thead>
<tr>
<th>Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area</th>
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<tbody>
<tr>
<td><strong>Priority Area 1: Low intensity mental health services</strong></td>
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<tr>
<td><strong>Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)</strong></td>
</tr>
<tr>
<td><strong>Existing, Modified, or New Activity</strong></td>
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<tr>
<td><strong>Description of Activity</strong></td>
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<tr>
<td><strong>1.1 Commission low intensity mental health services – including</strong></td>
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<tr>
<td>a. A group program for primary school aged children with anxiety issues</td>
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<tr>
<td>b. A peer led group program to increase mental health literacy and self-care behaviour</td>
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<tr>
<td><strong>1.2 The identification and low intensity management of people in primary care at risk of high prevalence mental disorders (depression and/or anxiety) or with undiagnosed mild mental illness</strong></td>
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<tr>
<td><strong>1.1</strong> is a new activity</td>
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<td><strong>1.2</strong> is new activity</td>
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**1.1 Commission low intensity mental health services**

**Aim:** The commissioned low intensity services will increase the availability of local referral pathways to low intensity, evidence based psychological services either delivered online or by coaches face to face/telephone and moderated and/or supervised by qualified mental health clinicians.

a. The group program for primary school aged children with anxiety issues will consist of the continuation of the evidence based group program ‘Cool Kids’ for primary school children aged 8-11 years with anxiety issues. It is an 8 session (delivered weekly) program and both children and their parents/carers attend separate but concurrent sessions. Group facilitators are ‘Cool Kids’ trained allied mental health professionals. It is offered in partnership and collaboration with the NBMLHD Child and Youth Mental Health Service and the Community Health Child and Family Counselling services.

b. The peer led group program to increase mental health literacy and self-care behaviour will deliver a short term, evidence based group program for young people and/or adults at risk of or with mild mental health issues.
The intention of the program is to engage appropriately trained peer workers as group co-facilitators together with an allied mental health clinician.

**Needs assessment priority:** A need for access to local low intensity services has been identified in the needs assessment, in particular a low intensity group program to support early intervention for children with anxiety issues. These activities also address priority 2 – mental health services for children and priority 3 – psychological services for underserviced/hard to reach groups. A lack of mental health literacy has been identified through the needs assessment and stakeholders. A low intensity psycho-educational group service will increase health literacy and support mental health self-care particularly among young people and commences engagement of a peer workforce.

**Expected results:** this activity will enhance existing and provide new local referral pathways for low intensity psychological support and increase the choice and service mix within a stepped care model to better target and support consumer needs.

NBMPHN has investigated a number of low intensity mental health service models and is in the process of discussing options with its stakeholders to decide the preferred model to be commissioned.

**1.2 The identification and low intensity management of people in primary care at risk of high prevalence mental disorders (depression and/or anxiety) or with undiagnosed mild mental illness**

**Aim:** There is evidence that people with chronic illness such as diabetes or heart disease are at heightened risk of developing depression and/or anxiety. There is also evidence that people with medically unexplained symptoms such as fibromyalgia or chronic fatigue are unnecessarily over serviced with clinical tests and procedures and the prolonged uncertainty of diagnosis increases the risk of depression and anxiety. The aim is to assist GPs in identifying such patients (either existing or new) to enable GPs to discuss low intensity support options with their identified patients or if necessary to refer to any other mental health services within the stepped care model. Such early intervention will assist in increasing self-care and provide tools to recognise and manage anxiety and depression issues.

**Needs assessment priority:** Based on the Flexible Funding Pool Implementation Guidance we have been advised that low intensity mental health services will relieve some of the burden on psychosocial services for people with mild to moderate mental illness and meet the needs for newly identified high risk people.
<table>
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<th>Target population cohort</th>
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<tr>
<td><strong>Expected results</strong>: Supporting more people identified in general practice who are at heightened risk or with low level depression and/or anxiety through referrals to low intensity mental health services.</td>
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<tr>
<th>Consultation</th>
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| **1.1 Commission low intensity mental health service**  
**Target population**: people with emerging and/or mild to moderate mental illness (as a first line service) and in some instances for people with moderate to severe mental illness as an additional or step down service. For the group programs:  
- primary school aged children aged 8-11 years with emerging or mild to moderate anxiety issues and their parents/carers. For the peer led groups:  
- young people 18-24 years and/or adults with an emerging or mild mental illness who can benefit from psycho education.  
**1.2 The identification and low intensity management of people in primary care at risk of high prevalence mental disorders (depression and/or anxiety) or with undiagnosed mild mental illness**  
**Target population**: people identified in specified general practices at increased risk of depression and anxiety due to physical chronic disease or medically unexplained symptoms. |

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<tr>
<th><strong>Consultation</strong></th>
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| **1.1 Commission low intensity mental health service**  
Targeted stakeholder consultations including with GPs, allied mental health providers, consumers/carers and LHD (through the newly established Mental Health Advisory Committee and Mental Health Consumer/Carer Advisory Committee) will occur at specified planned meetings. These consultations will be carried out during the first half of 2017.  
**a. Group program for primary school aged children with anxiety issues**  
Targeted consultation with key stakeholders such as GPs, LHD and allied mental health providers has been undertaken in the past when the group program was rolled out as part of the ATAPS Child Mental Health program. Consultations are ongoing with the LHD and allied health providers to ensure that the group program will be delivered in the future and a meetings has occurred between the parties in October 2016 to plan specific groups for 2017 school term and 2. Further consultations will occur during the first half of 2017 to plan specific groups for 2017 school term 3 and 4.  
**b. A peer led group program to increase mental health literacy and self-care behaviour** |


Targeted stakeholder consultations including with GPs, allied mental health providers, consumers/carers and LHD (through the newly established Mental Health Advisory Committee and Mental Health Consumer/Carer Advisory Committee) will assist in the co-design for the planned pilot program. These consultations will be carried out at one of the planned committee meetings during the second half of 2017. Further, consultations will occur with NGOs who engage peer support workers and peer workers from the LHD.

1.2 The identification and low intensity management of people in primary care at risk of high prevalence mental disorders (depression and/or anxiety) or with undiagnosed mild mental illness
Consultation will occur through the Mental Health Advisory Committee, Mental Health Consumer/Carer Advisory Committee and the GP Advisory Committee (as a potential provider of workforce for this activity).

1.1 Commission low intensity mental health service
The Mental Health Advisory Committee (which includes representation from GPs, AHPs, Psychiatrist, LHD Mental Health, consumers and community managed organisations) and the Mental Health Carer/Consumer Advisory Committee will assist in the co-design and procurement process for the local low intensity service.

a. Group program for primary school aged children with anxiety issues
Collaboration will continue with the LHD Community Health Child & Family Counselling services, LHD Child and Youth Mental Health Service, the LHD Child & Adolescent Development Unit and Cool Kids group trained allied health providers to continue joint deliver of the Cool Kids group program.

b. A peer led group program to increase mental health literacy and self-care behaviour
The Mental Health Carer/Consumer Advisory Committee and the Mental Health Advisory Committee (which includes representation from GPs, AHPs, Psychiatrist, LHD Mental Health, consumers and community managed organisations) will assist in the co-design and procurement process for the pilot group program. In addition it is expected that local community managed organisations with peer support workers will be involved in the co-design of the pilot group.

1.2 The identification and low intensity management of people in primary care at risk of high prevalence mental disorders (depression and/or anxiety) or with undiagnosed mild mental illness
NBMPHN will collaborate closely with a select number of general practices which will include a mixture of practices participating/not participating in the Healthcare Home project.

