LIVING WELL

A STRATEGIC PLAN FOR MENTAL HEALTH IN NSW 2014 – 2024

Mental Health Commission of New South Wales

This Plan is available on our website:
www.nswmentalhealthcommission.com.au

ISBN 978-0-9923065-4-0

This Plan may be cited as:
NSW Mental Health Commission (2014). Living Well: A Strategic Plan for Mental Health in NSW. Sydney, NSW Mental Health Commission.

Cover image by Rosemary Dugan:
Atmosphere – faces (acrylic on canvas)

Rosemary has a degree in fine arts and lives with mental illness. She attends weekly art classes at Gladesville Hospital run by CREATE/MARS Inc – a multidisciplinary rehabilitation program of the Northern Sydney Local Health District. The NSW Mental Health Commission purchased this artwork and reached an agreement with the artist to use her artwork on the cover of this Plan and online.

ACKNOWLEDGEMENTS

In presenting this Strategic Plan the NSW Mental Health Commission expresses its deep and continuing thanks to all the individuals, groups and organisations who shared with us their ideas, hopes and stories of personal and professional experiences.

In particular, we acknowledge the lived experience of those with mental illness. To you we say: your preferences, wishes, needs and aspirations are at the heart of all the work we do, your perspective is essential to defining and achieving our goals and your courage continues to inspire and drive the work of the Commission.

We acknowledge the families and carers of all people with a lived experience of mental illness. We recognise your commitment and the vital contribution of your role in supporting people who experience mental illness to live well on the terms they choose. Your knowledge and experience of mental health systems and services are among our most important sources of information and help guide our understanding of the change that needs to come.

We also acknowledge the dedication and continued effort, in spite of the hurdles they may encounter, of those working within the mental health system who strive for the change needed to make better lives for those with mental illness.

And we acknowledge and express our respect to the Wallumedegal people of the Eora Nation, the traditional owners of the land on which the offices of the NSW Mental Health Commission stand. We pay tribute to the resilience of Aboriginal and Torres Strait Islander people, and their enduring cultures, who continue to recognise the importance of social and emotional wellbeing.

We thank all the NSW Government agencies that contributed to the development of this Plan. Specifically, we acknowledge NSW Health, the Department of Family and Community Services, the Department of Education and Communities and the Department of Justice.

In writing this Plan we have aimed to honour the community of diverse voices and minds, all working towards positive change.

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1. PLANNING FOR OUR FUTURE

1.1 A letter from the Commissioner

For most of us, most of the time, our lives centre on our own activities, thoughts and feelings, and on our interactions with parents, partners and children, friends and neighbours, employers and colleagues, and those who share our interests.

Our work, community and family lives are full of richness and texture, and they support and sustain us, just as the people in our lives draw reciprocally on our strength and experience.

This is as true for those of us who live with mental illness.

This Plan sets out directions for reform of the mental health system in NSW over the next 10 years. These directions build on those extraordinary strengths we find in individuals, families and communities and hope to supplement them, when requested, with services which respect people and offer them support in ways they find helpful and that fit well with their lives.

It maps a demanding agenda for change that puts people – not processes – at the heart of its thinking.

It insists on principles of social equity: that at any stage of life, whatever our culture, wherever we live and no matter what other health or social difficulties may complicate our lives, we are equal citizens who should expect to find high quality, timely mental health support in our community when we need it.

It demands that we not wait for a crisis. Plenty of strong evidence tells us it is possible to promote good mental health in our community and prevent much mental illness, particularly in young people. And if the signs of distress are already apparent, the course of illness can be improved if we get in early to offer support before people's lives are badly affected.

It asks that the NSW Government recommit to completing the process of reform begun with the Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (Richmond Report) in the 1980s by taking two important steps. We must close the remaining stand-alone psychiatric institutions and shift the focus of mental health care from hospitals to the community.

The broad case for reform, told from the perspective of people whom it affects, is presented in the NSW Mental Health Commission's *Living Well: Putting People at the Centre of Mental Health Reform in NSW: A report,* which is a companion report to this Plan, *Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024* and should be read in tandem with it.

Aboriginal ideas of community, family and social and emotional wellbeing resonate powerfully as we prepare for a new generation of mental health reform. Aboriginal communities celebrate the connections among people and the strength and resilience that grow in communities when those connections are

properly honoured. These ideas have been a touch point throughout the development of this Plan and underpin many of its directions even when this is not described explicitly.

Many positive changes are already under way. In NSW, government agencies and community organisations are enthusiastically embracing new approaches that acknowledge that people who experience mental illness can and should expect to live well on their own terms, in their own homes, and be empowered to make their own choices.

But we must recognise that there is strenuous work ahead to reorient a system that has emphasised hospital beds for too long at the expense of other forms of support offered in or close to people's homes. Our supports are still, in many places, inflexible, ineffective, outdated and under-resourced, and often do not join up well when people's needs are complex and continuing. The situation is made all the more complex by the lack of clarity about state and Commonwealth responsibility for funding and service quality.

Across Australia it is recognised that for many years governments have underinvested in mental health, particularly in community mental health. The scale of this is reflected in the fact that 14 per cent of the impact of all illness can be attributed to mental illness but mental health expenditure accounts for only 8 per cent of the NSW Health budget. While this is a crude measure, it accords with other estimates of the service gaps and underspending on mental health services.

We can see with hindsight that this underspending on community activity was in part because the hospitals were and remain such a powerful centre of gravity. They have been and continue to be in NSW and Australia more broadly the main locus of funding and the centre of professional careers. And because they are more expensive than community support, they have sucked funds out of other programs in a self-perpetuating loop.

This experience tells us we will need to drive change much harder if we are to make it stick. But in the present economic climate we know there is no promise of significant additional investment in mental health in the short term. In fact the Plan comes at a time when Commonwealth and state governments are looking for substantial savings to cope with forecast exponential growth in costs associated with demand for other hospital services and the needs of our ageing population. So we will need to do things differently: more efficiently and more innovatively.

The good news is that if we can improve mental health and wellbeing we can boost productivity and greatly reduce the high service and transaction cost to government and the human cost to our society of failing to prevent mental illness and failing to keep people well in the community. And there is much that we can and must do.

In NSW Health, we will need to put our money where our mouths are – committing growth funding to community mental health and ensuring that funding intended for community mental health demonstrably gets there.

Across government services, a shift of focus is required, from crisis-driven responses towards prevention and early intervention. The lifetime costs for the individual, community and government of not responding appropriately to issues as they emerge are well documented. We must recognise that mental health is inextricable from the patterns of our lives. Our psychological wellbeing is a continuous thread that runs though our education, work, social relationships and communities.

Consequently, action will require co-ordination and co-operation across those services that contribute to the mental health and wellbeing of children and young people and their families.

This is a strategic plan for mental health in NSW. It does not directly govern the operation of services but instead lays out directions and principles for reform which agencies and service providers must find ways to embed in the supports they offer to people in our community.

As an overarching Plan, with a strong vision at its centre, this document cannot and does not replace the need for continuous planning and improvement at local and statewide levels. Excellent work is already in progress in many areas that are contained within or directly affect the mental health sector in NSW. The Plan does not replace that work; rather it gives context to, and sets person-centred directions within which to pursue such projects.

The Plan also cannot fully anticipate major changes to the environment in which these reforms will roll out. The National Disability Insurance Scheme, which will expand support choices for people with disabling mental illness, and activity-based funding, which will change how health funding flows from the Commonwealth to NSW, are two important examples of national initiatives with the potential to change significantly the lives and experiences of people in NSW.

This Plan sets a 10-year vision and describes the initial set of actions required to lay the groundwork for change within the mental health sector and our approach to mental health and wellbeing. It also provides a solid basis for a continuing engagement with service providers across a full spectrum of government and community activities, and the community itself.

The Plan will need to be revisited in the next two to three years to refocus activity on the next priorities. But now is the time to act on what we know. It is first a matter of basic fairness, but there will also be a dividend for the whole community when we achieve it.

John Feneley

NSW Mental Health Commissioner

October 2014

1.2 A message to people who experience moderate to severe mental illness

This Plan aims to improve the mental health and wellbeing of our community but it is particularly concerned with ensuring that those of us with moderate to severe mental illness are supported to remain well in our communities and to lead in our own recovery.

As a group we have borne the brunt of serious discrimination, often being marginalised and treated as second-class citizens. This discrimination has caused real damage to many people.

We have at times been deemed difficult because of our mental illness, have not been believed, or we have been shunned in the streets and we have lived with the knowledge that sometimes others are uncomfortable around us.

Our experiences of the mental health system and government services vary. While some of us speak of being helped and respected, many others speak of being further traumatised by services and treatments and of suffering terribly from unwanted effects of medication.

Some of us identify as consumers but no matter how we identify our experiences, we are all entitled to live with hope and to experience recovery that leads to meaningful and contributing lives in our communities and workplaces, where we are accepted, valued, appreciated – and where we not only survive but thrive.

We know that mental health care is, and will remain, a person-to-person endeavour. It is no longer acceptable for an individual experiencing an episode of serious illness to be the *subject* of care – 'care' that fails to respect the autonomy and dignity of the individual is not care at all. We need caring relationships both non-clinical and clinical where we feel respected.

Our care relationships must celebrate and work to our strengths, not our 'deficits', and should be prepared to support us to take the important risks necessary for recovery. These relationships support a recovery embedded in hope and choice.

Our experience demonstrates that there are common threads in preventing mental illness, recovering and maintaining wellbeing. These include a sense of purpose and valuable relationships, which are an antidote to isolation and loneliness.

We hope that all people with a lived experience of mental illness will be surrounded by carers, families (of origin or choice), their friends, pets and, in ever-increasing circles, service providers and agencies, workplaces and colleagues and community. But many people do not have families and carers to support them. They need extra support during the really hard times and as they recover.

Those of us who live with moderate to severe mental illness can then be assured that our interests are at the heart of this Plan and are the lens through which success will be measured.

1.3 The mental health environment in NSW

What we commonly refer to as the mental health system is an amalgam of state and Commonwealth government agencies and funding streams, along with community-managed organisations and private enterprise performing a variety of health service-related, community support, research and advocacy roles. The term 'system' could imply the presence of an overarching plan or design. The reality is that this 'system' has grown over time and is in part a rich tapestry of effort, commitment and innovation and partly a range of responses developed in an unco-ordinated way to meet immediate needs. This approach has produced a 'system' that achieves much for consumers but lacks integration, is difficult to navigate and is often inefficient.

State services & programs

Commonwealth services & programs

Private sector, research & charities (which may receive Commonwealth or state funding)

1.4 The values

The reforms described in this Plan are guided by a set of core values. These apply at all stages of life, across all cultures and for all communities in NSW.

Respect

Acknowledging the equal value of every human life should underpin everything we do to support and promote mental health and wellbeing. In particular we must ensure that government, community-managed and private services always assure the autonomy, dignity and individuality of people who experience mental illness.

Recovery

Those of us who live with mental illness have the right to expect to lead fulfilling lives, and to pursue our own choices about how we live and about the support we accept, regardless of whether we are experiencing symptoms. This should also be so for our families and carers.

Community

Strong connections among people are the foundation of mental health and wellbeing and resilience for individuals, families and our wider society. These connections nurture social inclusion and respect for diversity and are particularly important for people who experience mental illness and for their families and carers.

Quality

In partnership with people who live with mental illness, mental health professionals, service planners and policymakers must ensure that supports and services meet contemporary standards and are effective.

Equity

People who live with mental illness should expect to be supported equally in their recovery, regardless of their age, gender, culture, sexual or gender identity, where they live or any other health problems they have.

Citizenship

Responsibility for individual and community mental health and wellbeing is shared across our society. All of us, whether or not we experience mental illness, should expect to contribute to that shared mental health and wellbeing, and to be able get support when we need it.

Hope

We should create an environment where people whose lives are affected by mental illness can experience the benefits of positive change and be optimistic for a better future.

1.5 Key terms

Throughout the Plan, some key terms are used to describe how services, policies and legislation should be developed and implemented for people with a lived experience of mental illness and to improve the mental health and wellbeing of the people of NSW.

Resilience

Resilience describes the capacity to cope, adapt and grow in the face of stress or adversity. It recognises that stress and situations of deep sorrow and grief cannot be avoided and are a natural part of human experience. A resilience approach encourages individuals, families and communities to build capacity to care for their own, and one another's, mental health and wellbeing.

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 principles of trauma-informed care are safety, trustworthiness, choice, collaboration and empowerment, in parallel with the core tenets of a recovery-informed approach.[1] It requires services to ensure staff have a basic understanding of how trauma affects the life of a person and accommodate the particular 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.

Consumers

The term consumer is used interchangeably with terms such as 'person with a lived experience of mental illness' and 'person who experiences mental illness'. The term consumer is used by those in Australia who have advocated for the human rights and citizenship of people who live with mental illness, and is therefore strongly associated with this movement. The word consumer also powerfully endorses the principles of choice and autonomy for people with mental health issues, who are active participants in their own care and support.

Mental illness

This Plan considers many dimensions of human social and psychological experience, including relatively common and distressing disorders such as depression and anxiety. However many of the Plan's references to mental illness relate to conditions that are often the most severe, persistent and disabling – including schizophrenia and bipolar disorder. Cognitive disorders, such as Alzheimer's disease and other dementias, and developmental disabilities, such as attention deficit hyperactivity disorder (ADHD) or autism spectrum disorders, are generally not within the scope of the Plan except where they are also linked to a higher risk of psychological distress or mental illness.

1.6 Community at the heart of reform

The indicators and actions contained in the Plan are the outcomes of more than a year of intensive consultation by the NSW Mental Health Commission with the NSW community and government agencies.

In an innovative co-design approach, more than 2100 people came together either online or in person to develop ideas and comment on working papers. The Plan's development – one of the most inclusive policy projects undertaken in mental health – placed consumers and carers alongside professionals in an extensive collaboration themed around 'journeys', or typical mental health experiences at different stages of the life course. Further explanation of the methodology and results can be found in the Report, and the original working papers published online by the NSW Mental Health Commission.

This process was supplemented by in-depth consultation with groups in the community that have particular mental health concerns and needs. They included:

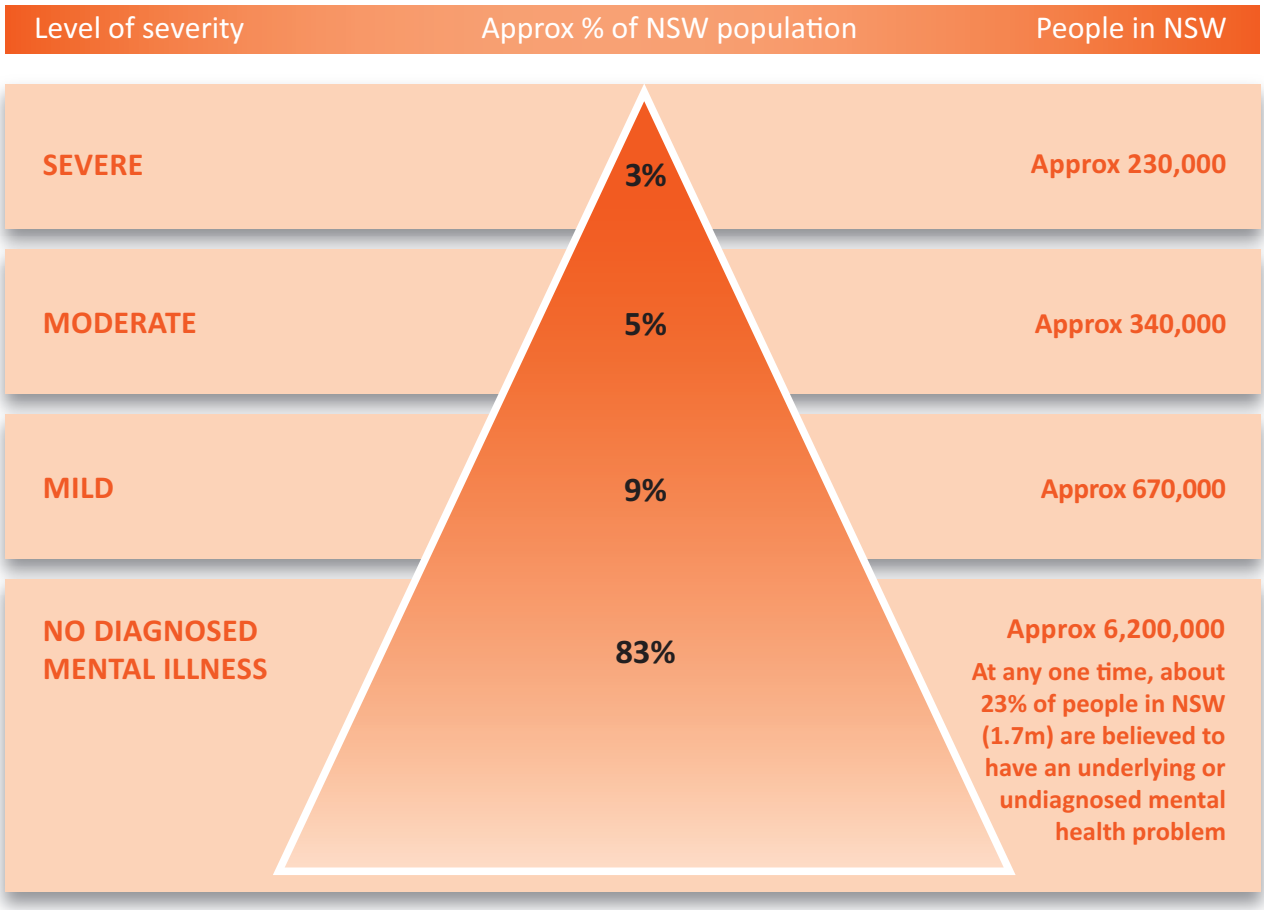
- a series of meetings with Aboriginal communities to discuss approaches to supporting social and emotional wellbeing
- visits to country towns where social disadvantage combines with lower access to mental health services
- forum-style meetings with culturally and linguistically diverse communities
- consultation with lesbian, gay, bisexual, transgender and intersex communities
- specialist discussions with consumer and professional groups about drugs and alcohol and the justice system
- written submissions and commissioned expert perspectives on a wide variety of issues related to mental health.

These consultations highlighted some common themes that apply to all aspects of mental wellbeing and to the full range of supports and services we offer to people who live with mental illness. Those themes were the genesis of the ideas in this Plan.

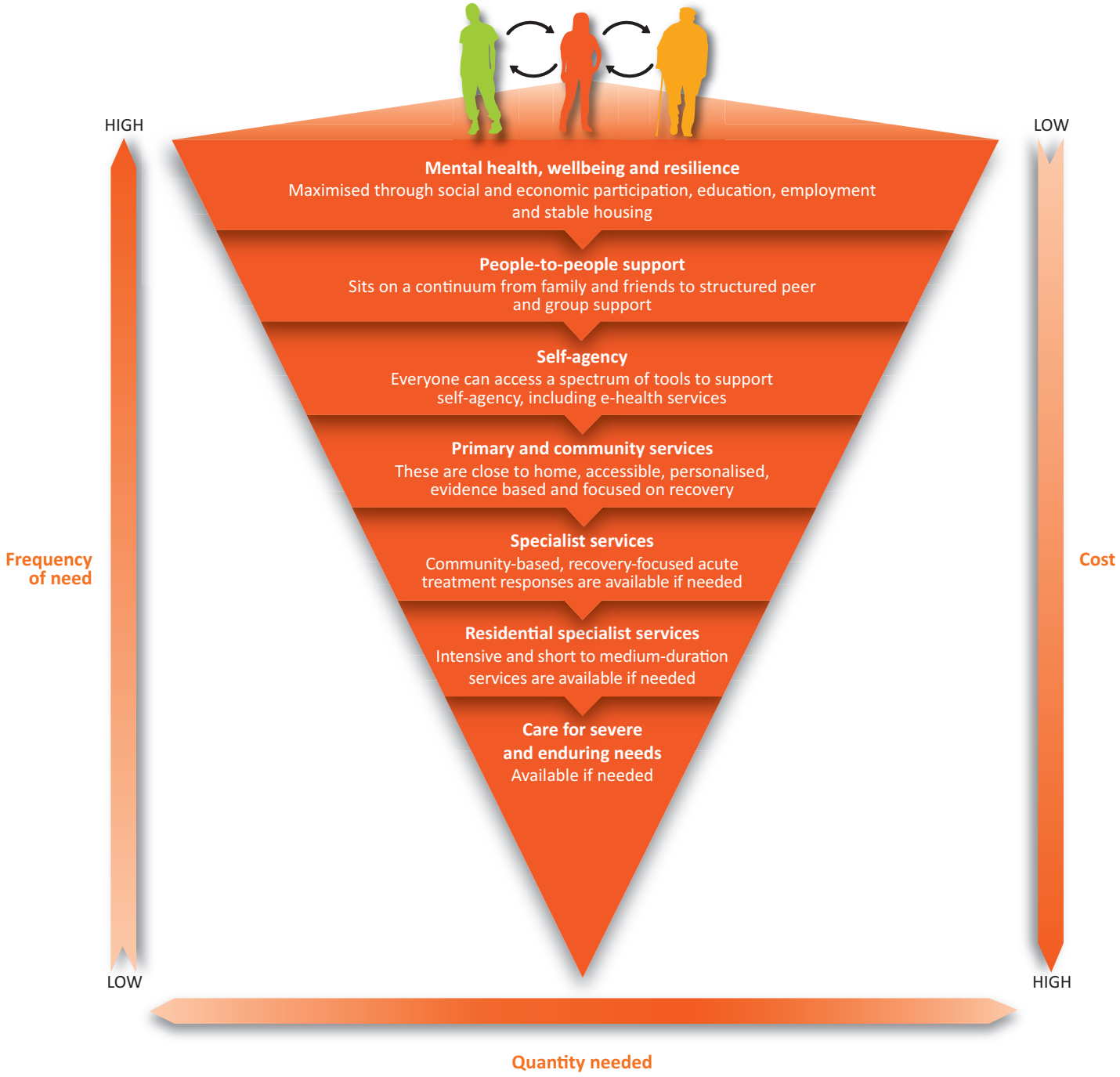
The Plan therefore is a powerful representation of the views of the community – and the directions it sets hold the authority of a collective voice.