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<th>Duration</th>
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| **1.1 Commission low intensity mental health service**  
Service delivery is expected to commence in October 2017 and continue to 30 June 2018 (anticipated to be ongoing beyond current PHN mental health funding cycle).  

a. **Group program for primary school aged children with anxiety issues**  
1 July 2017 – 30 June 2018 (anticipated to be ongoing beyond current PHN mental health funding cycle).  

b. **A peer led group program to increase mental health literacy and self-care behaviour**  
Planning will occur during September 2017 and procurement will be carried out during October 2017 to January 2018 with expectations that a contract will be signed by February 2018 with service to be carried out between March and June 2018. If pilot groups are successful the activity is expected to continue to 2019.  

**1.2 The identification and low intensity management of people in primary care at risk of high prevalence mental disorders (depression and/or anxiety) or with undiagnosed mild mental illness**  
Planning for this activity will take place from July to August 2017 and procurement will occur from September to December 2017. Service delivery will commence in January and continue to 30 June 2018. |

<table>
<thead>
<tr>
<th>Coverage</th>
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| **1.1 Commission low intensity mental health service**  
Across PHN region  

a. **Group program for primary school aged children with anxiety issues**  
Across PHN region  

b. **A peer led group program to increase mental health literacy and self-care behaviour**  
It is anticipated that initially four pilot group will be offered – one in each LGA of the region. However, once consultations have been undertaken for this activity a decision will be made in which LGA the pilot groups will occur. |
| Commissioning method (if relevant) | 1.1 Commission low intensity mental health service  
This activity will be partially commissioned as intake will occur through the current in house central intake service.  

a. **Group program for primary school aged children with anxiety issues**  
This activity will be fully commissioned.  

b. **A peer led group program to increase mental health literacy and self-care behaviour**  
This activity will be fully commissioned.  

| Performance Indicator | Priority Area 1 - Mandatory performance indicators:  
- Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services.  
- Average cost per PHN-commissioned mental health service – Low intensity services.  
- Clinical outcomes for people receiving PHN-commissioned low intensity mental health services.  

<p>| Local Performance Indicator target (where possible) | A local performance indicator will be developed in 2017 as part of a comprehensive performance monitoring framework for the PHN. |</p>
<table>
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<tr>
<th>Priority Area 2: Youth mental health services</th>
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| **Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)** | **2.1 headspace Penrith Centre Program**
**2.2 headspace Penrith Youth Early Psychosis Program**
**2.3 Early intervention mental health services for young people at risk of or with a non-psychotic severe mental illness**

Please note: activities specific to children aged 0-11 years are reported under the following:
Priority 1.1.a) Group program for primary school aged children with anxiety issues
Priority 3.3 Psychological therapy services for children |
| **Existing, Modified, or New Activity** | **2.1 is an existing activity.**
**2.2 is an existing activity.**
**2.3 is a new activity.**

**2.1 headspace Penrith**
**Aim:** headspace Penrith provides evidence based early intervention mental health and alcohol & other drugs services for young people 12-25 years of age. These services are augmented by primary care services addressing physical and sexual health as well as providing support for general wellbeing through education, employment and training services, support for those experiencing bullying or other issues at school or work and through social activities. Referrals can occur from any source, including self-referrals.

**Needs Assessment Priority:** young people at risk of, with emerging mental illness or with a mild to moderate mental illness. This activity aligns with the requirement to continue to fund existing headspace services within the PHN region until June 2018.

**Expected Results:** A high quality commissioned service is delivered to meet the mental health, AOD and other needs of young people in the region. |
| **Description of Activity** | **2.2 headspace Penrith Youth Early Psychosis Program (hYEPP)**
**Aims:** The headspace Youth Early Psychosis Program (hYEPP), provides youth friendly round the clock specialist treatment and care intervention for young people aged 12-25 years at risk of developing or with first episode psychosis. Families and friends are included in the treatment process. The program |
has two streams: hYEPP 1 for young people at ultra-high risk of developing psychosis and hYEPP 2 for young people with first episode psychosis. The program works on recovery based principles.

The program is integrated into headspace Penrith and currently forms a spoke of the hub and spoke service provided by the lead agency (UnitingRecovery) in three western Sydney headspace services (Parramatta spoke), (Mount Druitt hub) and (Penrith spoke). The service offers a specialist, clinical mobile assessment and treatment team (which will continue to be shared across the three sites) and a continuing care team, based at headspace Penrith to ensure young people receive planned, tailored and evidence based treatment and mental health support within a primary care setting and/or at home or other suitable and mutually agreed place. Referrals can occur from any source, including self-referrals. Referrals are usually made through the headspace centre.

Young people qualifying for hYEPP 1 (ultra-high risk) receive treatment for up to six months. They may be referred to hYEPP 2 during that period if they meet the criteria or are referred to the standard headspace services at the end of six months or any other suitable service to support the recovery journey.

Young people qualifying for hYEPP 2 (with first episode psychosis) will receive an initial two years of specialist care which may be extended if necessary.

**Needs Assessment Priority:** young people with and/or at risk of developing psychosis or presenting with first episode psychosis. This activity aligns with the requirement to continue to fund the existing Youth Early Psychosis Program within the PHN region during 2017-18.

**Expected Results:** Appropriate services will be provided for this high needs group.

### 2.3 Early intervention mental health services for young people at risk of or with a non-psychotic severe mental illness

**Aim:** This activity will provide services for young people with severe mental illness not suitable for the headspace Youth Early Psychosis program. The nature of the service will be co-designed with key stakeholders in particular with the LHD Child and Youth Mental Health Service to ensure suitable referral pathways can be developed which avoid duplication of service provision.

**Needs Assessment Priority:** young people with and/or at risk of severe mental illness other than psychosis.

**Expected Results:** Appropriate services will be provided for this high needs group.
<table>
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<th>Target population cohort</th>
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| **2.1 headspace Penrith**  
**Target population:** Youth aged 12-25 years. |
| **2.2 headspace Penrith Youth Early Psychosis Program (hYEPP)**  
**Target population:** Youth aged 12-25 years. |
| **2.3 Early intervention mental health services for young people at risk of or with a non-psychotic severe mental illness**  
**Target population:** Youth aged 12-25 years. |

<table>
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<tr>
<th>Consultation</th>
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| **2.1 headspace Penrith**  
Consultation with the lead agency will continue throughout the funding period. |
| **2.2 headspace Penrith Youth Early Psychosis Program (hYEPP)**  
Consultation with the lead agency and Western Sydney PHN (as the funder of the hub and another spoke) will continue throughout the funding period. In particular further consultation will occur for the modification of the existing annual plan template during April and May 2017. |
| **2.3 Mental health services for young people at risk of or with a non-psychotic severe mental illness**  
NBMPHN will consult with its key stakeholders including headspace Penrith, consumers and carers, LHD, local youth services, Mental Health Advisory Committee to discuss and co-design possible services for young people at risk of or with severe non-psychotic mental illness. |

<table>
<thead>
<tr>
<th>Collaboration</th>
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| **2.1 headspace Penrith**  
NBMPHN works closely with UnitingRecovery, the lead agency of headspace Penrith to ensure ongoing support for young people in the region through the headspace centre program. While NBMPHN used to be an active member of the headspace Penrith Consortium, as the new funder, it has stepped back from that role during 2016-17. However, the Consortium has indicated that it wishes to remain in contact with NBMPHN by inviting NBMPHN to select consortium meetings throughout the funding period. NBMPHN will initiate discussions in 2017 to address integration and broadening of youth mental health services within the stepped care model beyond the mandated dedicated funding period (2017-18) for the headspace Penrith centre. Further, NBMPHN will collaborate with headspace National if and when appropriate to support the smooth running of headspace Penrith. |
### 2.2 *headspace* Penrith Youth Early Psychosis Program (hYEPP)

NBMPHN works in close collaboration with the lead agency, UnitingRecovery, to ensure continuity of service for both, young people already enrolled in hYEPP and young people newly joining hYEPP through the Penrith spoke during 2017-18.

NBMPHN will continue to collaborate with WentWest (Western Sydney PHN) the funder of the hYEPP hub (Mt Druitt) and other spoke (Parramatta) to enable UnitingRecovery to deliver a coherent hYEPP hub and spoke model across the two regions.

### 2.3 Mental health services for young people at risk of or with a non-psychotic severe mental illness

Once funding amounts have been confirmed and NBMPHN will know how much, if any, funding is available during 2017-18 to broaden the program to include service provision for young people with non-psychotic severe mental illness, NBMPHN will collaborate with its key stakeholders (*headspace*, LHD, youth services) on how to progress the planned stepped care approach redesign in 2017-18.

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| Duration | 2.1 *headspace* Penrith  
Service delivery: 1 July 2016 – 30 June 2018 (with expectation to extend, possibly with modifications to June 2019) |
|----------|-------------------------------------------------------------------------------------------------------------------------------|
|          | 2.2 *headspace* Penrith Youth Early Psychosis Program (hYEPP)  
Service delivery: 1 July 2016 – 30 June 2018 (with expectation to extend to June 2019) |
|          | 2.3 Early intervention mental health services for young people at risk of or with a non-psychotic severe mental illness  
Planning and procurement: September 2017 – January 2018  
Service delivery: Anticipated to be from February 2018 to 30 June 2019 |
| Coverage | 2.1 *headspace* Penrith  
The *headspace* centre is located in Penrith. In theory, the service is available to young people across the PHN region if they are able to get to the *headspace* centre. In reality distance and transport issues generally impact access by young people from the upper Blue Mountains, Lithgow and part of the Hawkesbury LGA. The issue of broader coverage so young people across the region have reasonable |
access to services will be addressed in the comprehensive needs assessment and resulting plan and the stepped care design.

2.2 *headspace* Penrith Youth Early Psychosis Program (hYEPP)
In theory the hYEPP is open to any youth qualifying for the program, however in reality the program will be more limited in its reach due to geographical constraints.

2.3 Early intervention mental health services for young people at risk of or with a non-psychotic severe mental illness
Anticipated to be across the entire NBMPHN region.

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<thead>
<tr>
<th>Commissioning method (if relevant)</th>
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<tr>
<td>Briefly outline the planned commissioning method, including whether the activity will be commissioned in whole or part.</td>
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<tr>
<td><strong>2.1 headspace Penrith</strong></td>
</tr>
<tr>
<td>Fully commissioned service.</td>
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<tr>
<td><strong>2.2 headspace Penrith Youth Early Psychosis Program (hYEPP)</strong></td>
</tr>
<tr>
<td>Fully commissioned service.</td>
</tr>
<tr>
<td><strong>2.3 Early intervention mental health services for young people at risk of or with a non-psychotic severe mental illness</strong></td>
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<tr>
<td>Commissioned service and depending on the service design with possibility of intake to remain in house as part of a centralised intake.</td>
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<tr>
<th>Performance Indicator</th>
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<tr>
<td>Priority Area 2 - Mandatory performance indicator:</td>
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<tr>
<td>• support region-specific, cross sectoral approaches to early intervention for children and young people with, or at risk of mental illness (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group.</td>
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Local Performance Indicator target (where possible)

A local performance indicator will be developed in 2017 as part of a comprehensive performance monitoring framework for the PHN.

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<thead>
<tr>
<th>Priority Area 5: Community based suicide prevention activities</th>
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<tr>
<td>Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)</td>
<td>5.1 Establish regional assertive aftercare protocols to ensure linkage to primary health care where appropriate</td>
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<td></td>
<td>5.2 Establish dedicated referral pathways for people discharged from hospital after a suicide attempt or serious self-harm who can benefit from short term psychological intervention</td>
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<tr>
<td>Please note: the funding provided for Aboriginal specific services in regards to suicide prevention has been combined with the activities reported under Priority 6 in particular for:</td>
<td><em>Priority 6.3 Provide culturally appropriate mental health and alcohol &amp; and other drugs early intervention programs to young Aboriginal people with or at risk of dual diagnosis</em></td>
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<tr>
<td>This activity provides early intervention for young people through ‘connection to culture’ programs which will also address the link between mental health, suicide risk and substance use. The activity will help build resilience and increase protective factors in young people and reduce the number of young people progressing to risky AOD behaviour and/or complex mental health issues and increased suicide risk and teach them how to connect to mainstream services for support.</td>
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Existing, Modified, or New Activity

5.1 is a new activity
5.2 is a modified and expanded activity
Description of Activity

The activities identified under this priority area are guided by LifeSpan’s evidence based systems approach to suicide prevention framework.

5.1 Establish regional assertive aftercare protocols to ensure linkage to primary health care where appropriate

**Aim:** Aftercare is one of the identified strategies of the evidence based systems approach to suicide prevention framework. This activity addresses a clearly identified need by stakeholders for coherent and assertive aftercare support for people discharged from hospital after a suicide attempt or serious self-harm. Currently there is a lack of such assertive aftercare in the region. NBMPHN will work with the LHD, consumer and carers and other relevant stakeholders to address assertive aftercare as part of the regional mental health and suicide prevention plan as this will need a multi-agency approach.

However, one aspect which has been clearly identified by stakeholders is the lack of systematic and assertive linking to GPs after hospital discharge. This includes people who have an identified GP and those without access to a regular GP/GP practice. To support assertive linkage to GPs a service will be co-designed with relevant stakeholders with the intention to use a peer workforce to facilitate and link people to GPs after discharge form hospital.

**Needs assessment priority:** Lack of assertive and coordinated aftercare when people are discharged from the mental health unit has been clearly identified in the needs assessment by a variety of stakeholders. This activity aligns with the identified need to improve aftercare for people discharged from hospital after a suicide attempt or serious self-harm.

**Expected Results:** More people who have attempted suicide will be connected in with a GP or community service post hospitalisation to reduce rates of readmission. GPs will be more engaged with this vulnerable group and a highly trained peer led workforce will be developed.

5.2 Establish dedicated referral pathways for people discharged from hospital after a suicide attempt or serious self-harm who can benefit from short term psychological intervention

**Aim:** The current SOS (Seek Out Support) suicide prevention service provides a referral pathway to a quick response (within 72 hours of referral), short term, and evidence based psychological intervention for people at low to moderate risk of suicide who are managed within a primary health care setting. The proposed activity will modify and expand the existing service to ensure that people discharged from hospital after a suicide attempt or serious self-harm will have immediate access to this service.
through a dedicated referral pathway. The existing service model will be reviewed and may be further adjusted to efficiently support this cohort of people.

**Needs assessment priority:** Provision of evidence based psychological therapy intervention is one of the 9 key strategies of the LifeSpan suicide prevention framework. This activity also is part of priority 3 as it provides dedicated referral pathways and mental health services to an underserviced and hard to reach group.

**Expected results:** More people who have attempted suicide will have immediate access to free psychological services post discharge.