The consultation process has established a network across the community with which the Commission and government agencies can work towards change.

1.7 Prevalence of mental illness in NSW



1.8 Delivering mental health and wellbeing to NSW



1.9 The Strategic Plan at a glance

Our vision

The people of NSW have the best opportunity for good mental health and wellbeing and to live well in their community and on their own terms.

The indicators

Increasing

- Positive mental health and wellbeing
- Participation by people with a mental illness
- The peer workforce
- Positive experience of service delivery
- The proportion of NSW mental health funding spent on community-based services

Decreasing

- Psychological distress in the community
- Discrimination and stigma
- Suicide and suicidal behaviour
- The use of involuntary treatment orders
- The proportion of people in the prison population who have mental illness

How we will get there

Stronger local decision making and greater accountability

Stronger partnerships with Aboriginal communities

Consumer and carer participation at all levels

Improved prevention and early intervention for children and young people

Complete de-institutionalisation

A revitalised community-based mental health system

Better integration of care

Co-ordinated responses across human services

Better use of technology

Promotion of innovation, learning and leadership

1.10 A role for everyone

Mental health and wellbeing is an essential part of the fabric of our society. It runs through everything we do. We are all affected by it and we are all responsible for it.

At the highest level there is the need for improved Commonwealth and state government co-ordination, particularly in terms of mental health funding and programs. This will require closer co-operation and planning at the district level but also in relation to major Commonwealth funding initiatives such as the National Disability Insurance Scheme, *headspace* and Partners in Recovery.

Within the NSW Government, this Plan focuses on a number of key agencies including NSW Health, Family and Community Services, Education and Communities and Justice. But all government agencies will need to consider whether their services impact on people who experience mental illness and how they manage mental health and wellbeing in their workplace. Reform won't just happen in the ordinary course of business so agencies need to have committed resources to drive reform.

Local government plays a vital role and will be an important partner in the coming years in fostering local ownership and control over initiatives to improve community wellbeing.

Beyond government, there is a range of critical leaders and service providers. This Plan acknowledges the role played by general practitioners, private psychiatrists, psychologists, nurses and allied health professionals. We need to enhance and support their capacity to keep people well in the community, whether through better integrated care initiatives or by identifying and supporting improved funding through the Medical Benefits Scheme or the Pharmaceutical Benefits Scheme. But we also need their representative bodies such as colleges and unions to provide leadership by taking an active interest in reform and speaking out where necessary.

Keeping people out of hospital through the development of better community-based mental health care and support services is a critical element in the reforms. Community-managed organisations and the private sector are likely to play increasing roles in this. The extent of the community-managed sector's role will depend on its ability to operate in a market moving increasingly towards government contracting out of services and consumer choice through personalised funding that allows individuals to select support services according to their needs and preferences.

Workforce capabilities and strategies will be needed to develop a range of professional roles, including clinical ones either within community-managed organisations or as part of a collaborative team with other services, while also blending peer worker and social support roles into the community-managed workforce.

1.11 The role of the Commission

The NSW Mental Health Commission is not the owner of the Strategic Plan. It will have both an accountability function and an active role in reform delivery.

As made clear in its founding legislation, the Commission is required to monitor and report on the implementation of the Strategic Plan, taking into account not only health services but all other policies and services that affect our capacity to have satisfying, contributing lives such as employment, housing, social inclusion, choice and autonomy.

Part of this role will involve the Commission identifying meaningful performance indicators and reporting to the NSW Government, Parliament and the community on them and, more broadly, on whether things are getting better. But the Commission will not simply be a passive observer. It will, through its other statutory roles, work with agencies on the Plan's successful implementation.

The independence of the Commission enables it to operate with a wide range of stakeholders and to broker different conversations about reform. Its support for new relationships among stakeholders will be critical. This brokerage role enables the Commission to act as the independent bridge among stakeholders.

The Commission will also encourage reforms by sharing and seeding innovations, including drawing on those developed in NSW, across the rest of Australia and overseas. These may include emerging models of care and support that embody person-centred principles, or they may be new organisational or management practices that empower professionals to work more responsively and effectively.

Allied with this function is a Research Framework for Mental Health in NSW, developed by the Commission and currently subject to consultation, that emphasises collaborative projects with the potential to be scaled up quickly.

The Commission will foster an environment in which stakeholders feel able to share the results of reform – successful or otherwise. Without this, bad performance is often hidden or misreported, causing unintended consequences and unstable results.

The Commission's approach to its work will be based on a trust, support and shared ownership to make a real difference in the lives of individuals and our community.

2. MAKING IT LOCAL

2.1 Strengthening local action

NSW is a state of exceptional cultural, geographic and economic diversity. Over our vast 800,000 square kilometres we have communities facing significant disadvantage and others that include some of the richest people in the world. Three quarters of us live in big cities but within those cities we live very differently, in suburbs influenced by generations of migration. People who live along our 2137-kilometre seaboard may have very different experiences from the 15 per cent of us who live 50 kilometres or more from the coast.[2]

Our experiences of mental health and wellbeing and of mental illness echo this diversity. Yet our service system has tended towards a centralised approach, with planning and policy responses overwhelmingly developed in head offices in central Sydney. Regional managers have always had some authority to respond to local circumstances and to work in partnership with their peers in other government agencies and the community-managed sector. But in practice, doing so has too frequently involved complex and time-consuming bureaucratic processes.

We know that community is the heart of positive mental health and wellbeing. Extensive research shows that even people with more severe mental illness can best be supported at or close to home. Having positive relationships, meaningful activities and a secure place to live are essential to recovery.

We also know that people from the most disadvantaged groups are much more likely to experience mental illness and disability than those from the least disadvantaged groups. This disadvantage starts early and compounds, creating big costs for the community. Much of this mental health inequality is preventable or at least reducible.

We now need to put that knowledge into action and end our unsustainable approach to mental health by empowering government agencies and community organisations to work together at local levels guided by the participation of consumers, carers and families. Rural and remote communities in particular gain when they develop alliances that maximise the skills and capacity of everyone who lives and works in them.

The story so far

The NSW Government is already making changes that will support stronger local responses. The NSW 2021 plan has stimulated the emergence of regional development plans and cross-government initiatives to facilitate alliances and actions. A number have already made mental health a priority and have projects under way.[3]

More broadly, the NSW Government is exploring place-based reform to solve complex and interacting issues, based on the principle that responsibilities should be delegated to the lowest possible tier of government to promote better decision making and greater efficiency. Place-based approaches are often used to target areas experiencing significant disadvantage and focus on how this influences determinants of health, including mental health.[4]

The NSW Government is also developing the autonomy of regional operations within departments and agencies to allow them to respond more flexibly to local needs and to be more accountable.

The creation of 15 Local Health Districts, each with a board accountable to its community, provides a strong foundation for change that addresses local circumstances. The Department of Family and Community Services has aligned its regions along the same boundaries, enhancing the potential for local mental health and wellbeing initiatives that address housing, social support and other important aspects of people's lives beyond health care. The boundaries largely align with those of the Commonwealth-funded, primary care Medicare Local organisations, which include a focus on population-level health issues that is expected to continue when the Medicare Locals are replaced in 2015 by Primary Health Networks. This lays the groundwork for powerful collaborations in more localised planning and decision making, with more direct communication among local service managers.

Local Decision Making is also a key initiative under *OCHRE: The NSW Government Plan for Aboriginal Affairs,* which focuses on improving service delivery. Under Local Decision Making, Aboriginal communities will gain more control of government services, moving towards self-governance and building management skills, decision-making power and authority. Community-led Local Decision Making has begun, initially in three regions: Far Western NSW, Illawarra South East and the North Coast.[5] Two additional Aboriginal communities will also take part in the trial program at a later date: Central Coast and Central West.

Similarly, the NSW Government's Local Schools, Local Decisions policy gives public school principals more authority to make decisions about how best to meet the needs of their students – including in mental health and wellbeing – in consultation with their school communities. This Plan is well aligned with this focus on strengthening community-based decision making and planning for success across the lifespan, starting young and intervening early if problems are identified.

What local reform requires

There is an emerging understanding of what is required to initiate and sustain effective local action. A review[6] of effective community action in Australia showed action was needed on three fronts simultaneously: building more supportive communities; creating a better co-ordinated and more effective service system; and improving communication about policy between communities and services.

To harness the potential of local action to support better mental health and wellbeing, we will need support from government and agencies at all levels. For local collaborations to be sustainable, there need to be reliable benefits to all contributors. In the longer term, this will be seen through improved outcomes for individuals and reduced costs to the community and government. In the short term, a critical issue will be better access to information across agencies and levels of government. In particular, the alignment between Local Health Districts and primary care organisations such as Medicare Locals or their replacement Primary Health Networks provides an opportunity to access population-based information held by the Commonwealth. This includes health-based information such as from the Medicare Benefits Scheme and Pharmaceutical Benefits Scheme but also information on employment and Disability Support Pensions.

For the biggest impact we need to target regions and communities with the greatest and most entrenched mental health and social disadvantage. We need to understand how inequalities cluster in geographic areas, and how these relate to poorer mental health. Support will be needed to ensure these areas get priority.

Collective Impact

Collective Impact is an approach that is winning strong support internationally for its potential to address complex social problems that cannot be resolved by a single organisation or program, to create lasting large-scale change. It has particular relevance to mental health and wellbeing challenges at a community level, especially when these are associated with social disadvantage.[7]

Collective impact is distinguished from other types of collaboration when the following five key conditions are present:

- A common agenda: a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed actions. Facilitation of relationships may be needed because of prevailing power imbalances across agencies and organisations, and support will be needed for the development and maintenance of governance structures.
- Shared measurement systems: consistent data collection and measurement of results to ensure alignment of activities and accountability of all involved. Support will be required to allow agencies and community organisations to share data, subject to appropriate privacy protocols. This will allow for the development of local reform plans, based on an understanding of the population's needs and the resources available.
- Mutually reinforcing activities: separate and distinct activities that are co-ordinated through a plan of action. Support may be required for local managers to exercise their discretion and authority under this approach. Community-managed organisations will benefit from the support of government as they become partners in reform, beyond the scope and scale of their usual practice.
- Continuous communication: consistent and open communication among all participants to build trust, assure mutual objectives, and create common motivation. This should include transparent accountability mechanisms including evaluation of services and programs, benchmarking, and knowledge sharing within and among districts.
- The presence of a backbone organisation: separate organisation(s) that operates as the backbone for the entire initiative and co-ordinates activity.

The Northern Sydney district of the Department of Family and Community Services, in partnership with other government agencies, has adopted Collective Impact to define social issues, create solutions and deliver actions. It has created The Collective NSW, a social impact model which aims to protect the most vulnerable people through cross-sector and community collaboration and innovation. It aims to reduce government's prescriptive role in solving problems of disadvantage, and clears the path for communities themselves to lead the way in finding solutions to their difficulties, with the support of large and small businesses and government.

The Collective, in partnership with universities, is creating innovation laboratories, where communities can present their intractable problems. Teams of experts then re-examine the situation from new perspectives in order to find solutions.

Actions

2.1.1 Ensure all NSW districts have effective co-ordination structures to support population-based planning and action across local, state and Commonwealth agencies, to support the reform directions established by this Plan. These structures may be linked to existing Department of Premier and Cabinet Regional Coordination Groups or OCHRE Local Decision Making co-ordination groups.

2.1.2 Ensure district co-ordinating structures have access to timely, local and comparative data on the mental health and wellbeing of their populations, including in housing, health, justice and welfare. Districts should set up arrangements for the appropriate sharing of individual-level data for shared clients who have high rates of service access.

2.1.3 Two districts should act as demonstration sites to analyse the data they require and identify and resolve local, state and Commonwealth barriers to data access, including any issues relating to:

- privacy, which will be tested with the NSW Privacy Commissioner
- access to Commonwealth data.

2.1.4 Develop and implement a consumer experience feedback system across all services. For NSW Health, this will include the further development of the Mental Health – Consumer Perceptions and Experience of Services (MH-CoPES), which allows consumers to evaluate their experience of the public mental health system.

2.1.5 Ensure that data informs planning and review cycles and that reports are provided regularly to the community about its mental health and wellbeing.

2.1.6 Link local responses to broader efforts so that statewide policy and planning is informed by local experience and innovation is shared.

2.2 Aboriginal communities

Aboriginal culture promotes wellbeing, positive social relations and shared responsibility through its emphasis on family, community, respect and connection to land. It has proved its resilience by surviving intact and strong through many millenniums and through two centuries of injustice and cruelty, including violence, dispossession of land, imprisonment and the removal of children.

This exceptional culture continues to guide, sustain and console Aboriginal people but they still struggle with racism, discrimination, pervasive disadvantage and the continuing grief and trauma of a culture that honours ancestors and still experiences the early and preventable illness or loss of family members.

These experiences are important factors in the significantly worse mental health of Aboriginal people compared with other members of the community, and they will need to be acknowledged and addressed for this situation to improve.

In 2011 an estimated 208,500 Aboriginal people lived in NSW, comprising 2.9 per cent of its population and nearly one-third of the Aboriginal population in Australia. More Aboriginal people live in NSW than any other state or territory.[8] More than 90 per cent of Aboriginal people in NSW live in major cities or inner regional areas. Smaller numbers live in outer regional and remote areas but they represent a higher proportion of the population in those areas.[9]

Beyond mental health

Between 2010 and 2012 life expectancy at birth for Aboriginal men in NSW was 70.5 years and for women 74.6 years, respectively 9.3 and 8.5 years less than for non-Indigenous men and women.[10] The Commonwealth Government's *Closing the Gap* strategy aims to eliminate the gap in life expectancy by 2031. There is no specific target related to mental health or suicide.

For Aboriginal people, social and emotional wellbeing goes beyond mental health. It reflects a more holistic view of health and includes the importance of connection to land, culture, spirituality, ancestry, family and community.[11] Measuring social and emotional wellbeing is difficult but usually relies on self-reported feelings (such as happiness or calmness) or 'stressors' (stressful events in a person's life). Stressors included the death of a family member or friend, disability or serious illness, alcohol or drug related problems and inability to get a job.[12] About 20 per cent of Aboriginal adults in NSW experience high or very high psychological distress, including depression and anxiety, which is twice the rate of non-Aboriginal adults.[13]

In NSW, the overall rate of suicide for Aboriginal people is 1.4 times higher than for non-Aboriginal people.[14] During 2011 and 2012, the rate of hospital admissions for Aboriginal people in NSW for intentional self-harm was more than three times the rate for non-Aboriginal people and has increased by more than 50 per cent since 2001 and 2002.[15]

As with the Aboriginal population as a whole, young Aboriginal people suffer poorer mental health than their non-Aboriginal counterparts. The preliminary findings of a long-term prospective study of urban Aboriginal children in NSW show that a higher proportion are at risk of psychosocial problems than non-Aboriginal children, highlighting the need for early detection, appropriate referral and culturally appropriate programs. The factors promoting social and emotional wellbeing appear to include a more stable home environment with fewer moves or carers and less psychosocial distress in the carer.[16]

NSW Health staff are required to collect and record information on the Aboriginal status of all clients of public mental health services. Despite this, there is no routine data reporting of rates of access to mental health services by Aboriginal people. Any issues about the completeness of this data must be addressed.

Bush Circle

Weave Youth and Community Services is a community organisation that has been working with disadvantaged and vulnerable young people, women, children and families in the City of Sydney and South Sydney areas for more than 30 years. Bush Circle, an experiential, bush-therapy project for people aged 16 to 28 experiencing co-existing mental health and alcohol and other drug issues, is part of Weave's Speak Out Dual Diagnosis program.

Bush Circle is a six-week program that begins with a five-day bush camp in the Blue Mountains, followed by day trips once a week for five weeks that allow participants to stay connected to the city and integrate what they have learnt from their time in the bush. Based on a model of concentric circles of relationship with self, nature, culture, community and one another, young people return with a sense of who they are and new experiences of themselves. Bush Circle connects inner-city Aboriginal young people with the Aboriginal community of the Blue Mountains.

Striving for change

There are many passionately committed people, Aboriginal and non-Aboriginal, working to improve the mental health and social and emotional wellbeing of Aboriginal people. There are many examples of good practice in the Aboriginal community-controlled sector, non-Aboriginal community-managed organisations and government services. We have no shortage of foundations on which to build and plan.

There have been numerous inquiries, reports and recommendations on improving the mental health and social and emotional wellbeing of Aboriginal communities. Partnerships have been formed at national, state and local levels; protocols developed to aid the gathering of information on health issues; national policies developed for suicide prevention; commissions held into deaths in custody and the Stolen Generations; health strategies implemented to close the gap between Aboriginal and non-Aboriginal disadvantage and so on.

Extensive consultations by the NSW Government's Ministerial Taskforce on Aboriginal Affairs reveal that Aboriginal people are concerned about the need for individual and community healing.[17] [18]

The NSW Mental Health Commission has heard from NSW Aboriginal communities throughout the state that Aboriginal people are concerned about:

- access to mental health support that is culturally appropriate[19], including the need for more Aboriginal mental health workers and respect for women's business and men's business – circumstances when men and women should not mix.
- the capacity of Aboriginal communities to respond to the high rate of mental illness and suicide.

The hopes and aspirations of Aboriginal communities have been explored many times. Their strength and resilience in this sustained contribution has been patient and generous. Despite this, Aboriginal people are still the most disadvantaged in Australia and we must keep working together for change.

Effective and meaningful partnerships

Aboriginal people need access to the right type of care and this requires partnerships among service providers, mainstream and Aboriginal community controlled, committed to working together to support the recovery and healing of Aboriginal people. Effective and meaningful partnerships with Aboriginal communities must be a priority for leaders in government- and community-managed agencies.

Investment in these partnerships must be reflected in agency planning and visible in the actions of agency leaders and their staff. Leaders should be good role models in their behaviour and that expected of their staff. The relationships between agencies and Aboriginal communities should be a central concern for all services and senior leaders and should be monitored in assessments of agency performance.

NSW Health is committed to expanding its workforce to have one Aboriginal mental health worker for every 1000 Aboriginal people.[20] We also need an adequate number of qualified Aboriginal mental health professionals across all disciplines who can draw on their culture and professional skills to provide services to Aboriginal people. In whatever role, Aboriginal mental health professionals should be given adequate culturally appropriate support and mentorship.

And we need a culturally competent mainstream mental health workforce to respond to the needs of Aboriginal people and deliver trauma-informed support. Professional education, training and development for all health and mental health workers should strongly emphasise Aboriginal perspectives on health and wellbeing.