The co-design of these activities will also address how Aboriginal people will be supported in accessing these services. This will include a provider workforce trained in cultural competency for activity 5.2 similar to the workforce providing mainstream psychological therapy for Aboriginal people under Priority 3.

| Target population cohort | 5.1 Establish regional assertive aftercare protocols to ensure linkage to primary health care where appropriate  
Target group: people discharged from hospital after a suicide attempt or serious self-harm. |
|--------------------------|----------------------------------------------------------------------------------|
|                          | 5.2 Establish dedicated referral pathways for people discharged from hospital after a suicide attempt or serious self-harm who can benefit from short term psychological intervention  
Target group: people discharged from hospital after a suicide attempt or serious self-harm. |
| Consultation             | 5.1 Establish regional assertive aftercare protocols to ensure linkage to primary health care where appropriate  
Key stakeholder consultations will continue from the 2016-17 and will include GPs, LHD, consumers and carers and community managed organisations. Consultation will be through the Regional Suicide Prevention Working Group, Mental Health Advisory Committee, and Mental Health Consumer & Carer Advisory Committee. They contribute to the co-design about the proposed activity to support assertive aftercare on discharge from hospital.  
5.2 Establish dedicated referral pathways for people discharged from hospital after a suicide attempt or serious self-harm who can benefit from short term psychological intervention |
### Collaboration

Consultation about the modification of the existing SOS suicide prevention service will occur with the LHD, GPs, AHP workforce currently providing this service and consumers/carers.

#### 5.1 Establish regional assertive aftercare protocols to ensure linkage to primary health care where appropriate

Close collaboration with the LHD mental health unit and LHD ACCESS team and the newly established LHD Mental Health Triage and Assessment Centre is essential to identify and provide access to people discharged from hospital after a suicide attempt or serious self-harm. Clear and concise protocols will need to be established in partnership with the LHD to address clinical governance issues and to ensure each party is clear on their role and responsibilities.

GPs will play a pivotal role in the successful implementation of this activity. Collaboration and consultation will be ongoing to ensure that the commissioned service has access to current GP details including which GPs/GP practices are prepared to take on new clients.

It is anticipated service delivery will occur through the commissioning of a community sector organisation with an established peer workforce and/or experience with peer work and the ability to expand capacity as this will be instrumental to the successful roll out of this activity.

#### 5.2 Establish dedicated referral pathways for people discharged from hospital after a suicide attempt or serious self-harm who can benefit from short term psychological intervention

Collaboration with the LHD acute mental health services and the ACCESS team and the newly established LHD Mental Health Triage and Assessment Centre will be ensure that the modified referral pathway will be available to the identified cohort for this activity and it is anticipated that they will initiate the referral process.

Collaboration will also occur with GPs who provide the link and follow up after discharge to primary care and form part of the treatment alliance between the consumer, AHPs and primary care; and with suitably trained AHPs able to undertake the short term psychological intervention with the consumer to address the suicide and/or serious self-harm risk.

### Duration

List the anticipated activity start and completion dates, and key milestones including planning, procurement, and commencement of service delivery.
| **Coverage** | 5.1 Establish regional assertive aftercare protocols to ensure linkage to primary health care where appropriate  
*Activity duration:* October 2017 to 30 June 2018 with expectation to continue to June 2019.  
5.2 Establish dedicated referral pathways for people discharged from hospital after a suicide attempt or serious self-harm who can benefit from short term psychological intervention  
*Activity Duration:* September 2017 to 30 June 2018 with expectation to continue to June 2019. |
| **Commissioning method (if relevant)** | 5.1 Establish regional assertive aftercare protocols to ensure linkage to primary health care where appropriate  
This activity will be fully commissioned.  
5.2 Establish dedicated referral pathways for people discharged from hospital after a suicide attempt or serious self-harm who can benefit from short term psychological intervention.  
This modified and expanded SOS suicide prevention service will form part of the overall commissioned SOS suicide prevention service listed under priority 3. It is likely that this activity will be partially commissioned as referral intake will be provided through the current PHN central mental health intake service. |
| **Performance Indicator** | Priority Area 5 - Mandatory performance indicator:  
- Number of people who are followed up by PHN-commissioned services following a recent suicide attempt. |
<table>
<thead>
<tr>
<th>Local Performance Indicator target (where possible)</th>
<th>A local performance indicator will be developed in 2017 as part of a comprehensive performance monitoring framework for the PHN.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area 6: Aboriginal and Torres Strait Islander mental health services</td>
<td><strong>Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)</strong></td>
</tr>
<tr>
<td>6.1 Increase connected holistic care for Aboriginal people with a dual diagnosis of mental health issues and alcohol &amp; other drugs</td>
<td></td>
</tr>
<tr>
<td>6.2 Build Aboriginal mental health and alcohol &amp; and other drugs literacy and workforce capacity for the delivery of culturally appropriate services</td>
<td></td>
</tr>
<tr>
<td>6.3 Provide culturally appropriate mental health and alcohol &amp; and other drugs early intervention programs to young Aboriginal people (with a particular focus on crystalline methamphetamine) to young Aboriginal people with or at risk of dual diagnosis</td>
<td></td>
</tr>
<tr>
<td>Existing, Modified, or New Activity</td>
<td>These activities have been commissioned during 2016-17 and will continue during 2017-18.</td>
</tr>
</tbody>
</table>
| Description of Activity | **6.1 Increase connected holistic care for Aboriginal people with dual diagnosis mental health and alcohol & other drugs**

**Aim:** Dual diagnosis for mental health and alcohol & other drug issues is an identified concern across the region with a clear lack of any services addressing this issue. The activity to be commissioned during the first half of 2017 (as part of the 2016-17 Activity Plan) will be an Aboriginal specific coordinated care service for the NBM region to address this service gap. In the first instance the coordinated care service will identify people with dual diagnosis while acknowledging that these people are often subject to other complexities (e.g. chronic physical illness, housing and employment issues as well as involvement with the criminal justice system). The service will coordinate tailored care according to the needs and complexity of each client through mainstream health, mental health and alcohol & other drugs services. |
Given the current lack of any Aboriginal Medical Service (AMS) in the region and the time it will take for the neighbouring Mt Druitt AMS to establish the newly mandated physical outreach AMS location in Penrith the care coordination service will be commissioned as an outreach service from an appropriate out of region Aboriginal controlled organisation.

**Needs Assessment Priority:** The needs assessment indicates that dual diagnosis is a heightened risk in the Aboriginal community as they report higher rates of very high psychological distress in comparison to the rest of the population which may increase the likelihood of risky drinking or illicit drug taking. This activity addresses the need for better care coordination for people with dual diagnosis.

**Expected Results:** The identification and diagnosis of Aboriginal people with a dual diagnosis of mental health and AOD issues. That those identified are able to connect into both mental health and AOD mainstream services where they will have previously been excluded and to be able to move seamlessly into the inpatient area and back to community as required.

### 6.2 Build Aboriginal mental health and alcohol & and other drugs literacy and workforce capacity for delivery of culturally appropriate services

**Aim:** The activity to be commissioned during the first half of 2017 (as part of the 2016-17 Activity Plan) will deliver mental health and AOD first aid workshops to increase the mental health and AOD literacy among the existing Aboriginal (health) workforce and in Aboriginal communities across the region. The broad access to these workshops will assist in reducing stigma, increasing understanding of the issues and potentially increase help seeking behaviour. The workshops will also assist in identifying potential Aboriginal peer workers, mentors and trainees suitable for work force scholarships. Culturally appropriately supported scholarships will enable people interested in accessing formal education and work placement opportunities. Scholarships will be made available for either jointly paid positions within a suitable local host organisation or TAFE courses to gain formal qualifications in mental health and AOD. TAFE students will also be supported through placements within the region. Connections forged and practical experience gained in these placements will increase the likelihood of future employment.