Efforts to support Aboriginal mental health and social and emotional wellbeing must be grounded in respect for Aboriginal self-determination. Government programs must be co-designed, implemented and managed in partnerships with Aboriginal people and communities. It should not be assumed one person or group speaks for others; all Aboriginal people should be able to have their say.

Healing within Aboriginal communities must be driven by individuals and communities and cannot be directed or imposed by government. However, the NSW Government does have a role in encouraging healing and wellbeing in Aboriginal communities.[21] Aboriginal communities should be empowered to develop ground-up approaches, owned and promoted by the communities, including by Aboriginal people with a lived experience of mental illness. Mechanisms for community-driven mental health reform include the Aboriginal Local Decision Making Leadership groups being implemented under OCHRE: The NSW Government Plan for Aboriginal Affairs.

Actions

2.2.1 Strengthen partnerships and relationships among Aboriginal communities and service providers by assessing the quality and effectiveness of the relationships and taking steps to improve them. The strategies for evaluating and strengthening the relationships are to be determined in partnership by the Aboriginal communities and service providers.

2.2.2 Establish mechanisms by which non-Aboriginal organisations can access expert, practical advice from Aboriginal people on strategies to improve the cultural appropriateness of their services.

2.2.3 Measure and publicly report:

- perceptions of service quality and workplace supports of Aboriginal mental health and social and emotional wellbeing workforces
- Aboriginal consumer and carer experience of services.

2.2.4 Strengthen Aboriginal participation in the design, implementation and evaluation of NSW Government policies and initiatives to improve the mental health and social and emotional wellbeing of Aboriginal people.

2.2.5 Encourage Aboriginal people to train as mental health professionals to work in all settings, including by continuing to support and develop the NSW Aboriginal Mental Health Workforce Program and vocational and educational training initiatives.

2.2.6 Enhance culturally appropriate mental health first aid and mental health literacy training for Aboriginal communities, including programs delivered by Aboriginal trainers with a lived experience of mental illness.

3. GETTING IN EARLIER

3.1 Building community resilience and wellbeing

Mental health and wellbeing are fundamental to a strong, functional and resilient society which we, as individuals, make up.

The resilience that comes from good mental health and wellbeing is the foundation of:

- safer and healthier families, schools, workplaces and communities
- higher educational achievement
- improved relationships and personal dignity.[22] [23]

Poor mental health affects people of all ages yet, with the right approach, its impact can be reduced dramatically. And yet we also know that as things stand:

- 45 per cent of all Australians will be affected by a mental illness at some point in their life[24]
- by 2023 anxiety and depression combined are expected to be the second biggest contributor to burden of disease in Australia.

The individual, social and economic costs are immense, so promoting community-wide mental health and wellbeing makes good sense. But we must start early, across the whole population and across all of life.

Promoting wellbeing for everyone means targeting those social factors that foster good mental health and the development of resilience, including access to housing, education, employment or other meaningful activity when employment is not available.[25] But it also includes promoting a healthy lifestyle with exercise and good diet.

Able to meet life's challenges

Generally, we as individuals don't know enough about how to improve our mental health and wellbeing. If all of us – communities, schools and workplaces – took a wider responsibility for our mental health and wellbeing and that of our loved ones, in partnership with relevant agencies where needed, we would have access to the tools needed to cope with difficult life events and to connect with others around us. We would develop resilience.

Being resilient helps mitigate risk behaviours, such as tobacco, alcohol and drug misuse; social and economic problems, such as crime, absenteeism from work and dropping out of school; and the rates and severity of physical and mental illness. Therefore the benefits of resilience are experienced not only by individuals but flow across the whole community and, indeed, to government.

Singing for social inclusion and wellbeing

Choirs are a vehicle to achieve greater social inclusion and wellbeing. Creativity Australia co-ordinates the With One Voice choirs in Sydney, Melbourne and Brisbane that allow members to express their creative potential and participate in a community-building activity. The choirs bring together people of all ages and walks of life, cutting across socio-economic, cultural, religious, generational and linguistic barriers. The model includes a professional conductor, volunteer support, opportunities for interaction and connection at rehearsals, and mechanisms to connect with the wider community. Choirs can also be established in specific settings such as workplaces. No singing experience is necessary.

Family and education are the keys

To develop resilience, we must start at the beginning – childhood. Our capacity for being resilient and strong undoubtedly starts with our family of origin. We can give children a good start in life by supporting mothers and families in need and protecting children in dysfunctional families by working with those families. These important issues are taken up later in this Plan.

In addition, wellbeing programs for school-aged children are an important springboard into a healthy life trajectory. Many issues can be prevented or improved through school-based approaches with a strong focus on wellbeing.[26]

All schools should operate under a wellbeing framework that supports the development and promotion of wellbeing not only for all students but for staff. In line with OCHRE: The NSW Government Plan for Aboriginal Affairs, a strong sense of identity, belonging and self-determination for Aboriginal students must be fostered.

School-aged children and young people – a snapshot of challenges and support[27]

At present, among about 740,000 students in NSW Government schools:

- 25 per cent access additional support from one or more of the areas of: Aboriginal education; wellbeing and disability, learning and support; or child protection
- 25 per cent are at risk of not completing Year 12 or its equivalent
- 6 per cent identify as Aboriginal and 52 per cent of those are at risk of not completing Year 12
- 12 per cent have a disability and or difficulties in learning or behaviour
- there were 12,000 contacts with the Child Wellbeing Unit in 2012
- each day, 7 per cent of students do not attend school and this figure rises to 15 per cent among Aboriginal students.

School counsellors contribute significantly to student wellbeing in public schools by providing psychological services and participating in learning and support teams. They work with and supplement available departmental expertise.

The NSW Department of Education and Communities is building on this through the development of a network of specialist support that will link all public schools by 2017. This network will draw together the expertise of the department and broader government and community-managed health and welfare providers.

In complex cases involving children and young people dealing with adverse environments and individual high-risk vulnerabilities, the network will provide schools with:

- specialist information and guidance
- support for children and young people requiring services beyond those available in the school
- support to triage individuals into the broader government and community-managed health and welfare service system.

Committing to change

Mental health and wellbeing must be central to the Government's wider prevention and early intervention responses. A focus on resilience will connect with efforts to prevent and manage the adversity of natural disasters including flood, drought and bushfire.

The commitment to fostering community resilience is consistent with the NSW 2021 plan and with the goals of keeping people healthy and out of hospital and improving mental health. This means moving the centre of responsibility to the community and more effectively educating the wider public about mental health, mental illness and wellbeing.

This can be enabled through the use of mental wellbeing impact assessment tools[28] whose benefits include:

- focusing attention on inequalities and the social factors that impinge negatively on mental health
- shifting resources and services so that they foster positive mental wellbeing
- stakeholders developing a shared understanding of mental wellbeing.

Actions

3.1.1 Establish a NSW Wellbeing Collaborative to support wellbeing initiatives among organisations, share knowledge and promote innovative and successful activities.

3.1.2 Implement local mental health and wellbeing promotion activities, complementary to national activity.

3.1.3 Promote the use of wellbeing impact assessments to determine the impact of initiatives on the wellbeing of the community.

3.1.4 Implement and further develop the Department of Education and Communities' *Wellbeing Framework for Education* which:

- sets out the role of education in building and improving wellbeing
- establishes wellbeing standards for school communities and evidence-based approaches for improving wellbeing
- considers both students and staff, to help build their capacity to enhance the wellbeing of themselves and others
- builds the staff's capacity to support students with more targeted needs and provide direct services to students with more complex needs
- promotes online wellbeing and self-management tools for children and young people, such as those developed by the Young and Well Co-operative Research Centre
- establishes local partnerships and uses community assets, such as cultural, recreational and sporting groups, to support student wellbeing
- encourages joined-up responses from government and community organisations to support student need through networks of specialised support.

3.2 Promoting self-agency

Looking after one's self and others is part of daily living. Most of us are able to take care of most of our emotional and wellbeing needs without accessing formal services – and many of us never come into contact with services. It is about individuals taking charge of theirs – and others' – health and wellbeing whether in their homes, neighbourhoods, communities or elsewhere.

Self-agency describes what individuals do to maintain good physical and mental health, meet social and psychological needs, prevent illness or accidents, care for minor ailments and long-term conditions and maintain health and wellbeing after an acute illness or discharge from hospital. It is also about accessing self-help and self-referral options when necessary.

There is growing recognition that people who experience mental illness have enormous capacity to influence their health outcomes if they have quality information and appropriate self-management tools. They should not only have an opportunity to be involved in their mental health care and treatment because it is their right but because the delivery of care is more effective when this occurs.[29]

Evidence-based approaches

For a number of years in NSW, Mental Health Month campaigns have taken a positive mental health promotion and self-agency approach.

Supporting this is a suite of evidence-based e-health interventions to give people who are concerned about their mental health or who have a mental illness a better understanding of their situation, and to enable them to manage their illnesses and associated physical challenges. For some, this information may be all they need.

While e-health interventions are well developed for common issues such as anxiety and depression, research and development is under way for the full spectrum of mental illness. The limited take-up of e-health interventions in this country is surprising given their proven effectiveness and given that Australians have led the way in developing the technology.[30] [31] These issues are further explored in *Better use of technology,* p104.

myCompass – Black Dog Institute

myCompass is an e-health initiative developed by the Black Dog Institute to promote mental health and wellbeing. It is intended to assess the user's symptoms. Using email and text messages, *myCompass* can provide a personalised and interactive program that includes online psychological tools, monitoring of moods and behaviours and motivational tips.

Concepts of recovery and its links to self-agency and self-care are not well understood in the NSW mental health system. This should be seen as an opportunity to change the culture towards a recovery-oriented mental health system. The National Framework for Recovery-Oriented Mental Health Services[32] supports autonomy and self-determination through focusing on an individual's strengths, resilience and capacity for personal responsibility.

However, the prevailing language of clinical services is often about case management, discharge planning and relapse planning, thus reinforcing an illness model and a provider-centric risk management approach that negates the principles of recovery.

Recovery colleges

The concept of recovery education centres began with the consumer movement in the United States. Recovery colleges[33] offer programs in an environment where hope, empowerment and possibility are promoted. They deliver comprehensive education and training courses developed in partnerships between consumers, clinicians and accredited educational organisations. They help people become experts in their own self-care, and families, friends, carers and staff to better understand mental health conditions.

The South Eastern Sydney Local Health District has developed the first recovery college in NSW. It is based on the recovery college model in the United Kingdom, providing an alternative to traditional mental health treatment options.

Recovery colleges provide opportunities to consumers to live meaningful and contributing lives – and to NSW to develop its peer workforce and promote the principles of recovery within mental health services and the community.

A promotional approach

Act-Belong-Commit is an example of how positive mental health self-agency can be supported through a public campaign. It promotes behaviours that build and maintain good mental health, while encouraging wider community participation in mentally healthy activities. Developed through research at Curtin University and supported by the Western Australian Mental Health Commission, it describes an ABC of positive mental health[34]:

- Act – keep mentally, physically and socially active
- Belong – participate in formal and informal group activities
- Commit – have meaning and purpose in life by taking up realistic challenges, setting goals, and getting involved in a cause.

A recent evaluation[35] found this approach had a positive impact on mental health literacy.

The internet offers the opportunity for people to find the mental health resources most appropriate to their needs, but some – particularly older people – avoid the online world because of lack of skills or confidence or fear of potential hazards such as scams and bullying. Initiatives like the national eSmart Libraries project can help build community knowledge and capacity to use online resources safely and effectively.

The strategic opportunity for reform is to create a new layer of mental health self-care and support in the community that is low cost and high impact. For change to be fully realised, there must be a concerted and disciplined effort to fully establish self-directed, and recovery-oriented self-agency.

Actions

3.2.1 Develop and implement a mental health promotion campaign along the lines of Act-Belong-Commit to improve mental health literacy and self-agency with a strong focus on local initiatives.

3.2.2 Health and other relevant services such as housing, education and justice should promote the use of online and other self-management tools as a legitimate pathway to care.

3.2.3 Explore the potential for social media approaches to keeping people connected and supported, drawing on lessons from other sectors such as the NSW Police *eyewatch* (Neighbourhood Watch online).

3.2.4 Leverage off the successful national eSmart Libraries' digital literacy and cyber safety program and support efforts to improve e-literacy for older people.

NOTE: See also actions under *Better use of technology* p. 107.

3.3 Prevention and early intervention for children and young people

Children's early years are crucial in shaping the adults they'll become. What happens in their earliest years will affect not only their immediate health and wellbeing, but will lay the foundations for their future.

2011 Australian Early Development Index National Report

Signs of vulnerability to mental health issues are often clear by the time a child turns six. Patterns of drug and alcohol misuse and eating disorders commonly start in adolescence, sometimes earlier. Half of all mental illnesses manifest before the age of 14 and three quarters by the age of 25.[36]

Sadly, social and emotional development does not progress smoothly for a significant number of children and young people in NSW. Opportunities are being missed to intervene – and to intervene early – in circumstances that may undermine their mental health and wellbeing.

Parents' lives clearly affect their children's lives. The challenges a parent faces, such as financial hardship, domestic violence, postnatal depression and drug and alcohol misuse, expose children to greater risk of developing mental health and behaviour problems.[37] Patterns of disadvantage can become entrenched. Pre- and post-natal medical care, early education, specialist mental health services for children and young people, and intensive family support services, including models of family therapy, to name a few, can play a greater role in ensuring that more young people have the chance to realise the full potential of their lives.

We also know that positive participation in family, school, social and peer activities help promote resilience and wellbeing in children. We need to ensure that these are part of every child's life. Educational attainment is another protective factor and we must work to ensure that as many children and young people as possible complete the full 13 years of school education.

Risky beginnings

The process of mother, father and infant social and emotional bonding is widely recognised as laying the foundation for lifelong social and emotional wellbeing and cognitive development. The perinatal period represents a period of particular risk for mental illness for women, as a consequence of hormonal changes during and after pregnancy, increased stress, sleeplessness and renegotiation of family roles and relationships. About 15-20 per cent of women in Australia experience perinatal depression, but many women are neither diagnosed nor treated.[38]

Mental health issues of fathers are also commonly under-recognised with many, particularly younger fathers, unable to identify their mental health needs and not seeking help or engaging with appropriate services.[39] Children of fathers with alcohol issues are likely to have higher rates of premature death, greater risk of mental health problems, learning difficulties, behaviour problems and physical illness. Psychiatric illness among fathers can also have a devastating impact on a child's wellbeing. However, many services are configured only to identify and support the transition to parenthood for mothers and may fail to engage with fathers.

The disruption of the parental relationship can result in delayed social and emotional development and/or significant behavioural problems for the infant.[40] This negative picture needs to be balanced by an understanding that many parents with mental illness remain capable and able to support their children. The presence of mental illness does not itself create risk, rather it is the severity, duration and related

impact of mental illness on social circumstances and, importantly, the presence or absence of other supports that can mitigate any risks.[41]

When families encounter difficulties that hamper the wellbeing of children, child protection services may become involved.

In 2011-12, the NSW Department of Family and Community Services received 99,283 reports of children at risk of significant harm.[42] Physical abuse, neglect, emotional abuse and domestic violence were the top four reported issues as they were in the preceding three years.

Children or young people placed in state care can face lifelong disadvantage. A longitudinal study of wards leaving care found the lives of many were characterised by unstable and poor quality housing, unemployment, early parenthood, difficulties in making ends meet, difficulties in establishing and maintaining relationships, limited support and family contact, loneliness and mental health problems.[43]

The school years

In 2012, 8.3 per cent of NSW children were found to be developmentally vulnerable because of their low emotional maturity when they started school.[44] Their scores for anxiety and fear, aggression, hyperactivity and inattention were high, while those for pro-social and helping behaviours were low. This is of concern not only in the early years of schooling; in 2011, 14 per cent of secondary school students exhibited signs of high psychological distress.[45]

Peer leadership for young people

Batyr is a community-managed program that connects secondary and tertiary students with young speakers who have experience of mental health challenges and recovery. The speakers give the students information about the support networks and services available for people experiencing mental health problems. Batyr educates and empowers young people to speak out about mental health issues and normalises help-seeking behaviour. Batyr speakers share life experiences about issues such as depression, suicide, sexual assault, eating disorders, bullying and personal health and, through sharing their personal stories, encourage students to 'look, listen, talk and seek help'.

The prevalence of childhood and adolescent behavioural disorders is another area for concern. These disorders, particularly oppositional defiant disorder and attention deficit hyperactivity disorder (ADHD), are associated with mental illness later in life.[46] About 4.8 per cent of Australian boys aged six to 12 have been found to have conduct disorder or exhibit severe antisocial behaviour; 3.7 per cent experience depressive disorder and 19.3 per cent have ADHD.[47]

What we are doing

There are a number of prevention and early intervention services and initiatives for children and young people involving Commonwealth, state and community-managed organisations. There is good evidence of the effectiveness of many of these, such as school-based social and emotional learning programs[48], but these have not been implemented in NSW in a comprehensive way.

At the Commonwealth level, *headspace* centres – aimed at those aged 12 to 25 – are expanding in NSW, both in number and the range of services provided, with a small number of Early Psychosis Prevention and Intervention Centres expected to be established soon. But despite some notable exceptions, they remain largely disconnected from state-run specialist child and adolescent mental health services.

Working together

An example of how Commonwealth and NSW services can co-operate to provide people with better access to support and services is the Children and Young People's Mental Health service on the Central Coast. This NSW-funded service is co-located with the Commonwealth-funded *headspace* office in Gosford. Here, and online, the *ycentral* service offers a free, one-stop shop for young people aged 12 to 25. It provides early intervention for mental health and emotional wellbeing issues and assesses and refers young people to the most appropriate service – including *headspace*, specialist mental health services, drug and alcohol, vocational and employment support networks, accommodation services and primary health clinics.

In NSW there is a need for greater integration among school-based programs, community-based services and specialist child and adolescent mental health services. Initiatives aiming to achieve better integration include:

- *Keep Them Safe: A shared approach to child wellbeing* is the NSW Government's five-year plan to reshape the delivery of family and community services and improve the safety, welfare and wellbeing of children and young people.
- NSW Kids and Families is a statutory health corporation established in July 2012 in response to the recommendations of the Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (the Garling Report). Its purpose is to provide leadership within NSW Health and other government agencies to address the health and wellbeing needs of children and young people and their families. NSW Kids and Families is developing a 10-year plan which will be the foundation of a co-ordinated approach to meet these needs.
- Brighter Futures and Sustained Health Home Visiting forms part of the NSW approach to family-focused prevention and early intervention and consists of about 20 home visits, primarily by the same child and family health nurse, during pregnancy and the first two years after birth.
- Intensive Family Support services provide intensive, in-home crisis intervention, practical assistance, counselling and skills development for families who have children at risk of significant harm and are at risk of placement in out-of-home care.
- The NSW Government has initiated a pilot program of Whole Family Teams in four locations to assist families with mental health, drug and alcohol and parenting difficulties.

Despite this good work, services that aim to address complex mixes of behavioural and mental health issues and trauma are in short supply. The toll on individuals, families and communities is inestimable. The economic costs to government are immense and avoidable. We must intervene earlier in young people's lives, integrate services and make sure those most in need of support get it.

Actions

3.3.1 We must build on the NSW Government's priority for improving the prevention and early intervention system for vulnerable children and their families and establish a youth alliance which:

- considers holistic prevention and early intervention approaches across mental health, trauma and behavioural issues for children and adolescents
- comprises representatives from all relevant sectors, including child and adolescent mental health services, paediatrics, alcohol and drug services, education, community services and justice
- draws on relevant expertise from specialists such as the Brain and Mind Research Institute and the Black Dog Institute, ReachOut by the Inspire Foundation and national bodies such as the Young and Well Co-operative Research Centre, beyondblue, Butterfly Foundation and *headspace*.

The youth alliance will help guide the effective targeting of prevention and early intervention efforts by examining:

- the risk factors affecting children, young people and their families at different life stages and how these risks are responded to within the present system
- how the existing system could be better aligned to eliminate gaps and have an earlier impact
- opportunities for better co-ordination of services and service innovation in practice
- how the interaction between mainstream and targeted services could be improved
- opportunities presented by other reform activity, such as data and information work, already under way.

3.4 Suicide prevention

Suicide exacts a terrible toll, not only on individuals and those closest to them, but on entire communities. The most recent Australian Bureau of Statistics data, from 2012, indicates that 707 people in NSW completed suicide[49] during that year. This is likely to be an underestimate because many deaths are not recorded as suicide if there is uncertainty about the circumstances. We also know that many more people consider suicide[50] and that each year about 9000 people are admitted to NSW hospitals for intentional self-harm.[51] There is a clear need to take action to reduce these numbers and the suffering they represent.

Suicide and suicidal behaviours are varied, complex and surrounded by stigma. For a range of cultural, socio-economic and other reasons, they manifest differently among different groups of people and affect some communities more than others. Suicide is the leading cause of death for young people aged between 15 and 34 in Australia.[52] Men complete suicide at more than 2.5 times the rate of women in Australia, and Aboriginal and Torres Strait Islander people are completing suicide at just under 1.4 times the rate of non-Indigenous people in NSW.[53]

Some rural and regional communities experience higher rates of suicide and suicidal behaviour.[54] There are also elevated risks of suicide and self-harm in lesbian, gay, bisexual, transgender and intersex communities, among people who misuse alcohol and those with chronic illness including pain.[55]

Co-ordinated responses

At present, there are clear gaps in the co-ordination and integration of suicide prevention activities and programs across all levels of government.[56] There is a need for better governance and more clearly delineated roles and accountabilities for suicide prevention.

Funding for suicide prevention is split between federal and state governments. As a consequence, efforts aimed at suicide prevention may be poorly co-ordinated and opportunities for more effective action are easily overlooked. More specifically, some parts of NSW have suicide prevention groups and bereavement support networks but others do not. This reflects a fragmented system made up of isolated programs.[57]

Significant underlying issues, such as data collection and the dissemination of high-quality information and training, need to be addressed if we are to achieve a significant impact. Taking some key steps towards resolving these issues will reap direct benefits and provide a solid foundation on which we can build and refine further reform aimed at preventing suicide.

Tools for local communities

Local communities are crying out for sound information, tools and support for suicide prevention. People want to be able to help themselves and one another. They want to know how to support those bereaved by suicide and how to become more resilient. Well-informed, community-based action backed by evidence and professional expertise needs to be a cornerstone of suicide prevention activities.

Experts hold differing views about community-driven suicide prevention programs and their perceived potential to do harm.[58] Yet they also recognise that communities, particularly small towns, are keen to respond to local needs. Experts must engage with communities and build relationships that enable the implementation of evidence-based practices.

In 2012 the NSW Ministerial Advisory Committee on Suicide Prevention consulted communities in NSW about how local suicide prevention responses could be better supported. This resulted in recommendations targeting priority groups, including initiatives such as the development of strategies to prevent suicides in small towns, enhanced community engagement in suicide prevention, application of evidence-based practice, improved local data collection and workplace interventions.

Leadership in suicide prevention

Conversations Matter is a suite of online resources developed by the Hunter Institute of Mental Health which provides practical information for communities and professionals to support community discussion about suicide. The resources have been developed with the support of academics, service providers, people whose lives have been affected by suicide or suicide attempts, and community members in NSW.

Suicide Prevention Australia in partnership with the NSW Mental Health Commission has developed Communities Matter: A toolkit for community-driven suicide prevention. It aims to support local communities, particularly small towns, to turn conversations and interest in suicide prevention into activities that reflect local priorities and needs.

Evidence-based approaches

A challenge for suicide prevention is the need to continue to build the evidence base for effective strategies. While all funded initiatives are required to have an evaluation component, evaluation requirements are not always rigorous enough and funding is not always sufficient for meaningful evaluation, which limits their contribution to the evidence base.[59]

Centre for Research Excellence in Suicide Prevention

The Centre for Research Excellence in Suicide Prevention, based at the University of NSW, brings together researchers from Australia and New Zealand to undertake research in suicide prevention. The centre was established in 2012 and is funded by the National Health and Medical Research Council. It focuses on four key areas of research: better delivery of interventions, better knowledge of causes and risks, improved help-seeking and improved prioritisation of suicide funds. The centre's research seeks to produce positive change in lowering suicide rates in Australia.

Suicide prevention needs a systems approach. This requires that all evidence-based strategies are implemented simultaneously and that accountability is clearly delineated for each of the 'systems' used. Agencies and governments must jointly identify and agree on appropriate strategies within each system and operate cohesively to bring about change.

Any attempt to address suicide and suicidal behaviours needs to recognise the differences and risk factors for different population groups and respond accordingly. People from within these groups who have survived a suicide attempt or are bereaved as the result of suicide will have a vital role in shaping prevention efforts. Better, more timely and more localised data on suicide and suicide attempts will also be essential if we are to ensure prevention initiatives address local needs and priorities.

Responses to suicide and suicidal behaviour within the health system also need improvement. All front-line staff – emergency services, community and crisis support, mental health and emergency department staff, as well as general practitioners – need training to know what to do in a crisis and where to point people for further support. Whenever and wherever a person exhibiting suicidal behaviour encounters the health system, preventive action and follow-up must be systematic and assured.

Actions

3.4.1 Establish a NSW Suicide Prevention Forum comprising public, industry and community sector leaders, including those with lived experience of suicide, to strengthen the planning, monitoring and co-ordination of statewide suicide prevention efforts.

3.4.2 Prepare a NSW Suicide Prevention Implementation Plan to:

- strengthen the common vision for suicide prevention efforts
- set directions based on a rigorous review of data, evidence and need;
- strengthen connections among community, regional, statewide and national activities.

3.4.3 Ensure that suicide prevention efforts reflect the unique needs and higher rates of suicide in particular communities and populations, especially young people, and that the responsibilities of all agencies to support Aboriginal community responses to suicide are recognised.

3.4.4 Work with the Commonwealth and national suicide prevention agencies to improve the planning, co-ordination and delivery of nationally funded or delivered suicide prevention activities in NSW.

3.4.5 Assess the coverage of suicide prevention activities in NSW regions, cities and communities and ensure local responses are supported by local and statewide specialist supports.

3.4.6 Assess the data needs of local communities and service providers and provide timely reports to meet those needs, including by considering the recommendations of the National Committee for the Standardised Reporting on Suicide, working with first responders and assessing whether a suicide register should be established in NSW.

3.4.7 Ensure that front-line emergency, hospital, primary care and crisis personnel have access to good training about responding to suicidal behaviour, and that this training is strongly supported or mandated by employers.

3.4.8 Assess and improve the identification and response to suicidal people in hospital and community services, and at points of care or service transition, such as discharge from hospital.

3.5 Employment and the workplace

Mental health and wellbeing in the workplace

The economic and personal cost of poor workplace mental health management in NSW is significant. Consequently, mental disorders are one of the key priority areas in the NSW Occupational Disease and Wellbeing Strategy 2011-2015 and the Australian Work Health and Safety Strategy 2012-2022.

Between 2007 and 2010, mental health problems such as anxiety disorders, post-traumatic stress disorder and depression accounted for more than 17,000 workers' compensation claims in NSW, at an average cost of $19,600 a claim.[60]

A 2012 report into work hours and workplace culture in Australia found workers who were the most dissatisfied with the length and predictability of their working hours, job security and workplace culture were the most likely to report adverse impacts on their wellbeing.[61]

Other research has found that presenteeism (attending work and under-performing while unwell) and absenteeism as a result of work-related stress cost employers $10.11 billion a year and the national economy $14.81 billion a year.[62]

In most workplaces, physical and mental health are viewed as separate areas of concern and the focus is very much on physical health and safety. This needs to be expanded so that practices that promote mental health and wellbeing are as embedded in workplace culture as those that surround physical health and safety.

Some progress towards this shift is under way. The Mental Health Association NSW is demonstrating leadership in workplace mental health and wellbeing in the community-managed sector. It co-ordinates the Workplace Health Promotion Network, formed in 2006.

Collaboration between government and industry will also be required if we are to foster mental health and wellbeing in all workplaces. NSW Health's Get Healthy at Work initiative, for example, will provide participating businesses with information and tools to address mental health and wellbeing in the workplace.

At the national level, the Mentally Healthy Workplace Alliance, established by the National Mental Health Commission in 2013, is an excellent example of the collaboration that will bring positive change. The alliance sponsors research into interventions to help create mentally healthy workplaces and talks directly to business to identify practices that foster mental health. The alliance plans to develop a practical guide for business on workplace mental health and wellbeing.

The NSW Minerals Council – demonstrating industry leadership

In 2014 the NSW Minerals Council released a Blueprint for Mental Health and Wellbeing. It provides high-level guidance for industry in four areas: prevention of mental illness; building capacity and culture to address mental health and mental illness; promoting the recovery of employees with mental illness; and building the research base. Indicators for success have been defined at the industry, mine and employee level and monitoring will be conducted over the next five years. The development of the blueprint was a collaboration between the council, the University of Newcastle, the Hunter Institute of Mental Health and the Newcastle Institute for Energy and Resources.

Employment of people with a mental illness

Workforce participation is an essential part of the recovery journey for many people with a mental illness. A job brings opportunities for social inclusion and financial independence, both of which support mental health. By contrast, unemployment can lead to social exclusion, economic disadvantage, poor mental and physical health, and housing instability. The positive effects of participation in work have been well documented.

Recent data indicates that psychological or psychiatric conditions are the most common reason for a person to receive the Disability Support Pension. This cohort comprises 256,380 people or 31 per cent of people receiving the Disability Support Pension.[63]

The barriers to workforce participation among people with mental illness include: its episodic nature and the fear of losing income support and associated benefits; difficulties in accessing health, employment, rehabilitation and other services; unaddressed needs for continuing support; and stigma and discrimination. People with mental illness can also experience barriers to education and training.

But despite these barriers, many people with mental illness want to work. Participation in open competition for employment will not be the solution for everyone with mental illness and a range of options for participation and social inclusion are required.

JobAccess is a free service funded by the Commonwealth Government that offers information and advice for employees who have a disability (including a mental illness) and for employers. There are many opportunities for establishing and improving links among Commonwealth employment services and mental health services. In NSW efforts are already under way to link Commonwealth-funded Disability Employment Services with NSW mental health services through the co-location of Commonwealth and state services within Local Health Districts.

Of course there are many people who experience mental illness who have jobs at all levels of the workforce. The Australian Bureau of Statistics reports that 20 per cent of people aged between 16 and 85 will experience some form of mental disorder – including anxiety and depressive disorders – in a year. This is consistent with estimates of mental illness among the employed population.[64]

Resilience@law – the power of leaders as peers

A report published in 2009 by the Brain and Mind Research Institute, *Courting the Blues: Attitudes Towards Depression in Australian Law Students and Lawyers,* found that 41 per cent of law students reported symptoms of psychological distress severe enough to warrant clinical assessment.[65] Motivated by the opportunity to raise awareness about the issue, lawyers involved in the Resilience@law program, a collaboration among five big law firms (Allens Linklaters, Ashurst, Clayton Utz, Herbert Smith Freehills and King & Wood Mallesons) and the College of Law, seek to give students the tools to foster wellbeing and the information to respond to risks to their mental health. In a DVD created for the program, lawyers, including senior partners, speak about their lived experience of mental illness.

The four objectives of Resilience@law are:

- awareness and education
- removing the stigma surrounding mental illness
- self-care strategies
- support and resources for mental health concerns.

The Commonwealth Government has provided guidance in its Australian Public Service (APS) Disability Employment Strategy. This aims to strengthen the APS's capacity as a progressive and sustainable employer of people with a disability and to improve the experience of people with a disability working in the APS. It includes resources on mental health and wellbeing for public sector workplaces.[66] The APS has also set up an Employment Assistance Fund to help with the cost of modifications and services in the workplace, including mental health awareness training.

While the Commonwealth has a lead responsibility for national policies and programs on work safety and employee rights, there are important steps to be taken at state level.

The NSW Public Service Commission is leading the implementation of significant reforms in accordance with the *Government Sector Employment Act 2013*. These reforms include making the head of a government agency responsible for workforce diversity in that agency and ensuring that diversity is integrated in its planning.

These measures will ensure that workforce diversity objectives and initiatives are set in the agencies' mainstream strategies. The arrangements allow agencies to advertise specifically for candidates from particular groups, such as people with a disability. Public service heads will be able to appoint people to non-executive roles using this mechanism and to run targeted employment programs.

The Public Service Commission is also developing a workforce diversity framework, to ensure the public sector reflects the diversity of the wider community. Improving employment outcomes for people with a disability, including those with mental illness, is a priority.

The People Matter Employee Survey is conducted by the Public Service Commission every two years and includes questions about employee perceptions of their workplace wellbeing. The NSW Government employs more than 390,000 people – about 11 per cent of the employed population. The survey can be used to identify trends at sector-wide, cluster and agency levels.

In 2012, more than 60,000 NSW public sector employees responded to the survey and 6.5 per cent identified themselves as having a disability.[67] Although we know that about 20 per cent of all people experience an episode of mental illness in a 12-month period[68], the survey does not capture this because many people with mental illness would rightly not identify their condition as a disability, particularly when it is transient or episodic. This is likely to mean that many employers do not realise the extent of mental illness among their employees and may not be doing all they can to respond appropriately.

Mental health training for Fire and Rescue NSW managers

The Black Dog Institute and the University of NSW Workplace Mental Health Team are evaluating the effectiveness of a new training program in mental health literacy for managers in the metropolitan operations of Fire and Rescue NSW. The Black Dog Institute will deliver the training and the university researchers will evaluate the program. The program combines teaching about mental illness with practical advice about how to speak to and help those who may be experiencing mental distress. The study will evaluate the effectiveness of the program in increasing mental health literacy, reducing stigma regarding mental illness, and increasing managers' confidence and skills in having difficult conversations. It will also investigate the impact of the training on sickness absence among staff. The study is part of a funded collaboration between Employers Mutual, a workers' compensation insurer, and Fire and Rescue NSW.

The right to work and to be well at work

Many of us spend most of our waking life in our workplaces. Much of our identity and many of our life experiences are connected with work. Work environments are major determinants of health and wellbeing. The cultures, practices, programs and policies of all our workplaces should reflect this and the concept that we all have the right to work and be well at work.

Ensuring that workplaces promote mental health and wellbeing has the potential to generate benefits, including economic ones, for individuals, government, business and the community as a whole.

The 2012 Commonwealth report *Work Wanted: Mental Health and Workforce Participation*[69] recommended facilitating leadership advocacy among employers and industries, creating a platform for the recognition of success, supporting the development and sharing of best practice and the development of national frameworks and standards for promoting mental health and wellbeing.

Elsewhere in this Plan, p. 100, we propose that front-line services develop a peer workforce of people with lived experience of mental illness. The employment of peer workers has great potential to shift organisational culture in relation to mental illness – and improve service delivery.

Actions

3.5.1 Explore the potential to reduce stigma in the workplace by developing a network of ambassadors who work at various levels across a range of agencies and industries and have a lived experience of mental illness.

3.5.2 Support the recruitment and retention of people who experience mental illness including:

- Commonwealth-funded programs that provide tailored advice and support to managers and employees where an employee requires support to gain or retain employment
- Resources that provide advice to public sector agencies about workplace adjustments and other considerations for managing employees who experience mental illness.

3.5.3 Ensure that public sector reforms increase workforce participation among people with a mental illness through explicit consideration of this population in agency workforce planning. This planning should ensure agencies are equipped to sensitively and appropriately manage employees who experience transient periods of mental illness.

3.5.4 Improve the collection of data that relates specifically to employees who experience mental illness. This should include efforts to increase self-reporting among employees who experience transient, episodic or continuing mental illness. The Public Service Commission's People Matter Employee Survey is one example of how this might be done.

3.5.5 Ensure that agencies that provide services to people who experience mental illness, whether directly or through the community-managed sector, respond to the individual aspirations of clients living with a mental illness for education, training and employment, including through referral to Commonwealth-funded employment services.

3.5.6 Develop a better understanding of the economic impact on NSW associated with mental illness in the workplace (including absenteeism and presenteeism) and under-employment.

4. PUTTING PEOPLE FIRST

4.1 Families and carers

All facets of the mental health system must be guided by the needs, priorities and lived experience of those with mental illness. This includes the needs and interests of their families and carers, provided those relationships do not hinder the person's recovery or cause further traumatisation. This section is about the vital roles families and carers can and do play, but it is important first to recognise some distinctions between the two roles.

A carer is a person of any age who provides unpaid care and support to a relative or friend who has a disability (including a mental illness), a chronic health condition, a terminal illness, a drug or alcohol problem or who is elderly and frail. A carer can be a parent, spouse or partner, a child, a brother, sister or other relative, or a friend. The value of this underlying relationship should not in any way be diminished when they assume the role of carer. Some carers provide care a few hours a week, some occasionally, and some all day, every day.

Family members may be carers, but not always. Family members who are not carers nonetheless often have important relationships with the person with mental illness. As such, their role in promoting the person's recovery, resilience and wellbeing needs to be valued and considered in the provision and design of services.

There were an estimated 857,200 carers in NSW in 2012.[70] Data to specifically identify the number of mental health carers is not collected. But in its 2009 report *Adversity to Advocacy: The Lives and Hopes of Mental Health Carers*, the Mental Health Council of Australia compared national data about carers of all types with the prevalence of mental illness and found that the number of mental health carers was likely to be "extremely large".[71]

Family members and carers are in a unique position to contribute to a person's recovery. They can support people to live well in the community and enhance the effectiveness of service delivery. This helps to decrease the risk of episodes of acute illness and the need for hospital admissions. There is much to be gained from listening to the concerns of families and carers, and ensuring they also get the support they need. They are, in many ways, the backbone of community mental health support.

Extensive consultation

The NSW Mental Health Commission has consulted extensively with families and carers of people with mental illness. Unsurprisingly, they want the best care at the right time for the people they love, live with and/or care for. They also report a number of challenges to this goal:

- difficulty navigating the mental health system and accessing appropriate services
- being excluded from assessments, treatment and discharge planning.

Family members who are not carers report that they want more information about mental illness so they can understand what their family member is experiencing. They also want support to manage the effects of mental illness on family relationships.

Carers need care and support themselves. We know that:

- carers and their families experience high rates of mental health problems, significantly worse mental health and vitality, and higher rates of depression than the general population[72]
- carers are more likely to be in poor physical health than the general population[73]
- many carers cease working once they become a carer because of the responsibilities the role entails and a large number of these carers want to be in paid employment[74]
- more than a third of carers who are employed are concerned about losing their job[75]
- almost half of carers' families do not use support services.[76]

Recognising rights

We have come a long way towards recognising the contribution of carers and further reform is under way through the NSW and Commonwealth Carer Recognition acts, the National Carer Strategy[77] and the revised National Standards for Mental Health Services[78] which recognise the rights of carers to participate in the care and planning for those they support and the importance of protecting carers' individual needs.

The NSW Department of Family and Community Services is developing a NSW Carers Strategy which will strengthen the role carers play and better support the work they do. But it must also recognise the value of mental health carers in supporting the recovery of those who experience mental illness and the need for services within the community that support the wellbeing of these carers. There are significant social, emotional and economic costs associated with caring for a person with a mental illness, and we need a range of responses to address them.

Considered planning

The needs of mental health carers must become an essential, specified part of formal planning for mental health services. Failing to do so means we overlook or fail to address carers' needs. This in turn leads to poorer mental health and wellbeing for families and carers, which has an adverse impact on the supports available to consumers to live well in their community.

An effective system of mental health care must value the myriad ways families and carers contribute to the recovery of consumers – and it must also care for carers.

Actions

4.1.1 Consistent with the requirements of the *NSW Carers (Recognition) Act 2010*, embed the principles of the NSW Government's Carers Charter in policy, service design and care delivery and, for public sector agencies, report annually on compliance with the Act.

4.1.2 Ensure that workers have clear guidance on legislative and policy arrangements for information sharing with families and carers, and that they can work confidently within those arrangements. The appropriateness of families and carers being provided with information about the consumer will vary depending on the circumstances and, at times, may be as simple as knowing that the person they care for is safe.

4.1.3 Define the intervention points – such as hospital discharge planning or a change in a person's housing situation – at which a person's carer and family circumstances and preferences must be considered.

4.1.4 Ensure that in assessing a person's family and carer circumstances, advice is always provided about where to find more information and support for family members and carers, and that where required, assistance is provided in accessing these. This will include access to respite care, Centrelink benefits and return-to-work programs for carers, and information and advice on family and carer support groups.