**Addressing priority:** Consultations with Aboriginal community members and Aboriginal health workers across the region identified an insufficient clinical and non-clinical Aboriginal workforce in the mental health and AOD fields. They also identified a general lack of mental health and AOD literacy in the community. The needs assessment indicates that Aboriginal people are less likely to access
psychological and psychiatric services in the community but have higher rates of hospitalisations for mental health issues than the general population.

**Expected results:** Increased mental health and AOD literacy among the existing Aboriginal (health) workforce and in Aboriginal communities across the region. Increased number of suitably trained Aboriginal workforce to provide culturally appropriate services and/or to act as cultural translators to support Aboriginal community members when accessing mainstream services in the region to build the capacity of Nepean Blue Mountains to deliver culturally safe services.

### 6.3 Provide culturally appropriate mental health and alcohol & and other drugs early intervention programs to young Aboriginal people with or at risk of dual diagnosis

**Aim:** The activity will provide early intervention for young people through ‘connection to culture’ programs which will also address the link between mental health, suicide risk and substance use. The activity will help build resilience and increase protective factors in young people and reduce the number of young people progressing to risky AOD behaviour and/or complex mental health issues and teach them how to connect to mainstream services for support.

**Addressing priority:** This activity aligns with the funding objective to provide culturally appropriate services to Aboriginal people. This activity also addresses the need to support at risk young Aboriginal people from progressing to poor mental health and risky drug and alcohol behaviour by connecting to their cultural heritage to increase protective factors.

**Expected results:** An increasing number of young Aboriginal people with identified low to moderate mental health issues and AOD issues (especially crystalline methamphetamine) understanding the link between mental illness and substance use and how to connect with mainstream services; a reduction on young Aboriginal people progressing to complex mental health issues and progressing to regular use, especially for ICE users; and increased understanding of and connection to cultural heritage as an on-going protective measure.

<table>
<thead>
<tr>
<th>Target population cohort</th>
<th>6.1 Increase connected holistic care for Aboriginal people with dual diagnosis mental health and alcohol &amp; other drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target group:</strong></td>
<td>Aboriginal people within the NBM region with dual diagnosis.</td>
</tr>
</tbody>
</table>
| Consultation | 6.2 Build Aboriginal mental health and alcohol & and other drugs literacy and workforce capacity for delivery of culturally appropriate services  
**Target group:** Aboriginal communities across the region for the first aid workshops and Aboriginal people 18 year+ with an interest working in the mental health and/or ADO field.  
6.3 Provide culturally appropriate mental health and alcohol & and other drugs early intervention programs to young Aboriginal people with or at risk of dual diagnosis  
**Target group:** Young Aboriginal people 12-25 years, particularly those at risk of mental illness and AOD issues. |
| --- | --- |
|  | Consultations undertaken in 2016 with Aboriginal community members and Aboriginal community and health workers in each of the region’s four LGA’s have highlighted the need for: workforce capacity building to enable Aboriginal people to work within mental health and AOD services; increase mental health and AOD literacy in the community; strengthen cultural connections in Aboriginal youth.  
In 2016 a joint NBM PHN and LHD Aboriginal Advisory Committee for mental health and drug & alcohol has been established to guide any mental health and AOD activities specific to the Aboriginal communities in the region. The committee of key stakeholders includes: Aboriginal community representatives from each LGA within the region, Aboriginal health workers (including mental health and AOD), LHD and PHN mental health and AOD representatives, GP representative. Currently, the committee meets monthly with the intention to eventually meet bi-monthly. |
| Collaboration | The NBMPHN mental health and AOD teams collaborate very closely for all three of these activities and they will be jointly funded under this mental health priority and under the NBMPHN Alcohol & other Drugs funding stream.  
Collaboration will continue with the joint Aboriginal Advisory Committee to co-design and guide the activities identified under this funding stream.  
6.1 Increase connected holistic care for Aboriginal people with dual diagnosis mental health and alcohol & other drugs  
In addition to the stakeholders of the joint Aboriginal Advisory committee this activity also involves collaboration with the Marrin Weejali Aboriginal Corporation – an AOD and social and emotional wellbeing specific service located in the neighbouring Western Sydney PHN. |
| **Duration** | **6.2 Build Aboriginal mental health and alcohol & and other drugs literacy and workforce capacity for delivery of culturally appropriate services**  
In addition to the stakeholders of the joint Aboriginal Advisory committee this activity will also involve TAFE and community and health organisations providing student placements.  
**6.3 Provide culturally appropriate mental health and alcohol & and other drugs early intervention programs to young Aboriginal people with or at risk of dual diagnosis**  
In addition to the stakeholders of the joint Aboriginal Advisory committee this activity will also involve Aboriginal organisations and organisations working with Aboriginal families within the region to help identify suitable program participants. |
| **Coverage** | All three activities will be delivered in each of the four LGAs of the region. |
| **Commissioning method (if relevant)** | Briefly outline the planned commissioning method, including whether the activity will be commissioned in whole or part. |
| Performance Indicator | Priority Area 6 - Mandatory performance indicator:  
|-----------------------|-------------------------------------------------|  
| 6.1 Increase connected holistic care for Aboriginal people with dual diagnosis mental health and alcohol & other drugs  
The activity will be fully commissioned. | • Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate. |  
| 6.2 Build Aboriginal mental health and alcohol & and other drugs literacy and workforce capacity for delivery of culturally appropriate services  
The activity will be fully commissioned. | |  
| 6.3 Provide culturally appropriate mental health and alcohol & and other drugs early intervention programs to young Aboriginal people with or at risk of dual diagnosis  
The activity will be fully commissioned. | |  
| Local Performance Indicator target (where possible) | A local performance indicator will be developed in 2017 as part of a comprehensive performance monitoring framework for the PHN. |  
| Priority Area 7: Stepped care approach | |  
| Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc) | 7.1 Create and implement a central clinical primary care mental health intake and triage service for all NBMPHN commissioned mental health services  
7.2 Review mental health and suicide prevention needs assessment  
7.3 Continue stakeholder engagement and collaboration as outlined in the identified activities (priorities 1-6) of the stepped care model |  
| Existing, Modified, or New Activity | 7.1 is new activity |  

7.1 Create and implement a central clinical primary care mental health intake and triage service for all NBMPHN commissioned mental health services

Aim: The current NBMPHN in-house mental health intake service may not meet the future needs of the stepped care model. A new central clinical intake and triage system for NBMPHN commissioned primary care mental health services will be designed, implemented and commissioned (if appropriate) during the funding period. This service will be pivotal to support the regional stepped care model. It will provide GPs and other eligible referrers with referral support to mental health services for their eligible patients which are best suited to their needs and level of mental health disorder, providing support for the level of care required from low intensity to care coordination for suicide risk. If appropriate, consumers will be actively referred to NBMPHN commissioned mental health services commensurate to their needs. If referred consumers are not eligible for such a service or NBMPHN commissioned services are not appropriate to the needs of the consumer, they will be supported in accessing other relevant services including psycho-social support or state based mental health services. The service will be underpinned by clearly defined referral, communication, data collection and clinical protocols and processes to support a consumer centred approach. Further, protocols and processes will be developed with the LHD to support better coordination of care when people transition from acute mental health care to primary care. Depending on the outcome of “1.1 Commissioning low intensity services” this intake may include some coaching and low intensity services also.