4.1.5 Assess client data collections to ensure that information on family and carers is being captured and that, where appropriate, regular assessments of circumstances and need are undertaken.

4.2 Engaging consumers and carers in service design

If a business wants its product or service to succeed, it must first find out what its customers want and need. Government agencies, including NSW Health, the Department of Family and Community Services, the Department of Education and Communities and the Department of Justice provide services to people with mental illness, their carers and families. While some progress has been made in strengthening customer focus this remains under-developed and at times tokenistic.

The people who use government and associated services must be closely and actively involved with the improvement of those services – and with the design and delivery of future services. This is much more than a pleasant, inclusive idea. A substantial and growing body of evidence shows that services designed in collaboration with those who use them are more efficient and less expensive.

The benefits of designing services in collaboration with consumers and carers, whether housing, health or other human services, include:

- services become more relevant, accessible to and appropriate for consumers
- services become more accountable
- services and staff develop a better understanding of mental illness and of working towards recovery
- staff experience greater job satisfaction
- consumers and carers have their expertise in mental health issues acknowledged. As the staff with whom they work improve their skills and knowledge, so too do consumers and carers. This can also lead to future employment opportunities
- consumers are more likely to have better mental health outcomes.[79]

The path to full participation

At present, a range of barriers prevents consumers and carers participating fully in the design and delivery of the services they use. These include lack of status and power, geographic isolation and stigma. The biggest barrier may be the absence of formal systems that enable service co-design.

There are also challenges in the equality of access to participation. Different communities have different needs and capacities and formal arrangements for consumers, carers and families to participate need to be flexible and inclusive. Aboriginal people, lesbian, gay, bisexual, transgender and intersex people, people from culturally and linguistically diverse backgrounds, the young, the elderly, and people who live in rural and remote areas all have a right to participate in service and policy improvements and design. Effective ways to engage everyone need to be found, such as those offered through co-design.

The National Standards for Mental Health Services set out an expectation that each service will involve consumers in the planning, implementation and evaluation of its services.[80] The *National Mental Health Report 2013* found 55 per cent of services involved consumers and carers at a high level and 25 per cent had no structural arrangements for consumer and carer participation.[81] However, further work is required to meet this expectation, not only in health services but among all service providers.

Actions

4.2.1 Ensure that the development and evaluation of policies, services and programs include the participation of consumers and carers and that supports are provided so that participation is meaningful, including through remuneration for time and costs and participant training.

4.2.2 Agencies should identify multiple ways in which consumers and carers can influence policy, services and programs.

4.2.3 In recognising the challenges presented by power and status imbalances among consumers, carers, service providers and policymakers, agencies should routinely evaluate their efforts to achieve the meaningful participation of consumers and carers. This includes ensuring that the numbers of consumers and carers is sufficient to give full voice to their views.

4.2.4 Beyond the work of individual agencies, cross-agency collaborations, such as those described in *Strengthening local action*, p. 17, must foster and model the participation of consumers and carers.

4.3 Recovery-informed legislation and policy

Putting people, not processes, at the heart of service delivery goes beyond service design and practices. Legislation and policy need to support the autonomy of the individual receiving care and their journey towards recovery. Unfortunately, development processes for legislation and policy can create barriers to recovery. This requires urgent change.

The development of legislation and policy is undertaken by individual NSW Government agencies. While consultation processes engage other stakeholders and areas of government, the voices of people living with mental illness are easily lost. This is exacerbated by the historical disempowerment of this group, with outdated views about mental illness having influenced the development of government legislation and policy and limited the extent to which people with mental illness have been involved in the formal processes of review.

To support the reform priorities of this Plan, it is critical that government ensures future processes explicitly consider the effect legislation and policy will have on the mental health and wellbeing of the people of NSW. Relevant existing legislation and policies need to be similarly assessed. This extends across government agencies to include areas such as education, housing, disability, child protection and justice as well as the health sector.

In mental health legislation and policy, there is a need to look ahead to the sort of framework that will best support the person-centred, community-based services of the future. While the *Mental Health Act 2007* was reviewed only recently, it has not been possible to address some of the issues raised during the consultations. This is because the community-based services needed to achieve a truly person-centred system are not yet available to support more innovative legislation.

The practice of transporting people to mental health facilities when involuntary assessment is required is only one example of this. People living with mental illness, carers, police and health professionals, particularly in rural and regional NSW, have expressed great concern about this practice, in which people experiencing mental illness are transported away from their communities, often over long distances, and often in a police car.

But the Mental Health Act authorises only a limited number of designated hospital and community facilities to treat involuntary patients, and this restriction – combined with a lack of community-based alternatives – means improved practices have not been proposed.

With the implementation of the reforms set out in this Plan, it would be expected that an individual experiencing mental illness could be assessed in a warm, safe place in their community and offered an alternative to admission so that they would be taken to hospital only as a last resort.

We will need a flexible legislative and policy framework to support the changes in service capacity we expect during the coming decade.

Actions

4.3.1 All NSW government agencies should:

- develop a mechanism to include Mental Health and Wellbeing Impact Assessments in the development or review of policy and legislation (see *Building community resilience and wellbeing*, p. 25)
- review existing policies and legislation to assess the extent to which they are consistent with the aims of this Plan.

The NSW Mental Health Commission will review progress on the above in the third year of the Plan.

4.3.2 In anticipation of the development of mental health services in accordance with the principles set out in this Plan, the NSW Government should work towards addressing the following issues in mental health legislation:

- mirroring the human rights provisions of the Disability Inclusion Bill 2014
- strengthening the recognition of the principles of recovery at all stages of a person's journey through the mental health system, including when subject to mental health legislation
- exploring the potential to focus on people rather than places
- better reflecting the cultural and spiritual needs of Aboriginal people
- better addressing the sometimes conflicting needs of people with lived experience of mental illness and their carers.

4.4 Build the capacity of services to respond therapeutically

Despite the prevalence of mental illness in NSW, consumers and carers report that community, social and health services often don't respond well to the needs of people with a lived experience of mental illness and trauma.

Some agencies and services are unable to identify the extent of mental illness in the communities they serve and how mental illness contributes to people's need for support, which means they cannot determine staff training requirements.

People with a lived experience of mental illness and trauma, and their carers and family, often find the complex service system difficult to navigate and are likely to require additional support to do so successfully. Without appropriate training, front-line staff are unlikely to be able to meet this need. Difficult encounters with service providers may be traumatic for people who live with mental illness and, as a result, they may avoid further interactions and risk not getting the support they need.

The physical environment in which these interactions occur can also be a significant barrier. Glass partitions and 'cold' settings inhibit the development of rapport between agency staff and consumers. This can be seen even in the design of modern mental health facilities with nursing stations looking out on patient areas from behind glass partitions, creating a 'fishbowl' effect. Many consumers and carers express concern about the dynamic this creates, including the feeling of being 'imprisoned' and that the facility must be a dangerous place if nurses have to be kept safe behind glass walls.

Responding to trauma

Trauma can occur at any age and its effects can be long lasting. Trauma can be the result of a single incident such as a natural disaster, an accident, a physical or sexual assault, grief or loss. However, as evident in the Royal Commission into Institutional Responses to Child Sexual Abuse, trauma can also be the result of a continuing series of incidents. The cumulative and compounding effect of multiple traumatic incidents can affect all aspects of a person's functioning. The more severe and prolonged the trauma, the more severe the psychological and physical health consequences.

Trauma and its effects are often unrecognised or misdiagnosed. Many trauma survivors do not connect their current problems and behaviours with past traumatic experiences – and nor do those who provide services. Even when trauma is identified, many generalist services do not have access to suitable expertise to give the person the support they need. There are very few specialist services to refer people to, particularly in rural and regional areas. The resulting disconnection between the services available and the individual's needs risks re-traumatisation leading to the escalation and entrenchment of mental health issues.

We need a service system that understands trauma and responds appropriately. Such a system would focus on ensuring services do not re-traumatise or blame people for their efforts to manage their traumatic reactions but understand a person's behaviour in the context of their life experiences and attempts to cope.

Better awareness, better responses

Services are becoming more aware of the gaps in their understanding of clients but the steps taken to address this, while laudable, are not sufficient for the scale and complexity of the issue. For example, Housing NSW has recognised that in the past 30 years there has been a large shift in the demographics of people in social housing from low-income working families to significant numbers of people living with a disability.[82]

However, the way in which services are provided has not changed to accommodate the therapeutic needs of clients. Housing NSW is now reviewing how it trains front-line staff in public housing, community housing and specialist homelessness services in working with people with mental health issues. Better integrating the front-line services of Housing NSW and the Department of Family and Community Services would enhance the latter's capacity to respond.

Improving Family and Community Services responses

At least 225,000 people who receive support from the NSW Department of Family and Community Services (FaCS) have either experienced mental illness or are affected by a family member's mental illness, according to a recent study conducted by the agency with PricewaterhouseCoopers.[83] This is 31 per cent of all FaCS clients and providing services to this group costs $1.8 billion, or 42 per cent, of FaCS expenditure. The average cost of providing a service to a FaCS client who has mental illness is 1.7 times that of helping a client without mental illness. Among FaCS clients, 19 per cent of those who have a mental illness use more than two services, compared with 6 per cent among those who do not have a mental illness. They also use more crisis services and fewer long-term support services. This data demonstrates a need for FaCS staff to be supported in responding to clients with a mental illness.

A further example of efforts to address these issues is the mental health training program of the NSW Police. It was initially developed as a four-day program to train specialist Mental Health Intervention Officers to identify and respond appropriately to people experiencing a mental health crisis. This is now supplemented by a practical one-day mental health awareness course for all front-line officers to give equip them the skills to interact better with people living with mental illness. The goal is to train 10 per cent of operational police by the end of 2015. This training is essential as police are often the first responders to a situation involving someone with a mental illness.

There is an opportunity to provide similar training throughout the public sector not only through front-line training, but within the broader program of professional development.

For example, the Australian Professional Standards for Teachers require teachers to demonstrate knowledge and skills acquired from professional practice and continued professional learning to be accredited to a particular standard, from graduate teacher to professional leadership. Registered professional development courses on student mental health and wellbeing could be offered to schools, and/or the Department of Education and Communities could require all teaching staff to complete such courses.

Centrelink and the federal departments of education, employment and social services also offer mental health awareness training for front-line staff. The Commonwealth Ombudsman has recognised that staff generally do a good job but in 2010[84] made several recommendations to agencies, including about developing continuing communication strategies for some clients and ensuring people are not financially disadvantaged if their mental illness prevents them following the best course of action.

Work such as this can and should be informed by recovery and trauma-informed practice. The National Framework for Recovery-Oriented Mental Health Services draws heavily on the experience of those who live with mental illness, provides an overview of the concept of recovery and sets out the principles for recovery-oriented practice. While developed for the mental health service system, the concepts and broad principles are equally applicable to services that have frequent contact with people who experience mental illness. As will be discussed in *Peer workforce*, p. 100, establishing a peer workforce within an organisation has the potential to change culture and improve service delivery.

Improving service delivery

All government agencies and community-managed organisations that serve the public need to know what proportion of their clients have a mental illness, and how those people are affected by the ways in which services are delivered. A commitment to improving the service offered by front-line staff could make services more accessible and easier to navigate for consumers and carers and has the potential to make a real difference in the lives of people with mental illness.

Agencies must be determined to respond whenever a person reaches out for help, recognising that seeking support may be difficult, and may not happen again. This will require service providers to plan how to assist those whom they cannot support directly to obtain the right information and care and to help people to navigate those pathways.

Actions

4.4.1 Strengthen the responsiveness of services to people who experience mental illness and their families and carers through a 'no wrong door' approach to services. For all services, this involves a new determination to support those seeking assistance to find the right entry point for the services they need, even if not provided by that agency itself.

4.4.2 Ensure that suitable, basic training in mental health literacy is available and promoted to all public sector employees who provide services directly to the public (such as nurses and counter staff of public services), or whose work involves making decisions related to people's welfare, such as human services assessment officers and members of the judiciary).

4.4.3 Ensure that tailored training is provided to public sector employees whose work requires more frequent or specialist contact with people who experience mental illness, including housing, drug and alcohol, community services and emergency services workers. This includes mental health first aid training as well as training that supports therapeutic approaches in settings such as housing and justice or recovery-oriented and trauma-informed responses among emergency services personnel.

4.4.4 Explore the opportunities to better integrate the front-line service response of FaCS agencies.

4.4.5 Implement the National Framework for Recovery-Oriented Mental Health Services in Local Health Districts and community-managed sector mental health services.

4.4.6 Explore the potential to create more therapeutic environments for the delivery of services where there is frequent or specialist contact with people who experience mental illness, including in the design of new facilities and those being refurbished.

5. PROVIDING THE RIGHT TYPE OF CARE

5.1 Shift to community

Hospital-based mental health care, including acute and crisis care, is one part of a good mental health system, but it should be accessed only when community-based support is not feasible. This approach is consistent with our human rights obligations and our NSW 2021 goal of keeping people out of hospital and well in the community. It also makes good economic sense in terms of having a sustainable health system. But we have a long way to go to achieve this.

NSW remains overly reliant on hospitals in the delivery of mental health care, spending less per capita on community mental health care than any other state or territory.[85] While funding for community mental health care in NSW has increased, most mental health sector spending occurs in expensive acute hospital settings.

In 2011-2012, almost 54 per cent of the NSW Government's mental health budget was spent on inpatient services in public psychiatric and acute hospitals. Only 36 per cent was spent on community mental health care and hospital-based ambulatory care settings. Less than 1 per cent was spent on specialised community residential services such as crisis and respite places, community residential units and tenured housing.[86]

Similarly, there has been limited investment in psychosocial rehabilitation and support services often provided by the community-managed sector, with NSW having the lowest rate of expenditure (6 per cent) of any state on non-government organisations.

The failure to fund and develop community-based services has meant consumers and their families and carers have had limited access to services that would enable people with severe mental illness to live well in their community. This creates a revolving door for consumers. Because there is inadequate care in the community, people are readmitted to hospital. For the mental health system, it creates a vicious circle: the lack of care in the community increases pressure for expensive inpatient mental health care, which draws more money from community-based services.

The present situation often leads to people being 'lost' to follow-up care in the community after a hospital admission. This can result in tragedy as seen all too commonly in the stories of those who become forensic patients and those who complete suicide after discharge.

Another perversity is that for those who do need hospital care, the pressure on the system is so great that they receive suboptimal care in quality and duration.

The impact of this system is felt well beyond the individual and their family and carers, and beyond the health system. Failure to provide adequate mental health support in the community leads to crisis and difficulties maintaining continuity of services for those in need that directly impacts on other government agencies and the broader community. Police, ambulance, housing and community services can all attest to the cost of dealing with immediate crisis and the high transaction costs of connecting and reconnecting with a person whose life is regularly disrupted because of inadequate mental health support in the community. Furthermore, even with the best will in the world, in the absence of a strong community mental health service there is nothing for these other government agencies to connect to or partner with.

A rational approach to mental health care in NSW requires that we recognise and interrupt these cycles. Many of those receiving care in hospitals would recover better in community settings. We should admit people to hospital only because they need specialist, inpatient care and support. Admission to hospital should never occur because we have failed to make more effective care available in the community.

The hospital is too often the front door for mental health services. We must urgently make hospitals our last resort. Under this Plan, community-based care and support will become the locus of the mental health system. This is not a new or radical idea and it is fully consistent with the goals of NSW 2021, but we have failed to deliver it. To make a successful transition to a community-centred mental health system, we must break from the gravitational pull of the hospital system.

A better community-based system

An effective community system wraps services and support around people living with severe mental illness. This includes mobile treatment and crisis resolution teams and whole-of-person support services with a variety of residential alternatives to hospital. An effective community system also requires strong integration and partnership among clinicians in hospitals and in the community, such as general practitioners, private psychiatrists and other care providers. These partnerships support community clinicians, and GPs in particular, by giving them access to specialist advice. This focus on community and partnership allows the Local Health Districts (LHDs) to make the best use of scarce specialist clinical resources and over time will greatly reduce the demand for hospital admissions.

Under the reforms in this Plan, LHD boards will need to make a clear choice about how to revitalise and build their community mental health system. One option will be for the LHD to retain its community mental health services 'in house'. But this means boards will need to examine why such approaches have not realised their potential to date. Boards may also embark on more sophisticated and extensive partnerships with the community-managed sector. Or they may embark on public-private models, competitively tendering their community mental health services to private sector providers. Or they may do a mixture of both.

Whatever option is taken, Local Health Districts are responsible under the *Health Services Act 1997* for providing care and treatment to sick and injured people and for the promotion, protection and maintenance of the health of the community.

In the context of the shift to community and contracting out of services, it will be important that any existing service provided directly by the LHDs is not switched off until there is a sustainable alternative. This could be particularly difficult where community-based services depend upon non-recurrent Commonwealth funding – such as for the National Perinatal Depression Initiative for early detection of antenatal and postnatal depression. This was initially funded from 2008 until 2013 and subsequently extended, but without any guarantee about its longer term future.

There are exciting community-based initiatives that we can learn from, such as Tupu Ake in Papatoetoe, New Zealand. It is a peer-led acute service for people struggling with mental illness in the community and provides a real alternative to hospital admission.

The NSW Government has already laid the groundwork for more extensive partnerships with the community-managed sector. NSW Health's Grants Management Improvement Program will reform the

purchasing of existing community-managed activity and, under modernised contracting arrangements, open up avenues for community-managed organisations to tender for a wider range of services.[87] The reforms include a transition from a system based on grants allocation to one that uses contracts to better align the activities of community-managed organisations with NSW Health priorities and allow closer performance monitoring.

The NSW Health reforms explicitly seek opportunities for services delivered in the public sector to be devolved to the community-managed sector, including the full range of clinical and non-clinical community mental health services.

As government moves towards efficient and high quality services through contracting models, it will be important to ensure the capacity for innovation is not lost. This could happen in particular if the community-managed sector, which has been a source of innovation, becomes entirely responsive to contract specifications.

Commitment, resources and collaboration

Developing a contemporary, community-focused, integrated mental health care system will require commitment, human and financial resources, and co-operation and collaboration at the community and state level. We need to strive for a mental health care system that directs energy and resources towards services outside the hospital, delivered close to home. It needs to place greater emphasis on providing support that helps people remain in their communities and avoid hospitalisation.

To achieve meaningful psychosocial rehabilitation in the community, the community mental health service must include step-up and step-down care as an alternative to inpatient admission or to provide support after an acute episode of illness. This will allow hospital services to support community-based care with accessible and responsive service for acute-phase needs requiring hospital stabilisation and care. In turn, community-based care will support hospital services to achieve the best use of their limited beds and scarce specialist clinical resources.

These refocused efforts will result in the better provision of mental health care and will help those with serious mental health problems to participate more fully in community life. A reconfigured mental health system will divert patients from expensive inpatient treatment to less expensive community care and catch mental health problems before they reach a crisis stage. This will increase capacity in the hospital system to meet unmet demand in areas such as eating disorders or specialist care for the young and the elderly.

Essential elements of community mental health

With shared Commonwealth and state responsibility for health services, the delivery of a good community mental health system involves some complexity in achieving a balance.

While mental health service provision operates in a policy-rich environment at both NSW and Commonwealth levels, we lack a clear articulation of what a community mental health system should look like. To start to address this gap, the NSW Mental Health Commission has begun work with NSW Health on an essential care components framework that outlines the necessary elements of community-based mental health care. This will aim to define a 24-hour, locally based, co-ordinated and seamless community mental health system comprising primary care and specialised community-based mental health services. Such a system would reduce the need for hospital admissions and readmissions by allowing people to seek support earlier.

Given the challenges inherent in a state the size of NSW, we cannot provide the same level of services everywhere. But we need to know what is required in order to find innovative ways to meet the need. For community-based care to be effective, we must ensure:

- easy access and availability of services
- co-ordination and continuity of care
- early detection and intervention
- evidence-based medical and psychological treatments
- safety and risk management
- acute and emergency interventions
- rehabilitation approaches that support social inclusion
- opportunities for learning, employment, housing and social relationships.

Actions

5.1.1 Rebalance our mental health investment to transform NSW from the lowest spending to the highest spending Australian jurisdiction, per capita, on community mental health by 2017. This will involve:

- The NSW Ministry of Health directing all mental health growth funding to community mental health.
- The NSW Ministry of Health using its service agreements with Local Health Districts to purchase greater community activity volumes to rebalance existing investments.
- Local Health Districts adjusting the mix of local services to achieve the rebalancing required and reporting regularly on activity levels and against service performance measures established with the NSW Ministry of Health
- Local Health Districts forging new partnerships with community-managed organisations and/or the private sector to: coordinate mental health care in the community; leverage and integrate with general practice, and private psychiatry and psychology; and explore opportunities for new models and service arrangements that offer efficiencies and meet the needs of people with mental illness and their families and carers.
- The NSW Ministry of Health providing leadership to the reforms through the articulation of a new framework for a contemporary NSW community mental health system, underpinned by recovery-oriented values.
- Supporting the development of innovative community-based alternatives to hospital admissions. This could include the use of social benefit bonds and other mechanisms.

5.1.2 Local Health Districts will work with the National Disability Insurance Agency to ensure that eligible people with a psychosocial disability obtain packages under the National Disability Insurance Scheme.

5.2 De-institutionalisation

In the 19th and the early 20th centuries, 'asylums' were the main place of care for people with severe mental illness. These institutions isolated people with mental illness from the outside world, subjected them to dehumanising, prison-like routines and stripped them of any identity beyond that of psychiatric inpatient.[88]

Now the detrimental effects of institutionalisation are well recognised. As the World Health Organisation stated more than a decade ago: "Community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders. Shifting patients from mental hospitals to care in the community is also cost effective and respects human rights".[89]

In 1983, David Richmond led the NSW Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled. That inquiry recommended that a gradual process of de-institutionalisation begin in NSW. Long-stay psychiatric hospitals were to be gradually reduced in size and replaced by "a system of integrated community-based networks, backed up by specialist hospital or other services as required".[90] However, while some long-stay psychiatric units were subsequently closed, the community-based networks have not been fully developed.

Long-term institutionalisation is a continuing practice. In February 2014[91], there were 2337 mental health inpatients in the NSW public health system and a quarter of them, or 566 people, had been in hospital for more than a year. About 87 per cent of these long-stay patients were accommodated in older, stand-alone psychiatric institutions known as Schedule 5 hospitals. In its response to the 2012 report by the NSW Ombudsman, *Denial of rights: the need to improve accommodation and support for people with psychiatric disability*[92], the NSW Government has already committed to resolving the systemic issues leading to these circumstances, and to developing appropriate care plans to support these individuals' transition into the community. But there is still a long way to go and the process of de-institutionalisation must address the community-based support services needed by each individual.

Into the community

With the right community-based support, including that offered under the National Disability Insurance Scheme, the vast majority of long-stay patients in NSW will be able to return to live in the community. Some will require supported, community-based accommodation, such as that offered under the Housing and Accommodation Support Initiative. A minority will require long-stay care in a safe, supported environment, outside an institutional setting.

If this is to be done effectively, government will need to consider transition funding to allow the timely provision of community-based alternatives. This funding would be recouped in the medium term from recurrent funding now going into Schedule 5 hospitals and long-stay beds. If any recurrent savings come from the closures, they must be used to expand community-based mental health services. If this does not occur, we risk repeating the mistakes of the past where much of the money disappeared out of mental health.

Similarly, if it is necessary to develop purpose-built accommodation as part of the move to the community, funding would be required for that. In the longer term this should be recouped as noted below from the realisation of the existing sites.

The mental health workforce also needs to be considered in the closure of these institutions. Staff may be displaced and we can't afford to lose their expertise. For those who choose to move to community-based services, NSW Health will need to ensure they have access to the training and transitional support required to work in the community-based mental health sector of the future.

Reinvesting in mental health

The question of what happens to the sites of the remaining Schedule 5 hospitals, once they are no longer required, is important. These institutions represent a misguided investment in mental health but an investment nonetheless. They were places of great suffering for people with mental illness. Much of this suffering is recent and many in our community remain traumatised by their experiences. There is therefore a strong moral argument for the Government to ensure that any funds raised from their sale or re-use are used solely to address the substantial remaining need for community-based alternatives to hospitalisation, including for those in our community who require continuing care after their experiences of these institutions. This would not preclude some re-use for appropriate commemoration of the history of the sites.

The Schedule 5 hospital sites remaining in NSW include Gladesville, Kenmore (54 beds), Morisset (130 beds), Macquarie (195 beds), Cumberland (261 beds) and Bloomfield at Orange (235 beds). Not all these beds can be lost to the mental health system. For example, the capacity of the forensic units at Morisset and Cumberland would need to be replicated elsewhere if these sites were to be closed. In addition, these sites house services run by other areas of NSW Health (ranging from education to linen facilities) as well as other government and community-managed organisations. The re-location of these would need to be factored into any site closures.

The controversial closure of Rozelle Hospital, known as Callan Park, demonstrated that any decision about realising the economic value of a site needs to involve respectful engagement with people with lived experience of mental illness, families, carers, clinicians and the broader community. Ensuring total transparency about the use of any capital obtained through the sale or re-use of these sites will be required.

Actions

5.2.1 NSW Health, in partnership with the NSW Department of Family and Community Services, should complete the work of finding appropriate community accommodation and support for individuals still in long-stay psychiatric institutions by 2018. This work should consider the availability of community-based supports to be provided under the National Disability Insurance Scheme.

5.2.2 The recurrent funding which supports individuals in long-stay beds should, in the first instance, be used to provide the appropriate level of community-based or other support for those who are discharged. Any remaining funding should be redirected to expand community-based mental health services more generally.

5.2.3 Any planning process for the realisation of the value of the Schedule 5 hospital assets should:

- engage consumers, carers, clinical professionals and the local community in the decision making
- ensure, through a transparent mechanism, that the proceeds of any sale are fully directed to the development of mental health services in accordance with the reform priorities.

5.3 Addressing inequalities

We know that access to the NSW mental health system is not equitable. The pattern of service provision and access is uneven, with some areas apparently reasonably well served by services and staff while others miss out.

People living with mental illness can face significant issues when needing to travel to health services – sometimes because of symptoms associated with their illness and the side effects of medication. This is more difficult where public transport is limited or unavailable, such as in remote and rural areas.[93]

Others, including those with a mix of complex health problems, find major gaps in access to specialist services and that the system does not connect up all their care needs.

Many of these impediments are interrelated, which means people risk being channelled towards the wrong forms of care or receiving no care at all.

Responding to complexity

There are significant service gaps for:

- people in rural and remote NSW
- Aboriginal people
- young people
- people from culturally and linguistically diverse backgrounds
- lesbian, gay, bisexual, transgender and intersex people
- people with multiple issues, for example, when mental illness and intellectual disability affect each other.

There is a cluster of people with more complex problems, such as eating disorders, who cannot access specialist treatment services and the families of these people say lives are put at risk.[94]

Families that are poor or have children with other disabilities or health concerns have an especially difficult time getting services that would identify, prevent or treat mental health problems. And many people find it difficult to navigate an often complex health system.

Service systems should be able to respond to the needs of people of all ages but some groups are missing out. There is a lack of mental health services for children and adolescents – and a lack of mental health workers with special training to work with children. Children and young people, whose need for mental health care is greatest, have some of the lowest access to care. For example, only 13 per cent of young men with a mental illness get assistance.[95] Even among those who do receive care, many don't get the most suitable treatments at the most opportune time.

We also know that demand for services for older people is increasing rapidly – 2.8 per cent a year[96] – and we do not have the resources to meet this need.

In NSW, great effort has been put in over many years to develop models to guide the distribution and development of services in response to population need. Most recently, the NSW Ministry of Health has led work on the National Mental Health Services Planning Framework. While still in draft, this population-based

planning tool tells us that the distribution of beds across NSW is uneven with some Local Health Districts having high numbers of acute inpatient beds for their population, and others too few. We also know there are not enough beds for specific populations, including the young, elderly and those with particularly complex conditions such as eating disorders.[97] The framework identifies that the greatest gap overall is in community-based services.[98]

Is the system safe?

It is not appropriate or possible for uniform service provision to exist in every area or across all age groups. Nonetheless, we should strive for equality of access and quality.

One of the fastest ways to achieve equity is to close the gap between what we know and what we do, and to ensure a consistent approach in service delivery in all mental health services. However, there is evidence of considerable variation in clinical practice. Unchecked, it has the potential to reduce safety, quality, effectiveness and efficiency.

For instance, the seclusion rate for mental health in-patients in NSW hospitals is 6.9 episodes per 1000 bed days. This is the lowest rate since recording began in 2008.[99] However, the statistics exhibit high levels of variability among mental health units, which suggests that not all units are using contemporary good practice and there needs to be more focus on these 'hot spots'.

While policy, clinical standards and audits have a role in reducing clinical variation, engaging clinicians and information systems and data are the foundation for quality improvement.

The NSW Ministry of Health leads benchmarking initiatives for the public mental health system. Benchmarking provides an opportunity for public mental health services to examine data on their models of care, service usage and outcomes. The intent is to improve the experience and outcomes of care by using routinely collected information to understand variation, learn from services that are doing well and focus efforts on areas that require improvement.

The Agency for Clinical Innovation's specialty clinical networks engage clinicians and community members to design and support the implementation of models of care which spread best practice in the health system and meet the needs of consumers, and their carers and families. At the instigation of the NSW Mental Health Commission, a Mental Health Clinical Network is soon to be set up.

To improve access, we need an agreed range of service options, in the health and community support sectors. This means providing the right funding to the right places, as well as innovation in service delivery to ensure an appropriate mix of services. For the consumer, this means access to the services they need, when they need them. We can't simply say everyone has a universal entitlement to access to subsidised medical services under Medicare if people cannot realise that entitlement because there are no GPs in their community.

Strengthening our community mental health system and completing the process of de-institutionalisation will ease some of the pressures on inpatient services and allow existing resources to be refocused to better meet the needs of those missing out. This work should be informed by population-based planning frameworks that specify the mix and level of services required, along with resourcing targets to guide planning and service development based on evidence, such as those contained in the draft National Mental

Health Services Planning Framework. We also need mental health services to work together to achieve the most effective and efficient use of services, minimise duplication and streamline access.

Actions

5.3.1 Local Health Districts should implement strategies to ensure that scarce clinical skills are employed to best effect by maximising their face-to-face time with consumers. This could include employing more peer workers and utilising community-managed organisations to provide non-clinical services.

5.3.2 NSW Health should use the draft National Mental Health Services Planning Framework to determine the right level and mix of services to cater for needs at the local level and, over time, redistribute funding in accordance with need.

5.3.3 Local Health Districts should examine their pathways to care and ensure there is reliable and accessible information about these to assist people in navigating the mental health system.

5.3.4 Build on initiatives such as the Mental Health Emergency Care – Rural Access Program to ensure communities have access to the full range of services through improved technology and specialist mental health support of general health services. Community-based services should be provided with advice and support, through good consultation, liaison, and integration of care arrangements.

5.3.5 Consider the development of specialist tertiary referral and advice centres for the provision of care to people who experience serious mental illness, including psychosis, and the treatments for mental illness, such as electro-convulsive therapy.

5.3.6 Support initiatives to track and publicly report on clinical variation in NSW.

6. BETTER RESPONSES

6.1 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."

NSW Ministry of Health, 2014[100]

Mental illness and physical illness are typically addressed by different parts of the health system. This fragmented approach contributes to poorer physical health among people with mental illness. This is discussed further in *Physical health and mental health,* p. 69.

Fragmentation occurs across the sector with government, private and community-managed services failing to work together to support consumers. Many consumers struggle to understand and navigate the complex web of services they need and families with multiple challenges do not receive the co-ordinated assistance they require. GPs and community health professionals often do not have access to relevant information about the people they see, and public and private sector clinicians do not understand one another's priorities or ways of working. [101]

The good news is that there is universal support for integrated care within the health system. Integrated care is seen not only as important to improving the health of consumers – and helping them to recover from both physical and mental health problems – but as a way of reducing inefficiency and waste. Integration saves money.

Achieving truly integrated care that supports the mental and physical health and wellbeing of the people of NSW will require changes to a wide range of systems.

A number of factors contribute to the provision of good integrated care for people with mental health needs, including[102]:

- information-sharing systems
- shared protocols
- joint funding and commissioning
- co-located services
- multidisciplinary teams
- liaison services
- care navigators
- research
- reduction of stigma.

Positive initiatives

There are some good examples of Commonwealth and NSW initiatives that aim to achieve system integration. Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy takes a broad view of comprehensive primary health care. Recognising the growing importance and complexity of community-based care, this strategy acknowledges the need for better integration of primary health care with ambulatory, acute, aged and Aboriginal health services. It identifies five building blocks: regional integration; information and technology, including e-health, a skilled workforce, infrastructure and financing and system performance. These building blocks underpin the key directions of improving access and reducing inequity, better management of chronic conditions, increasing the focus on prevention and improving quality, safety, performance and accountability.[103]

At state level, NSW Health is piloting an integrated service model of community-based care and support for adults with mental health needs. Two sites are being developed with plans for a possible third site. The community mental health hub model of care is based on the principle that care is best provided by closely integrated teams of health care professionals that have the needs of the consumer as the primary focus of attention.

The service will bring together existing community health services in an accessible location, central to public transport, shopping and other facilities. Care and support will be provided across the four specific service streams of mental health, primary health, drug and alcohol and social needs, including linkages to employment and housing. Each pilot site will provide quality onsite services and have a commitment to reach out to individuals in need in their home and other community settings. To achieve this, it will be important to establish linkages or co-location with relevant services on all levels of government and to use communication technologies innovatively.

The community hub model will require services that might once have been located separately to be brought under one roof. This will enable health and social service professionals to work as an integrated care team and will help avoid duplication of effort.

More broadly, the HealthOne NSW program seeks to integrate care by bringing together GPs and community health and other health professionals in multidisciplinary teams, including pharmacists, public dental services, private allied health professionals, other government agencies and community-managed organisations.

The NSW Ministry of Health recently launched its Integrated Care Strategy 2014-2017.[104] Funding of $120 million will be allocated over four years to support local integrated care initiatives through a planning and innovation fund and statewide enablers such as Real Time Patient Feedback and the electronic health record system, Health*e*Net. Three Local Health Districts – Western NSW, Central Coast and Western Sydney – will become demonstrator sites. The proposals for each site include the integration of mental health services with other services.

As noted in *Strengthening local action,* p. 17, there are also major social and structural influences on health and wellbeing, such as education, unemployment, housing, poverty and discrimination. As such, a range of sectors beyond 'health' is central to the success of integrated care, including income support services, education, employment and housing supports. These matters are dealt with elsewhere in the Plan.

Actions

6.1.1 The NSW Ministry of Health will implement its Integrated Care Strategy 2014-2017 which provides:

- new funding for systems that support integrated care
- seed funding for innovative, local integrated-care initiatives
- contributions to the cost of demonstration sites.

6.1.2 Local Health Districts to pursue opportunities for better integration between mental health and primary care providers.

6.1.3 The Agency for Clinical Innovation, in partnership with the NSW Mental Health Commission and the NSW Ministry of Health, will establish a Mental Health Clinical Network and a Drug and Alcohol Clinical Network:

- The networks will bring together a wide range of clinicians, service providers and consumer and carer representatives, to improve care through innovation in clinical practice.
- The networks' focus will include the establishment of links with other clinical networks, including those concerned with chronic care, intellectual disability and endocrinology.

6.2 Physical health and mental health

The United Nations Convention on the Rights of Persons with Disabilities states that "persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability".[105] Yet it is widely known that people who experience serious mental illness are at higher risk of physical health problems, including heart disease and diabetes, than the general population.[106] [107] The risk for those with mental illnesses involving psychosis is even higher.[108] About 27 per cent of Australians with a mental illness that involves psychosis develop heart or circulatory conditions, compared with 16 per cent of the general population.[109]

The prevalence of other conditions, including kidney disease, asthma, stroke and chronic pain, is also notably higher among people who experience psychotic illnesses[110] and concerns have been raised about rates of hepatitis, HIV, anaemia, Parkinson's disease and injury among people with mental illness.[111]

There are also clear links between some of the more common mental illnesses, such as depression and anxiety, and poorer physical health. It has been found that 43 per cent of people with diabetes experience some form of psychological distress compared with 32 per cent of those who do not have diabetes.[112] Depression is a significant risk factor for heart disease[113] and screening for depression is recommended for those diagnosed with heart disease.[114]

Estimates of the effects of mental illness on life expectancy vary. A recent study examining mortality among people in contact with mental health services in Western Australia found that psychiatric disorders reduced the life expectancy of men by about 16 years and women by about 12.[115] Suicide is a leading cause of death in people with serious mental illness, followed by respiratory and heart disease.[116] [117]

Some of the key risk factors for poor physical health and reduced life expectancy are more prevalent among people with mental illness than among the general population.[118] In Australia between 35 and 40 per cent of adult smokers have a mental health disorder.[119] [120] Smoking is particularly prevalent among those with psychotic illnesses. Sixty-six per cent of people with psychosis smoke compared[121] with about 16 per cent of the general population.[122] The study, *People Living with Psychotic Illness in 2010: The Second Australian National Survey of Psychosis,* also found high rates of alcohol use or dependence. About 58 per cent of men and 39 per cent of women with psychotic illnesses had a lifetime history of alcohol abuse or dependence, whereas about 35 per cent of men and 14 per cent of women in the general population drink at harmful or dependent levels.[123]

Excessive weight gain and low levels of physical activity among people with mental illness are also concerning. About 45 per cent of participants in the 2010 survey were obese, compared with 21 per cent of the general population. Ninety-six per cent of those surveyed were classified as either sedentary or undertaking low levels of exercise. Lack of motivation, tiredness and pain or discomfort were the most commonly reported reasons.[124]

Weight gain is a common effect of some anti-psychotic medications and research has linked some of these to increased risk of diabetes.[125] Experts and researchers have recommended that doctors consider carefully the physical effects of anti-psychotic medications they prescribe and monitor patients closely.[126] [127]

Many consumers, carers and families are concerned about side effects associated with anti-psychotic medication and also prescribing practices, including polypharmacy where more than one antipsychotic is prescribed at a time.[128] The NSW Mental Health Commission has established a Pharmacotherapy in Mental Health advisory group to consider these and related issues.

The need to monitor, promote and support the physical health of people with mental illness is clear, but this is often overlooked or ignored.[129] [130]

Some good initiatives

Urgent action is required to improve the physical health and life expectancy of people with mental illness and to ensure the health system responds as it should to their physical ailments.[131] [132] [133]

In 2013 a national summit was held in Sydney, co-hosted by the NSW and Commonwealth ministers for mental health to address the premature death of people with mental illness. The summit noted that action would require not only engagement and participation among health disciplines and service providers but with other portfolios across government.

There have also been a number of recent initiatives in NSW. In 2013, for example, the NSW Government endorsed the HeAL – Healthy Active Lives – statement. It was developed by an international group led by NSW clinicians and comprising consumers, family members and researchers as well as clinicians from a range of disciplines. HeAL describes a series of principles, processes and interim goals to improve the physical health of young people who experience psychosis. Its five-year target is: "Any young person developing psychosis should expect their risks for future physical health complications (particularly obesity, premature cardiovascular disease and diabetes), when assessed two years after initial diagnosis, to be equivalent to their peers from a similar background who have not experienced psychosis."[134]

The Nutrition Standards for Consumers of Inpatient Mental Health Services in NSW developed by the NSW Agency for Clinical Innovation were also launched in 2013. These provide detailed guidance for the preparation of meals in all mental health units and facilities. The standards recognise that the needs of people undergoing inpatient care for mental illness may vary from those of the general hospital population. The poor physical health of people living with mental illness has been a central impetus for the development of the standards.[135]

Wider efforts towards the prevention of physical illness include the NSW Healthy Eating and Active Living Strategy: Preventing Overweight and Obesity in NSW 2013-2018.[136] It is crucial that such initiatives also address the needs of people with a lived experience of mental illness.

More must be done

Despite the excellent initiatives described above, we are clearly not doing all we can to meet the physical health needs of people with mental illness. The problem may be widely acknowledged but this needs to be matched by action, right across the health system.

GPs and primary care services clearly have a role to play here. GPs are well placed to monitor and support interventions aimed at the physical health of people with mental illness. They also have responsibility for addressing the mental health needs of people who present with physical illnesses. Medicare Locals have a

role in supporting GPs and in the co-ordination of care, and it is expected this role will continue under Primary Health Networks which will replace Medicare Locals in July 2015.