Needs assessment priority: The needs assessment has identified that mental health services in the region are impacted by fragmentation of service provision including between acute mental health and primary care and there is a lack of sufficient after care and/or continuity of service support when people are discharged from acute mental health facilities. The planned activity will support better coordination of care across the mental health spectrum including for people transitioning from acute to primary care.

Creating a regional stepped care model is a mandated for all PHNs. This activity forms a pivotal part of the stepped care model in the NBMPHN region.

Expected Outcome: An efficient, safe and effective clinical primary care mental health triage and referral service for consumers across the spectrum of mental health care.
### 7.2 Review mental health and suicide prevention needs assessment

**Aim:** The mental health and suicide prevention needs assessment is an iterative process and regular reviews help direct which particular areas may need updating or expanding to support the development of the regional stepped care model and the regional mental health plan, especially when a new central clinical primary care mental health triage is expected to be in place.

### 7.3 Continue stakeholder engagement and collaboration as outlined in the identified activities (priorities 1-6) of the stepped care model

**Aim:** Stakeholder engagement, consultation and collaboration are a vital part of the stepped care model. Engagement as outlined throughout this activity plan ensures that stakeholders are involved across all aspects of the NBMPHN mental health planning and implementation. During 2016-17 committees have been set up to support such engagement. They include the Mental Health Advisory Committee, the Joint NBM PHN/LHD Aboriginal Advisory Committee for Drug & Alcohol and Mental Health, the Mental Health Consumer/Carer Mental Health Advisory Committee (evolved from the PIR Consumer and Carer Regional Development Teams) and the Regional Suicide Prevention Working Group. These committees will meet regularly throughout the reporting period to support the mental health reform work. Further, the NBMPHN Clinical Council and GP Advisory Committee will continue to be consulted during the reporting period as appropriate. Stakeholder engagement will also continue with allied health providers, the wider GP community and any other stakeholder specific to a priority area.

The target population for activity 7.1 are the identified cohorts of priorities 1-6.

### 7.1 Create and implement a central mental health intake and triage service for NBMPHN commissioned mental health services

The Mental Health Advisory Committee, the Joint NBM PHN/LHD Aboriginal Advisory Committee for Drug & Alcohol and Mental Health, Consumer/Carer Advisory Committee and the Regional Suicide Prevention Working Group will be consulted on an ongoing basis through their regular meetings throughout the reporting period. In addition special consultation events for GPs and allied health providers across the region will be planned to ensure broad input for this activity. These events will be linked to consultation events for the re-design of the psychological therapy services (activity 3.1) and the re-design of care coordination and support for people with severe mental illness (activity 4.1).
addition the GP Advisory Committee and Clinical Council and the LHD will continue to be consulted about these activities.

| Collaboration | 7.1 Create and implement a central mental health intake and triage service for NBMPHN commissioned mental health services  
Collaboration will be required with the LHD, primary care providers (GP and Allied Health), peer workforce, and NGOs. |
|---|---|
| Duration | 7.1 Create and implement a central clinical primary care mental health intake and triage service for NBMPHN commissioned mental health services  
This activity will be carried out throughout the funding period. Stakeholder engagement, design and planning will occur from July to December 2017. Procurement will commence in early 2018 and contractual arrangements will be in place for service delivery to start from 1 July 2018.  
7.2 Review mental health and suicide prevention needs assessment  
The current mental health and suicide prevention needs assessment will be reviewed in conjunction with the development of the regional mental health plan during 2017-18. Further work may be undertaken, when the need arises, to refine identified areas to support the development of the regional mental health plan.  
7.3 Continue stakeholder engagement and collaboration as outlined in the identified activities (priorities 1-6) of the stepped care model  
Stakeholder engagements occur on a regular basis throughout the funding period through regular meetings of the various advisory committees identified in priorities 1-6 and through other planned meetings/events to assist in the development of the stepped care model. |
<p>| Coverage | The central clinical primary care mental health intake and triage service as described in activity 7.1 will cover the entire NBMPH region. |
| Commissioning method (if relevant) | Once decisions have been made in consultation with stakeholders about the model and implementation of activity 7.1 they will inform the commissioning approach for this activity. |
| Performance Indicator | • Proportion of PHN flexible mental health funding allocated to low intensity services, psychological therapies and for clinical care coordination for those with severe and complex mental illness. |</p>
<table>
<thead>
<tr>
<th>Priority Area 8: Regional mental health and suicide prevention plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)</strong></td>
</tr>
<tr>
<td><strong>Existing, Modified, or New Activity</strong></td>
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</tbody>
</table>
| **Description of Activity**                                   | **8.1 Develop and agree on a regional mental health and suicide prevention plan**  
* **Aim:** NBMPHN will continue to develop a longer term regional mental health and suicide prevention plan in consultation and collaboration with stakeholders including with the LHD to create jointly agreed priorities. This activity has been started during 2016-17. The plan will reflect regionally agreed strategic aims to work towards fulfilling the vision of joined up consumer centred mental health care in the region. Further guidance is expected from the Department of Health which will assist in shaping the regional plan.  

**Target population cohort** | The target population are people across the region with mental health issues spanning the whole spectrum from emerging to severe and persistent mental illness. |
<p>| <strong>Consultation</strong>                                               | Consultations will continue with the LHD, NGOs, Local Councils and various NBMPHN committees set up to support the PHN overall (Clinical Council, GP Advisory Committee) and those specifically set up to meet regularly to progress the mental health reform work (Mental Health Advisory Committee, Joint NBM PHN/LHD Aboriginal Advisory Committee for Drug &amp; Alcohol and Mental Health, Consumer/Carer Advisory Committee and Regional Suicide Prevention Working Group). Stakeholder engagement undertaken for priorities 1-6 will also be taken into consideration and during the first half of 2017 a stakeholder engagement plan will be created to ensure the expertise of relevant community managed |</p>
<table>
<thead>
<tr>
<th>Collaboration</th>
<th>organisations, other state departments such as Department of Family and Community Services or Corrective Services (in addition to Health through the LHD) are consulted as appropriate. It is likely NBMPHN will host a series of regional mental health workshops to focus specifically on plan development.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>Please see entry above (Consultation).</td>
</tr>
<tr>
<td>Coverage</td>
<td>Current to 31 March 2018.</td>
</tr>
<tr>
<td></td>
<td>The proposed plan will address issues across the whole NBMPHN region.</td>
</tr>
<tr>
<td>Commissioning method (if relevant)</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
| Performance Indicator | Priority Area 8 - Mandatory performance indicators:  
  - Evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery. |
## 1. (b) Planned activities funded under the Primary Mental Health Care Schedule – Template 2

Use this template table for Priority Areas 3 and 4

<table>
<thead>
<tr>
<th>Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area 3: Psychological therapies for rural and remote, under-serviced and / or hard to reach groups</td>
</tr>
<tr>
<td>Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)</td>
</tr>
<tr>
<td>Existing, Modified, or New Activity</td>
</tr>
<tr>
<td>Description of Activity</td>
</tr>
<tr>
<td>3.1 Roll out of modified model for delivery of psychological therapy services</td>
</tr>
<tr>
<td>3.2 Psychological therapy for those unable to access alternative referral pathways (low income)</td>
</tr>
<tr>
<td>3.3 Psychological therapy services for children</td>
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<tr>
<td>3.4 Psychological therapy services for women with perinatal mental health issues</td>
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<tr>
<td>3.5 Psychological therapy for people at risk of suicide</td>
</tr>
<tr>
<td>3.6 Mainstream psychological therapy for Aboriginal people</td>
</tr>
</tbody>
</table>

These activities will be modified during the funding period.