But this is not solely a primary care issue. Specialist mental health clinical services must also take responsibility for the holistic care of the people they support. Community-managed organisations also have a role in supporting the self-agency of people with mental illness and in delivering health promotion programs.

Partnerships among mental health and medical services, general practice and community organisations will be needed, and health system policy development and local service development will need to make room for integrated and shared-care programs.

Actions

6.2.1 Implement the HeAL declaration in NSW Local Health Districts to ensure physical health needs are prioritised from the first episode of psychosis.

6.2.2 Ensure all access points for people experiencing severe mental illness assume responsibility for facilitating physical health assessments and monitoring of physical health status.

6.2.3 Ensure that locally based mental health and wellbeing promotion activities developed under *Building community resilience and wellbeing,* p. 25, promote healthy and active lifestyles.

6.2.4 Ensure that the local co-ordination structures established under *Strengthening local action,* p. 17*,* include partnerships with local government and facilities such as gyms and swimming centres to facilitate referral and access to such facilities by people who experience mental illness.

6.2.5 Build connections with and learn from work in chronic disease prevention already under way in NSW and Australia.

6.2.6 Ensure that population health activities appropriately target people with a lived experience of mental illness, including interventions to address smoking, physical activity, nutrition and use of alcohol and other drugs.

6.2.7 Encourage and support GPs in a holistic approach to treat people with both mental and physical illness, including improved collaboration across general practice and specialist mental health and acute services. These mechanisms will need to consider issues such as appropriate access to information to support collaborative approaches.

6.2.8 Advocate for continuing professional development training for GPs in mental health to assist with early diagnosis, continuing training in emerging therapies, and opportunities for placements in mental health services.

6.3 Integrating mental health and drug and alcohol responses

Drug and alcohol problems, especially when they are more severe, frequently go hand in hand with mental illness. Among people who seek assistance from a drug and alcohol service, 90 per cent experience mental illness. Meanwhile, 71 per cent of people who receive support from a mental health service also have a difficulty with drug and alcohol use. These rates vary depending on the treatment setting, disorder, demographics and methods of assessment.[137]

Once mental health and drug and alcohol problems have become established, they can perpetuate and exacerbate each other. Drug and alcohol misuse makes it harder to recover from mental health problems. Conversely, mental distress makes dealing with a drug and alcohol problem more challenging. The presence of both may also complicate treatment, leading to the need for more intensive services – including hospital treatment – and poorer results.[138]

Cardiovascular disease, cancer and respiratory system disease are the most common causes of death among this population, with an average lifespan of 25 years less than the general population.[139]

Research evidence is showing with increasing clarity that people who have both mental health and drug and alcohol problems have often experienced trauma earlier in life. This may make it more difficult to treat and support them appropriately and their recovery may be inhibited as a result. A recent study of people receiving inpatient detoxification treatment indicated about 80 per cent had had at least one traumatic experience, with most experiencing multiple traumas. Almost 45 per cent had current post-traumatic stress disorder symptoms.[140]

Despite what we know about the intimate relationship between them, we continue to respond as if mental illness were separate from drug and alcohol misuse. Although the evidence shows clearly that an integrated approach can prevent further illness and improve the results of treatment and support, we have been inconsistent in taking up the opportunities this presents.

How we need to change

The National Comorbidity Initiative, which began in 2001, has laid the foundations for better integrated and co-ordinated approaches in research, treatment and clinical practice.[141] This has shown that mental health and drug and alcohol problems can be treated together successfully, and that programs that address multiple risky behaviours at the same time are more effective than those that respond separately and sequentially to different issues in a person's life.[142]

Other research shows that the onset of drug and alcohol misuse in adolescence is typically several years later than the recognised onset of mental health issues. This highlights the question of whether intervention at the point of recognition of mental health issues to reduce the risk of drug and alcohol misuse could reduce the incidence or severity of co-occurring mental health and drug and alcohol problem in early adulthood.

The potential benefits for individuals and for the whole of community are very large if we follow these and many other similar findings through to their logical conclusion, acting decisively to bring our mental health and drug and alcohol sectors closer together.

Centre of Research Excellence in Mental Health and Substance Use

Funded by the National Health and Medical Research Council, the Centre of Research Excellence in Mental Health and Substance Use aims to provide much-needed research capacity in mental health and substance use disorders, which account for more years of life lost due to disability than any other disorders. This centre is a world first, bringing together nationally and internationally recognised comorbidity researchers from four Australian universities – NSW, Newcastle, Sydney and Macquarie – and three international universities: Birmingham in Britain, the Northwestern University Medical School in the United States and the Medical University of South Carolina, also in the US.

The centre is generating research to increase knowledge about the prevention and treatment of comorbid mental health and substance use disorders. The centre's three research streams focus on the prevention, treatment and epidemiology of comorbid mental health and substance use disorders. It will translate its findings into educational curriculums, training programs, clinical resources and resources for the public.

An integrated mental health and drug and alcohol response will need to:

- acknowledge the benefits of drug and alcohol treatment and care earlier in life, particularly within families with mental health, trauma and drug and alcohol issues that create risks to children's safety
- address the eligibility, philosophical and language disparities between the mental health and drug and alcohol sectors and develop a shared understanding and vocabulary
- respond to critical transition periods when people are leaving mental health or drug and alcohol support programs or are released from jail
- share information to co-ordinate care.

A combined approach should also consider mental health and drug and alcohol issues broadly, within the context of programs that help people take control of their general health and wellbeing. This has the potential to reduce stigma associated with drug and alcohol problems. It is also more appealing to young people as it avoids prematurely focusing on mental health and drug and alcohol problems.

Things we need to consider

There is nothing easy about integrating drug and alcohol and mental health responses. Access to treatment and support are generally low for mental health and drug and alcohol problems. Studies suggest less than 20 per cent of people with a drug and alcohol problem seek help but those who are more severely affected are more likely to do so.[143]

Clinicians say there are substantial gaps between demand and capacity to provide services but the system has done little to quantify these gaps and therefore we have little information on which to base our response to them.

We need integrated treatment and care capacity within community mental health and drug and alcohol services. We need to provide assertive follow-up when people leave mental health or drug and alcohol support.

A pragmatic approach bases the level of co-ordination and integration on the severity of symptoms and the impact of each aspect.[144] This provides for a 'no wrong door' approach and offers the least intensive and most appropriate treatment in the setting first encountered by the consumer, for example advice and a brief intervention delivered by a GP, followed by more intensive support if warranted.[145]

This Plan seeks to accelerate efforts to better co-ordinate mental health and drug and alcohol services, to give better support to people – including families and carers – whose lives are affected by both issues.

Actions

6.3.1 Strengthen mental health and drug and alcohol health promotion through better alignment and integration with responses to other population health and healthy-lifestyles priorities, including tobacco, healthy weight, physical activity and sexual health.

6.3.2 Provide a 'no wrong door' approach in a wider range of agencies so that stepped care is more widely available to people with mental health and drug and alcohol issues. As well as specialist mental health and drug and alcohol services, this will include increased access points through general practice, social services, community health centres and community-managed organisations.

6.3.3 Strengthen the management of critical transition points between mental health and drug and alcohol care settings or after release from jail, including by increasing the accountability of services for assessment, planning and formal referral and support of people between services.

6.3.4 Recognise the philosophical and language differences between the mental health and drug and alcohol sectors and ensure services and care for people who experience mental illness and drug and alcohol issues are not compromised as a result of these differences.

6.3.5 Prioritise the workforce, information and other infrastructure requirements that will support a co-ordinated and integrated mental health and drug and alcohol response. This will include collaboration between the NSW Agency for Clinical Innovation's forthcoming Mental Health and Drug and Alcohol Clinical Networks.

6.4 Housing and homelessness

The right of a person who experiences mental illness to live, as much as possible, in the community is recognised within NSW[146] and internationally.[147] [148] Implicit in this is the importance of consumer preference and choice. People with mental illness have a right to live in safety and with stability, and to choose where they want to live, with whom, and the amount of support they require.[149]

Consultations and a survey undertaken in NSW in 2012 with mental health consumers and carers found accessing affordable housing was a major problem.[150] Many consumers on low incomes reported living in unstable and marginal housing such as boarding houses, backpacker accommodation, crisis accommodation, pubs and other forms of temporary housing. People also reported that obtaining public housing was difficult because of long waiting lists and the burden on individuals to "continually prove their needs and advocate for their 'case'".[151]

A 2006 study from the Law and Justice Foundation of NSW[152] found the prevalence of low incomes and reliance on social security payments among people with mental illness was a primary contributor to housing stress and the threat of homelessness. Low incomes and stigma and discrimination make it difficult for many with mental illness to find stable, safe accommodation and, as a consequence, there is intense demand for and reliance on social housing.[153]

We know there is a strong relationship between homelessness and mental illness. In 2011-2012, about 24 per cent of all Specialist Homelessness Service clients in Australia were experiencing a current mental health issue.[154] This problem is particularly felt by young people, and it is estimated that 50 to 75 per cent of homeless youth in Australia have some experience of mental illness.[155]

NSW has shown it can find innovative solutions to these issues with the Housing and Accommodation Support Initiative supporting people who experience mental illness to live independently and sustainably in the community in a range of tenure types. One of the initiative's main aims is to give people access to secure housing and support to maintain their tenancy. It is a proven model for homelessness prevention that merits expansion across new client groups.

A recent evaluation found about half of the Housing and Accommodation Support Initiative participants had access to secure accommodation at the time they were accepted into it. Ninety per cent have not ended a tenancy since joining it. Of those that ended theirs, 86 per cent were for planned reasons such as moving to more appropriate or other long-term housing.[156]

Many other NSW and Commonwealth government initiatives seek to address the housing needs of people who experience mental illness and the mental health needs of people who experience homelessness. These include the NSW Premier's Council on Homelessness, the NSW Aboriginal Housing and Accommodation Support Initiative, Going Home Staying Home, the NSW boarding house reform, the NSW Homelessness Action Plan and the National Affordable Housing Agreement.

The private rental sector also presents opportunities that deserve exploration. The 90 Homes for 90 Lives project, for example, is a successful collaboration aimed at rough sleepers in Woolloomooloo, a central Sydney suburb with one of the highest concentrations of rough sleepers in NSW.[157] It is a partnership between community-managed, corporate and philanthropic organisations to secure independent

supported accommodation via private rental opportunities. The program's first target, to house 70 homeless individuals in 18 months, has been exceeded and it is now working towards housing 90 individuals.[158]

Despite these and similar efforts, however, the needs of many people remain unmet.

Cadre Project

Described as 'mental health neighbourhood watch', the Inner City Cadre Project was funded in 2011 by Sydney Lord Mayor Clover Moore's lord mayoral trust to support inner-city residents, including those with experience of mental illness, to care for one another.

A cadre is a community group that promotes positive mental health and community outcomes. A cadre member might be called on to assist people in distress, provide support for someone with a mental illness, help a neighbour, act as a community leader or spokesperson, and understand and facilitate recovery. The project is a collaboration among a number of organisations including St Vincent's Hospital, Mind Australia and the Inner City Mental Health Recovery Working Group.

Public housing communities in Surry Hills, Woolloomooloo, Glebe, Ultimo, Waterloo, Potts Point and Redfern have participated in the program. It is an example of ground-up change to achieve mental health recovery.

Housing and recovery

Initiatives to improve housing stability and prevent homelessness among people experiencing mental illness must be guided by consumer housing preferences to ensure they support recovery. In 2013, the NSW Consumer Advisory Group – Mental Health (NSW CAG) surveyed mental health consumers to determine the types of housing and housing support they used. It asked consumers for their perspectives on the relationship between recovery and having a place to call home. Consumers identified home as a sense of ownership and belonging, a sanctuary of safety and security in their community, and having appropriate support when needed which is available but not imposing.[159]

Work such as this must guide our efforts in ensuring that people have safe, stable, affordable housing and are supported to maintain it. There is a particular need to re-focus resources from temporary crisis accommodation services to delivering effective prevention and early intervention strategies. Addressing mental health issues and housing needs before they escalate into crises will generate cost efficiencies for government and huge improvements in quality of life for many people with mental illness.

Actions

6.4.1 Build on the success of the Housing Accommodation and Support Initiative (HASI) by increasing the number of packages and expanding the model to include new cohorts. Develop a model to support people who experience mental illness to maintain their tenancies, such as through the provision of lower-intensity HASI-style packages.

6.4.2 Improve referral pathways to state and Commonwealth-funded housing, homelessness and mental health services. This will require district implementation and co-ordinating committees to work with specialist homelessness services to develop a better understanding of the mental health system.

6.4.3 Investigate mechanisms that assist people with mental illness to access the private rental market. This will require working with business and community-managed organisations, and consideration of economic disadvantage and discrimination in the private rental market.

6.4.4 Develop and implement therapeutic models for public, community and Aboriginal housing where a substantial number of tenants experience mental illness. This will require consideration of:

- the physical environment
- the local community environment and support structures
- the relationship between housing staff and tenants.

6.4.5 Use cross-agency data to identify issues and provide support to people with mental health and housing needs. This will require improved cross-sector, interagency information collection and sharing. The data collected must identify:

- people with a mental illness who are homeless
- public housing, Aboriginal housing and boarding house tenants with a mental illness
- people with a mental illness using crisis accommodation services
- the housing status of people leaving mental health care facilities and people with a mental illness leaving corrective service facilities.

6.5 Bringing a holistic therapeutic approach to youth justice

About 90 per cent of young people in custody have at least one psychological disorder, such as a personality disorder or mood disorder, and about 70 per cent have two or more.[160] However, they do not always meet the criteria for mental illness set out in the *Diagnostic and Statistical Manual of Mental Disorders* and this can limit their access to publicly funded specialist services.

Young people in custody often present with behavioural problems[161] such as poor impulse control, aggression, lack of empathy and difficulty making good decisions, often stemming from neglect or abuse. Not surprisingly, these problems make them difficult to engage in therapeutic relationships and contribute to their reoffending, which in turn results in considerable cost to government in demand for services. And, of course, it results in terrible outcomes for the young people.

Custodial sentences are a punishment and a way to protect the community. But they also offer an opportunity to establish therapeutic interventions, particularly for behavioural issues, that will benefit the young person and the community. Those who do not deal regularly with young people within the criminal justice system are often surprised to find that such interventions result in measurable reductions in aggressive behaviour, improvements in cognitive and social functioning, and improved life trajectories. This makes it more likely that the young person will be accepted by mainstream community-based services.

While it may not be possible to fully address complex issues that require long-term care, plans for long-term care in the community can be formulated, reviewed and begun in custody. This will increase the young person's chances of living a better, more functional life after release.

Making the most of our opportunities

The real goal with young people must be to develop holistic early interventions that address their needs so as to improve their quality of life and reduce the possibility of their coming into contact with the criminal justice system. And, for those who do come into contact with the criminal justice system, diversion from it wherever possible is a desirable alternative and long-term goal. But the extent to which this can happen will depend on increasing the capacity within community-based services, which are now under-developed.

There are substantial efforts to divert young people from the criminal justice system, including Youth on Track, Brighter Futures, Best Start and the Children's Court initiatives. But some children will still end up in custody. It is critical that we make the most of the opportunity to intervene with those children entering the criminal justice system by providing an appropriately therapeutic environment and responses.

Actions

6.5.1 Complete a needs analysis for this cohort over 12 months. It will be important to identify the data that needs to be collected on a continuing basis to inform and support service development and evaluation.

6.5.2 In the following 12 months, use the results of the analysis, review the relevant literature and do a cost-benefit analysis of evidence-based programs to develop options for holistic, therapeutic, cross-agency responses, including from NSW Health, the Department of Family and Community Services and Juvenile Justice. These responses should:

- aim to promote normal developmental trajectories, reduce aggressive behaviour and help young people acquire vocational and basic social skills
- help to improve the way mainstream community services respond to the needs of young people who have been in contact with the justice system
- help build a young person's connections with family and community as appropriate and safe
- be flexible enough to apply to a range of custody periods
- consider opportunities to improve training for specialist child and adolescent mental health practitioners, including links with the Sydney Children's Hospitals Network.

6.5.3 Examine the potential for enhancing therapeutic responses in secure juvenile justice environments. Appropriate governance models will be needed to support this, together with any associated law reform.

6.6 Improving access to services for adults in custody

People with mental illness are significantly over-represented in the criminal justice system. Research published in 2013 estimated that about 77 per cent of prisoners in NSW had a mental health problem.[162] We also know that people who have a mental illness are three to nine times more likely to enter prison than those who do not have a mental illness.[163]

In general, most NSW inmates spend less than 12 months in custody but many find themselves in custody repeatedly. Up to 65 per cent of people living with mental illness reoffend within 24 months of leaving prison.[164]

The over-representation of people with mental illness in the criminal justice system does not arise from any simple relationship between mental illness and crime. Rather, there is a complex interaction between a person's mental illness and a host of other factors, such as disrupted family backgrounds, family violence, abuse, drug and alcohol problems and unstable housing. As such, these people often need access to a broad spectrum of services.[165]

Of course, it would be far preferable to reduce the number of people experiencing mental illness entering our criminal justice system and this must be our long-term goal. Diversionary programs, which are at the heart of achieving this, have already been prioritised in the NSW 2021 plan and initiatives such as Life on Track and court liaison services are doing good work in this area, as discussed further in *Broader context of reform*s, p. 118.

However, until such programs are available on a statewide basis, there will continue to be a high number of people with a lived experience of mental illness entering custody. Failure to address their needs results in considerable cost to government in service demand and repeated transaction costs, as well as poor outcomes for individuals. Efforts to address mental health problems while a person is in custody are hampered by the limited availability of specialist mental health staff within the correctional system and the fact that these services are concentrated in the Sydney metropolitan region. This situation is aggravated by the fact that most people are in custody for short periods and some are neither in the community nor in custody long enough to establish any links to appropriate services.

If a person with a mental illness must be in custody for a fairly short period, ideally this should not interrupt the continuity of care they might have had with a community service provider. Where possible that service should follow the person into prison. Alternatively, where a person in custody is identified as having a mental illness, they should leave custody linked to a community-based service.

This will require the creation of new, more flexible ways for prisons and community services to interact to:

- enable the delivery of services and programs for those inmates likely to be released to the community after a relatively short stay
- ensure a continuum of care that facilitates treatment engagement, limits repeated contacts and improves wellbeing.

Actions

6.6.1 Develop models that facilitate interaction between community mental health services and prisons. Implement those models in two demonstration sites – potentially Broken Hill and the Mid North Coast. After an evaluation of these sites, statewide application of the models will be considered. These models will take into account the:

- needs of the local inmate population, noting the particular needs of Aboriginal and female inmates
- need to ensure that treatment for mental illness is integrated with interventions aimed at reducing criminal behaviour, such as social skills and vocational training
- experience of similar, existing models, including those operated by Aboriginal Medical Services.

6.6.2 To improve our understanding of the interaction between mental illness and offending, the NSW Mental Health Commission has contracted with the University of NSW to do research on the population impact of mental illness on offending behaviour. The research will be informed by a data linkage study drawing on NSW Health, the NSW Bureau of Crime Statistics and Research and Corrective Services NSW datasets.

Special considerations and future directions

Future work will be required to address the needs of three particular cohorts within the justice system – forensic patients, Aboriginal people and women.

Forensic patients

A forensic patient falls into one of the following categories:

- a person who has been found not guilty by reason of mental illness and detained in a correctional centre, mental health facility or other place, or released subject to conditions to live in the community
- a person who has been found unfit to be tried for an offence and ordered to be detained, or
- an individual who has been placed on a limiting term following a special hearing and detained.[166]

Forensic patients have a very different profile to individuals who are convicted of crimes. Commonly, they do not have prior criminal records.[167] Too often, the stories of those who become forensic patients includes previous contact with the mental health system and having become 'lost' to follow-up care in the community due to a poorly resourced community-based mental health system.

As at June 2013[168] there were 364 forensic patients in NSW, 267 of whom were detained in specialist forensic mental health facilities or other mental health facilities or correctional centres. The number of forensic patients has trebled in the past 20 years and each year the courts refer more people than are discharged from the system.[169]

This is partly due to the balance of services. Most specialist resources are concentrated in the high-security, 135-bed Forensic Hospital at Malabar in Sydney, with far fewer beds and resources dedicated to helping forensic patients move to medium- and low-security facilities, and eventually to the community.