---

3.1 Roll out of modified model for delivery of psychological therapy services

Current services delivered under this priority provide crucial referral pathways for GPs to enable their patients with mild to moderate and in some instances severe mental illness to access evidence based short term psychological therapies. Initially current activities will carry over from 2016-17 to ensure continuity of these established and well utilised referral pathways while processes are put in place for the transition to the new model. All referrals continue to be made through a central intake point at the NBMPHN. Services are provided by individually commissioned psychologists, clinical psychologists, mental health social workers or mental health nurses who work in conjunction with the referring GP (and forming part of the GP mental health treatment plan) to provide evidence based psychological therapies.
**Needs assessment priority:** The current and proposed modified model continue to address regional service gaps in the provision of psychological therapies for under-serviced hard to reach groups. Services provided under this priority area form a crucial part of the suite of services provided under the stepped care model.

**Expected results:** more hard to reach people with diagnosed mental illness will be able to access psychological services. The service provision will not duplicate current Medicare services, more high risk and people with mild mental illness will be able to access low intensity services.

3.2 **Psychological therapy for those unable to access alternative referral pathways (low income)**

**Aim:** This service is currently available through established GP referral pathways for people who are unable to access alternative referral pathways due to financial constraints. The service is aimed at people with a diagnosed mild to moderate mental illness who can benefit from short term psychological intervention. In most instances referrals will be for high prevalence disorders such as depression and/or anxiety.

This activity will be reviewed as part of remodelling the access to psychological services for hard to reach/underserviced groups.

**Needs assessment priority:** This current activity continues to address regional service gaps in the provision of psychological therapies for under-serviced hard to reach groups.

**Expected results:** Continuity of existing referral pathways until new service model is rolled out.

3.3 **Psychological therapy services for children**

**Aim:** This established referral pathway enables GPs and paediatricians to refer children at risk of or with an emerging/diagnosed mental illness who can benefit from short term psychological interventions of up to 12 sessions of evidence based psychological therapy in a calendar year. Parents/primary carers are involved in the therapy process to maximise the benefit to the children.

In addition to individual therapies, this service also offers the evidence based group program ‘Cool Kids’ for primary school children aged 8-11 years with anxiety issues as a low intensity service (see priority 1 activity 1.2). **Needs assessment priority:** This current activity continues to address regional service gaps in the provision of psychological therapies for under-serviced hard to reach groups.

**Expected results:** Continuity of existing referral pathways to provide psychological therapy services

3.4 **Psychological therapy services for women with perinatal mental health issues**
Aim: This referral pathway enables GPs to refer women with perinatal depression and related issues, and who can benefit from short term intervention, for up to 12 sessions of evidence based psychological therapy in a calendar year.

Needs assessment priority: This current activity continues to address regional service gaps in the provision of psychological therapies for under-serviced hard to reach groups.

Expected results: Continuity of existing referral pathways until new service model is rolled out.

3.5 Psychological therapy for people at risk of suicide

Aim: This service offers quick response, short term psychological intervention for people who have self-harmed, attempted suicide or have mild to moderate suicidal ideation and are managed within a primary health care setting. People do not need a diagnosed mental illness to be eligible for this service. The service is aimed at people who can benefit from evidence based short term psychological interventions. People receive their first therapy session within three days of the referral date and can be seen for an unlimited number of sessions within a defined two month period. While this is clearly not a crisis service and service providers are not expected to work outside their normal business hours, the increased risk of this client group is addressed through after hours telephone support. This support is available to all enrolled consumers through the national ATAPS Suicide Prevention Support Line and ensures that clients are linked into dedicated support 24 hours a day.

Needs assessment priority: This current activity continues to address regional service gaps in the provision of psychological therapies for under-serviced hard to reach groups.

Expected results: Continuity of existing referral pathways until new service model is rolled out.

3.6 Mainstream psychological therapy for Aboriginal people

Aim: This mainstream service is suitable for Aboriginal people with a mild to moderate mental illness, in particular depression and anxiety. Aboriginal people can be referred by their GP or AMS for evidence based short term psychological strategies for up to 12 sessions of psychological therapy in a calendar year. The service providers have undertaken Aboriginal cultural competency training to support Aboriginal clients appropriately in their recovery journey. Needs assessment priority: This current activity continues to address regional service gaps in the provision of psychological therapies for under-serviced hard to reach groups.

Expected results: Continuity of existing referral pathways until new service model is rolled out.
### Target population cohort

<table>
<thead>
<tr>
<th></th>
<th>3.1</th>
<th>Role out of modified model for delivery of psychological therapy services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Target population:</strong> As part of the model redesign current target populations will be reviewed. Services will be specifically targeted at hard to reach/underserviced groups which will include at a minimum people at risk of suicide, women with perinatal mental health issues; Aboriginal people and children with the intention to add further cohorts as identified in the needs assessment and prioritised during the service re-design.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>3.2</th>
<th>Psychological therapy for those unable to access alternative referral pathways (low income)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Target population:</strong> people aged 12+ with a diagnosed mild to moderate mental illness, living in the community, who can benefit from individual short term psychological therapies.</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>3.3</th>
<th>Psychological therapy services for children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Target population:</strong> children aged 0-12 years at risk of or with emerging mental illness whose parents/carers are on a government low income health care card.</td>
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<table>
<thead>
<tr>
<th></th>
<th>3.4</th>
<th>Psychological therapy services for women with perinatal mental health issues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Target population:</strong> women with perinatal depression and related issues – the perinatal period is defined as: during pregnancy to child up to 12 months of age.</td>
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<thead>
<tr>
<th></th>
<th>3.5</th>
<th>Psychological therapy for people at risk of suicide</th>
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<tbody>
<tr>
<td></td>
<td><strong>Target population:</strong> people aged 14 years+ who have self-harmed, attempted suicide or with mild to moderate suicidal ideation.</td>
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<tr>
<th></th>
<th>3.6</th>
<th>Mainstream psychological therapy for Aboriginal people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Target population:</strong> Aboriginal people</td>
<td></td>
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</tbody>
</table>

### Consultation

|   | Initial consultations with key stakeholders (GPs, allied mental health providers, consumers) have occurred as part of the needs assessment. Consultation for the redesign and modification of the existing psychological therapy services will be undertaken with all key stakeholders (including new ones for CALD, LGBTI, post-prison services) generally and through the following: dedicated consultation meetings with GPs and allied mental health providers; NBMPHN GP Advisory Committee; NBMPHN Clinical Council; NBMPHN Mental Health Advisory Committee (which included the NBMLHD); NBMPHN Consumer/Carer Advisory Committee. |
Collaboration will be required with the LHD, primary care providers (GP and Allied Health), peer workforce, and NGOs. NBMHPN will also collaborate closely with the Mental Health Advisory Committee (which includes representation from GPs, AHPs, Psychiatry, LHD, Consumers/Carers, and community managed organisations) and the Carer/Consumer Advisory Committee to co-design the modification to the existing model.

<table>
<thead>
<tr>
<th>Collaboration</th>
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**3.1 Role out of modified model for delivery of psychological therapy services**

The staged role out of the re-designed model will have a transition period commencing 1 January 2018. Full transition will be completed by 30 June 2018 and the model will be in full operation from 1 July 2018.

**3.2 – 3.6** These services will be provided throughout the funding period from 1 July 2017 to 30 June 2018. However, modification of the referral pathways and service delivery particularly for 3.2 will commence during the transition period.

All activities for this priority are delivered across the whole PHN region.

The deliberate staged approach to the implementation of the re-designed model which includes a six months transition period will ensure that continuity of care is safeguarded and risk of stakeholder disengagement is kept at a minimum.

Current commissioned individual service providers will be offered an extension of their existing contract into the 2017 – 2018 period. If there is a need for new providers prior to the implementation of the new model they will be commissioned through current contract processes.

The model re-design will ultimately determine the best commissioning approach to be used going forward but consultation with stakeholders to date favour the continuation of commissioning individual and group practice providers across the region to ensure access to a wide range of skills and expertise and a sufficient workforce able to meet the demand for services.

Priority Area 3 - mandatory performance indicators:

- Proportion of regional population receiving PHN-commissioned mental health services – Psychological therapies delivered by mental health professionals.
### Local Performance Indicator target (where possible)

- Average cost per PHN-commissioned mental health service – Psychological therapies delivered by mental health professionals.
- Clinical outcomes for people receiving PHN-commissioned Psychological therapies delivered by mental health professionals.

A local performance indicator will be developed in 2017 as part of a comprehensive performance monitoring framework for the PHN.

### Proposed Activities

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<th>Priority Area 4: Mental health services for people with severe and complex mental illness including care packages</th>
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<td><strong>Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)</strong></td>
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<td>Activity 4.1: Role out of modified model to support people with severe mental illness through clinical care coordination and support</td>
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<td>4.2: Credentialed mental health nurse program</td>
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<td>4.3: Build capacity in practice nurses to support GPs in systematically addressing physical health needs of patients with severe mental illness</td>
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<tr>
<th>Existing, Modified, or New Activity</th>
<th>4.1 and 4.2 are modified activities</th>
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<td>4.3 is a new activity</td>
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</table>
4.1 Roll out of modified model to support people with severe mental illness through clinical care coordination and support

**Aim:** During 2017-18 the current mental health nurse incentive program will be re-designed and a staged roll-out will ensure an orderly transition to the re-designed model. The re-design will include clinical care coordination for people with severe mental illness managed in primary care. The re-designed model will be fully implemented by 1 July 2018. The new model will take into account the re-design of the psychological therapy services (see priority 3) and the central intake model (see priority 7). It will also apply learning from the PHN lead sites with particular attention to clinical care packages for this cohort. The service re-design will also take into account the regional mental health plan and how it relates to the issues of aftercare.

**Needs assessment priority:** The current and proposed modified model continue to address regional gaps in the provision of clinical care services for people with severe mental illness managed in primary care. The modified service will form an important part of the stepped care model.

**Expected Result:** A new nurse led service for the management and support of severe and complex patients in a community setting.

4.2 Credentialed mental health nurse program

**Aim:** The current mental health nurse program will continue during 2017-18 to ensure continuity of service for existing clients. This program offers people with severe and complex mental illness whose disorder has a significant impact on their life a referral pathway through their GP or private psychiatrist to mental health nursing services. Credentialed mental health nurses support clients through individualised and tailored clinical nursing services which include medication management and regular reviewing of mental states as well as providing ongoing therapeutic support and supporting physical health in close consultation with carers and family where appropriate. All referrals are made to a central intake point at the NBMPHN.

In addition the current mental health nurse program for women with severe perinatal mental health issues will continue through the St John of God Raphael Centre outreach service in Windsor.

**Needs assessment priority:** This activity ensures continuity of service during the re-design phase as outlined above.

**Expected Result:** Smooth transition of clients to a newly designed service.
### 4.3 Build capacity in practice nurses to support GPs in systematically addressing physical health needs of patients with severe mental illness

**Aim:** This activity will increase capacity in practice nurses to monitor the physical care needs of people with severe mental illness who are managed within primary care. Coherently and consistently addressing the physical health needs of this cohort will assist in the management of mental health issues. Practice nurses are well placed to support GPs in regularly monitoring the physical health needs of these patients if they are appropriately supported through education and training.

**Needs assessment priority:** Physical health needs of people with severe mental illness has been nationally identified as a gap in service provision.

**Expected Result:** The general health needs of patients with severe and complex mental health issues are monitored and met. An increase in patients from inpatient services accessing primary health care.

<table>
<thead>
<tr>
<th>Target population cohort</th>
<th>The target population for the proposed activities are adults with severe mental illness who are managed in the community through primary care. The re-design of the clinical care coordination and support may further identify specific sub-cohorts to be supported.</th>
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<tbody>
<tr>
<td><strong>Consultation</strong></td>
<td>Stakeholder consultations have occurred with currently contracted mental health nurses. Consultations with the GP Advisory Committee, Mental Health Advisory Committee and the Consumer Carer Advisory Committee, mental health nurses and practice nurses, LHD, St John of God Raphael Centre, Australian College of Mental Health Nurses and the Australian Practice Nurse Association will be undertaken to assist the re-design of the model.</td>
</tr>
<tr>
<td><strong>Collaboration</strong></td>
<td>NBMPHN will collaborate with the LHD, GPs, mental health nurses, consumers/carers to assist in the co-design of the proposed activities. Further it will collaborate with a select group of general practices which signed up to the healthcare home project, including practice nurses and the Australian College of Mental Health Nurses in the co-design of activity 4.3. NBMPHN will also be collaborating with the Western Sydney PHN and the St John of God Raphael Centre, Blacktown to ensure that existing clients of the Raphael Centre and living within the NBM region who have received services through commissioning arrangements of WSPHN during 2016-17</td>
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</table>
transition seamlessly under the new commissioning arrangement with NBMPHN from 1 July 2017 onwards.

| Duration | 4.1 Roll out of modified model to support people with severe mental illness through clinical care coordination and support  
The procurement phase is anticipated to take place between June and October 2017 with a staged roll out of service delivery to commence in early 2018.  
4.2 Credentialed mental health nurse program  
This activity is a continuation of the existing commissioned service and service delivery will occur from 1 July 2017 to 30 June 2018 with a transition to the new service.  
4.3 Build capacity in practice nurses to support GPs in systematically addressing physical health needs of patients with severe mental illness  
Planning for this activity will occur from July to September 2017, followed by the procurement period from September 2017 to January 2018 and commencement of service delivery planned for February 2018. |
| Coverage | 4.1 Roll out of modified model to support people with severe mental illness through clinical care coordination and support  
This activity will cover the entire PHN region  
4.2 Credentialed mental health nurse program  
This activity is provided in each of the LGAs across the region.  
4.3 Build capacity in practice nurses to support GPs in systematically addressing physical health needs of patients with severe mental illness  
This activity is initially limited to practice nurses from general practices participating in the healthcare home project with the expectation that it will be expanded to all interested practices across the region. |
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<tr>
<th>Continuity of care</th>
<th>Continuity of care to existing clients is assured through the continuation of the current mental health nurse program and through a staged 6 month transition period to the re-designed model. This transition period aligns with priority 3 and the roll out of the expanded central intake and triage system.</th>
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| Commissioning method (if relevant) | **4.1 Roll out of modified model to support people with severe mental illness through clinical care coordination and support**  
This activity will be fully commissioned.  

**4.2 Credentialed mental health nurse program**  
This activity will commission the current mental health nurse workforce through individual contract extensions of existing arrangements. If new nurses are recruited to the program they will also be contracted under existing arrangements until the re-designed model is rolled out.  

**4.3 Build capacity in practice nurses to support GPs in systematically addressing physical health needs of patients with severe mental illness**  
This activity will be fully commissioned. |
| Performance Indicator | Priority Area 4 - mandatory performance indicators:  
- Proportion of regional population receiving PHN-commissioned mental health services – Clinical care coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses).  
- Average cost per PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness. |