This necessarily results in a relatively inflexible system and delays in forensic patients receiving services and programs to aid their recovery. It is also at odds with the underpinning principle of NSW mental health legislation, which requires that all patients receive care and treatment in the least restrictive environment, having regard to the safety of the patient and the broader community.

Future direction

Plans should be developed and implemented to invert the mix of services, by increasing the availability of medium- and low-security placements, focusing on the recovery needs of individuals.

Aboriginal people

It is well known that Aboriginal people are over-represented in the criminal justice system. About 23 per cent of all inmates in custody in NSW in December 2013 identified as Aboriginal,[170] despite accounting for just over 2.9 per cent of the total NSW population.[171] Reports on the prevalence of mental health problems among Aboriginal inmates compared with non-Aboriginal inmates vary but it appears to be similarly high: the 2009 NSW Inmate Health Survey: Aboriginal Health Report[172] found the rate of previous assessment or treatment for mental or emotional problems for Aboriginal men was 44.5 per cent compared with 48.5 per cent for non-Aboriginal men, and 51.9 per cent compared with 55.2 per cent for Aboriginal and non-Aboriginal women respectively.

Despite this, there are discrepancies in the access to prison-based mental health services by Aboriginal inmates compared with non-Aboriginal people, such as the low rate of admission to Long Bay Prison Hospital for Aboriginal people as correctional patients. There appears to be no understanding of why this is so. It may reflect a broader failure to identify mental distress within this population. Further, it has been reported that Aboriginal inmates may be less likely to seek help for mental health issues.[173]

Future direction

Barriers which prevent Aboriginal offenders accessing mental health care within the correctional system should be identified and potential solutions explored.

Women

Although women represent about 7 per cent of the prison population[174], they tend to present with more complex needs, including those related to mental health. According to the 2009 NSW Inmate Health Survey[175], 54.4 per cent of women reported they had been assessed or treated for a mental or emotional problem compared with 47.2 per cent of men.

However, because of the relatively low number of women in custody, there are issues in terms of equity of access to services which have mainly been designed to meet the needs of male inmates. There are no dedicated beds for women at the 40-bed mental health unit at Long Bay Prison Hospital, with the result that women requiring treatment there are, in effect, kept in seclusion.

Future direction

Barriers which prevent female offenders accessing mental health care within the correctional system should be identified and potential solutions explored.

7. CARE FOR ALL

7.1 Lesbian, gay, bisexual, transgender and intersex mental health

International and Australian research has found that lesbian, gay, bisexual, transgender and intersex (LGBTI) people suffer from mental health disorders at a significantly higher rate than the heterosexual population.

In a national survey of the health and wellbeing of lesbian, gay, bisexual and transgender Australians, the proportion who had been diagnosed by a doctor with depression in the past three years ranged from 25 per cent of male respondents to 50 per cent of transgender men. Anxiety was also common, with 17 per cent of men and 34 per cent of transgender men reporting a recent diagnosis.[176]

In a separate NSW study, more than two in five LGBTI young people surveyed had thought about self-harm (41 per cent) or suicide (42 per cent). In addition, 33 per cent of young respondents had harmed themselves and 16 per cent had attempted to take their own lives.[177]

But the higher risk of mental illness and suicidal behaviours among LGBTI people is not the direct result of their sexuality, sex or gender identity; rather, it flows from the stigma, discrimination and marginalisation they experience. This is sometimes referred to as minority stress and occurs across genders, and in both youth and adult populations.[178]

There have been recent improvements in legislative equality in Australia, such as the Commonwealth Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013, and advances in the general acceptance of lesbian, gay and bisexual people and, to a lesser extent, of transgender and intersex people.

Despite these improvements, there is still a very high experience of homophobic[179] and transphobic[180] discrimination and exclusion, both within families and in the broader society. LGBTI people continue to be a very marginalised group.

Initiatives outside mainstream services

In NSW and nationally, initiatives addressing the mental health and wellbeing needs of LGBTI people include:

- the National LGBTI Health Alliance (the peak national body for health organisations and individuals focused on LGBTI issues)
- mindOUT! (the National LGBTI Mental Health and Suicide Prevention Project aimed at reducing suicide rates)
- ReachOut by the Inspire Foundation (offering help to young people who are LGBTI or questioning)
- Twenty10 (offering a range of support services)
- ACON (helping the LGBTI community to improve their mental health and wellbeing through health promotion, peer support and advocacy).

Despite these initiatives, mainstream services remain largely inattentive to the mental health needs of LGBTI communities and tend to focus on individual psychological intervention rather than on community-level responses. There is also a lack of recognition and support for the resilience of the LGBTI community in the design and delivery of services and programs.

Disparities must be addressed

ACON's Mental Health and Wellbeing Strategy 2013–2018[181] sets out the building blocks to improve mental health care among LGBTI communities and several of these relate to recommended actions elsewhere in this Plan, such as:

- strong service delivery partnerships
- implementing mental health and wellbeing promotion campaigns
- developing and documenting referral pathways
- providing health service and occupational education to promote social inclusion
- providing direct individual and carer support
- continued advocacy on behalf of the community in relation to mental health.

Actions in other parts of this Plan will also have an impact on the mental health and wellbeing of LGBTI people, provided their implementation takes into account the needs of this community. These include actions outlined in:

- *Building community resilience and wellbeing,* p. 25
- *Suicide prevention,* p. 36
- *Integrating mental health and drug and alcohol responses,* p. 72.

Actions

7.1.1 Agencies should ensure that the needs of LGBTI communities are considered in mental health and suicide prevention planning and that policies, tools and health promotion resources are inclusive of LGBTI communities.

7.1.2 Ensure that health providers, employers and other organisations are aware of the availability of LGBTI cultural awareness and inclusion training and that staff receive training.

7.1.3 Improve the accessibility of services by reaching out to LGBTI communities and tailoring services where necessary.

7.1.4 Continue to improve partnerships with LGBTI organisations, promote inclusion and respond to evidence and data showing unmet population need.

7.1.5 Improve research, population surveys and routine data collections by including appropriate gender and sexuality indicators.

7.2 Multicultural NSW

NSW is multicultural.[182] About 1.8 million people who now call NSW home were born outside Australia[183] in more than 250 countries and 25 per cent of us speak a language other than English at home.[184] With 3.1 million (or 45 per cent) of us having at least one parent born overseas[185], we have a rich array of experiences to guide our understanding of what mental health and wellbeing means for different communities.

While the self-reported prevalence of mental illness is slightly lower for people born overseas (about 18 per cent of men and 20 per cent of women) than for people born in Australia (about 20 per cent of men and 24 per cent of women)[186], research suggests the process of settlement may have a detrimental effect on the mental health of some migrants.[187] This is often linked to the stressful process of acculturation, language and social difficulties, and struggles in finding employment.[188] Some data shows that people from refugee backgrounds may experience significant levels of psychological distress compared with other Australians.[189] But the research available is limited and does not provide a coherent account of the mental health of these population groups.

While the experience of migration varies hugely and mental health is likely to vary among people from culturally and linguistically diverse (CALD) backgrounds as much as it does within the population at large, we also know that particular experiences – such as living through violent conflict in your country of origin – place some at higher risk of mental illness.[190] [191] The stigma about mental illness that still exists within established CALD communities can also make individuals reluctant to seek help for themselves or their loved ones.[192] [193] [194]

Some families have lived in fear in their countries of origin and endured hardship and danger to come to Australia. This can be particularly stressful for children.[195] Being pulled away from a familiar culture and its traditions, and adapting to a new one, can also undermine a child's mental health and wellbeing.[196] Children are far more likely to thrive when they have a positive sense of belonging to both cultures and when their new school and community environments support this.

It is also important to recognise the mental health and wellbeing needs of second and subsequent generation migrants. While the experience of second generations varies according to their parents' country of origin, they too can experience stress in finding their identity between their family's traditional culture and the culture of the society in which they now live.

We need to know more about mental health and wellbeing in our CALD communities so that appropriate information, tools, services and other resources can be directed where they are needed most.

There is also an urgent need to address language barriers and cultural differences and sensitivities. This means mental health services, government and other relevant agencies need to be far better informed about cultural differences and needs about mental illness. It will require comprehensive training, and people from CALD backgrounds who have lived experience of mental illness will be invaluable to the process.

Mental health services also need to capitalise on the language skills of their workforce, including employing people who speak more than one language and valuing existing staff who speak more than one language.

We must also look for ways to make multilingual, culturally skilled staff more readily available in areas with smaller populations. The Transcultural Mental Health Centre will have a vital role here.

Speaking the language of promotion

This Plan is as much about mental health and wellbeing as it is about mental illness. As such, efforts to enhance the resilience of CALD communities through mental health promotion and community initiatives will need to provide for cultural and linguistic diversity. The best way to do this will be to work directly with CALD communities, including community leaders and cultural advisers.

Providing culturally relevant information will allow people to make informed decisions about their mental health, wellbeing and recovery.

Mental health services and organisations need to ensure they work collaboratively with people from CALD backgrounds, their families, friends and community groups to ensure initiatives to engage with those communities are meaningful, respectful and sustainable.

Actions

7.2.1 Consider the needs of CALD communities in the development of local mental health and wellbeing promotional activities as described under *Building community resilience and wellbeing*, p22. These activities should look to strengthen the capacity of ethno-specific community organisations to support people with mental illness within their communities. These activities should provide community organisations with appropriate referral pathways to mental health services.

7.2.2 Ensure that the development of mental health and suicide prevention policies, tools and health promotion resources take into account the particular needs of CALD communities. This will include the use of inclusive language that expressly acknowledges CALD communities. Such considerations should form part of service planning, especially in locations where there are larger CALD communities and in relation to issues that are of special concern to CALD communities, such as trauma-informed care.

7.2.3 All staff responsible for the delivery of services where there is a significant cohort of people with a lived experience of mental illness should receive cultural competency training in relation to the mental health needs of CALD communities. Given the higher incidence of exposure to trauma within CALD communities, this training is to have particular regard to the principles of trauma-informed care.

7.2.4 Develop tools to enable a more objective measurement of access and equity for mental health services by CALD communities. These tools will need to be responsive to the needs of CALD populations and readily accessible by the workforce. Information gathered should be incorporated into the population-based planning undertaken by local action groups to inform service development and responses.

7.2.5 Given the changing demographics of CALD communities, not only with emerging communities from new patterns of migration but the intergenerational effects of culture and trauma, there is a need to improve our understanding of:

- the prevalence of mental illness among CALD communities
- the capacity of CALD communities to identify and respond to their mental health needs
- the systemic requirements to enable the mental health and broader service sector to respond appropriately.

These issues should be considered in the context of setting priorities under the *NSW Mental Health Research Framework*.

7.3 Mental health and intellectual disability

People with an intellectual disability account for about 1.8 per cent of the population and experience significant disadvantage.[197]

Intellectual disabilities involve deficits in both intellectual and adaptive functions, affecting how well a person copes with everyday tasks. The impact of intellectual disability on a person's functioning varies greatly from person to person and increases if the person also has a mental illness. People with an intellectual disability experience very poor mental health compared with the general population.[198] It has been estimated that up to 40 per cent of people with an intellectual disability have experienced a mental disorder of some kind.

People with a mental illness and intellectual disability also experience increased physical health issues that are compounded by difficulty accessing health and mental health services. Compared with the general population, people with an intellectual disability experience significantly lower rates of participation in preventive health initiatives, illness and disease detection and treatment of physical and mental health problems.[199]

There are significant implications for carers, who form the backbone of support for people with an intellectual disability because of the shortage of appropriately skilled services. This is especially the case where the person with an Intellectual disability experiences mental illness and associated challenging behaviours.[200]

People with an intellectual disability are also poorly catered for within the prison system unless they also have a mental illness. While there is a Justice Health service for health concerns, including mental illness, there is no equivalent Justice Disability Service. Corrective Services has developed some good programs for people with an intellectual disability but these are limited in number and the locations in which they are available.

What is happening now

People with an intellectual disability are more likely than others to experience mental illness, and yet access to mental health services for people with an intellectual disability is limited and falls far short of that for the general population.

People with an intellectual disability and mental illness face a range of barriers to service access, including communication difficulties and atypical and complex presentations. There is also a lack of training, leading to a lack of confidence on the part of mental health professionals and poorly developed interagency service models. There can also be a perceived difficulty in applying a mental health recovery framework to the care of individuals who have a permanent disability such as an intellectual disability. The danger is that some clinicians may not believe a person with an intellectual disability is capable of successful mental health recovery and therefore may not invest the effort required.

The structure of services means people are falling between the gaps in services, with neither the health nor disability systems taking full responsibility. And they do not have the appropriate skills to address the complexity presented by people with intellectual disability and mental illness.

The situation is further exacerbated by the lack of adequate resources in both sectors. The NSW Ombudsman found that as a result of this silo culture and a lack of an appropriate model of care for treating mental illness in people with intellectual disability, hospital rehabilitation units were in effect becoming long-stay units for them as there was no appropriate step-down level of community support.[201]

Addressing these issues has proved complex and may temporarily become more so as we move from a state-based disability service system to a national model of individualised packages with the introduction of the National Disability Insurance Scheme. This scheme is a welcome development and will offer consumers greater choice and control in how their non-clinical care and support is provided and managed. However, the reforms mean Health will lose its counterpart NSW agency – Ageing, Disability and Home Care. This issue is further described in *Broader context of reforms,* p. 118.

E-tool supports better mental health care for people with intellectual disability

An innovative e-learning website developed by the Department of Developmental Disability Neuropsychiatry (3DN) at the University of NSW and funded by the NSW Government provides an avenue for service providers and carers to access up-to-date information on intellectual disability and mental health. The initiative provides extra training for health and disability professionals so they can provide expert care to people with intellectual disability and mental illness.

The education tool – available at www.idhealtheducation.edu.au – is the first of its kind in Australia. It aims to promote best practice in mental health care and to build the capacity of the workforce to prevent people with intellectual disability and mental illness falling between the cracks of the two systems. People with an intellectual disability have the same mental health concerns as everyone else, and this tool encourages inclusion of people with an intellectual disability and a person-centred approach in line with the National Disability Insurance Scheme.

NSW reform activity to date

In recognition of the particular needs of this group, the NSW Government established a Chair of Intellectual Disability Mental Health at the University of NSW in 2009. Working closely with NSW Health and Ageing, Disability and Home Care, the chair's primary purpose is to improve supports for this cohort.

Projects undertaken since its establishment include the e-learning supports outlined above and, more recently, the development of *Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers*. This outlines principles and practical strategies to develop inclusive and accessible services. This work is an important step towards a more integrated approach between disability and health services.

Why change must occur

While pockets of expertise in supporting the physical and mental health needs of people with intellectual disability exist in NSW, their scarcity and lack of integration with mainstream services remain a problem. NSW can now build on this work by taking steps to implement the guide and undertaking further work to develop the models of care.

The implementation of the National Disability Insurance Scheme will offer the potential for improved services for those who are eligible, provided we achieve appropriate integration and partnerships among clinical mental health services and community-managed and private service providers.

For this key group, this Plan offers the opportunity to address long-standing systemic issues relating to access and co-ordination of care and support and ensure that the potential of the National Disability Insurance Scheme is realised.

Actions

7.3.1 Ensure that Local Health Districts and community-based services implement Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers.

7.3.2 Ensure that adequate training in the recognition, assessment, referral pathways and treatment for people with an intellectual disability and mental illness is given to all staff in mental health and disability services. Such training will need to include particular reference to adopting reasonable adjustments in clinical approaches and adopt a recovery-oriented approach.

7.3.3 As part of the NSW implementation plan for the National Disability Insurance Scheme, develop strategies to change from the present partnership between NSW Health and other state services with Ageing, Disability and Home Care to one with the community-managed and private sectors. This will need to take account of the impact on:

- joint projects
- memorandums of understanding
- co-developed guidelines
- relationship management
- dispute resolution
- systemic and strategic planning.

7.3.4 Develop a recovery-oriented model of care for the provision of public mental health services to people with an intellectual disability that:

- builds the capacity of mainstream community and inpatient mental health services
- increases specialist capacity to meet more complex needs
- facilitates joint planning by disability services, mental health and other relevant services, including in relation to referral and treatment pathways and collaborative responses where intellectual disability and mental disorders coexist.

7.3.5 Develop accessible information for people with an intellectual disability and their families and carers about mental health services.

Future direction

A sharper focus is required on policy and program development for the mental health needs of children and young people with an intellectual disability. This should include tailored prevention and early intervention programs and services that offer timely and skilled mental health assessment and intervention.

7.4 Eating disorders

While predominantly affecting adolescent girls, eating disorders occur across all genders and ages, with increasing diagnoses in younger and older people. Although data is limited, it is estimated that the lifetime prevalence of eating disorders is 9 per cent for the whole population and 15 per cent for women.[202]

In 2012, 913,986 people in Australia had eating disorders, or about 4 per cent of the population[203], including an estimated 289,560 in NSW.[204] Of these, 3 per cent had anorexia nervosa, 12 per cent had bulimia nervosa, 47 per cent had binge eating disorder and 38 per cent had other eating disorders.[205]

Anorexia nervosa has the highest mortality rate of any psychiatric disorder and eating disorders generally have an overall mortality rate of 20 per cent.[206] The high death rate is due to the physical complications of eating disorders and a highly elevated risk of suicide.

Gaps in service availability, poor service integration, and regional differences have been identified[207] with significant barriers to access in regional and rural communities due to social stigma, lack of professional expertise in treating eating disorders and lack of services. For example, many cases of binge eating disorder are misdiagnosed and treated as obesity. Although someone with binge eating disorder will often present as 'obese', the traditional treatment of dieting is not only unlikely to be successful but can cause significant further harm.

The estimated socio-economic cost of eating disorders in Australia in 2012 was $69.7 billion, including productivity costs of $15.1 billion and burden of disease costs of $56.2 billion, comparable to the costs of anxiety and depression.[208]

Special circumstances

The NSW Government has addressed eating disorders with the NSW Service Plan for People with Eating Disorders 2013-2018. The plan[209] has the following aims:

- ensuring every health service which may be a point of entry to eating disorder care has the capacity and capability to provide all necessary services for people who have, or are at risk of developing, an eating disorder
- ensuring every health service has the capability to link with and be supported by specialist eating disorders expertise
- ensuring eating disorder outpatient programs are accessible within the patient's Local Health District on a flexible basis to allow patients to transition between general and intensive outpatient treatment
- increasing access by expanding services (adult, child and adolescent)
- funding the development and expansion of tertiary eating disorder services and support throughout the system; dissemination of high-level clinical skills; support of best practice for eating disorders; and maximising the use of limited tertiary beds.

Despite a recent increase, there are still insufficient specialist beds to meet the needs of the population, particularly in regional centres.

The impact of this is exacerbated by the lack of community-based services. As with any other psychiatric disorder, an integrated continuum of care is required based on a step up/step down model with varying levels of support – ranging from inpatient episodes (for medical stabilisation) through to residential care, day programs, intensive outpatient programs, sessions of outpatient service, and community-based recovery support. In most instances, re-feeding, development of healthy eating and exercise behaviours and addressing the psychological aspects of the illness are best addressed in a community-based, non-hospital environment.

What community supports are available have usually been developed for mental health problems more generally, and therefore do not take into account the fact that treatment for eating disorders normally takes a long time. For example, the Commonwealth-funded Access to Allied Psychological Services – ATAPS – and Better Access programs provide access for a limited number of psychology sessions (generally 12 and 10 respectively) whereas a person with an eating disorder is likely to require significantly more sessions over an extended period. Withdrawing treatment prematurely may increase the risk of relapse. The criteria for funding treatment must take these circumstances into account to ensure that people with eating disorders have access to evidence-based treatment for the recommended duration.[210]

In 2012 the National Eating Disorders Collaboration developed two reports for the Commonwealth Department of Health and Ageing. The first looked at gaps in service delivery for eating disorders and the second focused on prevention and early intervention. Unfortunately, at the time of writing, these reports had not been publicly released, which limits the extent to which their content can inform service development nationally and in NSW.

Broad-based understanding

Given the complexity of the relationship between the physical, psychiatric, nutritional and functional aspects of eating disorders, their safe treatment requires close co-ordination of care across a number of disciplines, either through multi-disciplinary teams or specific mental health care co-ordination roles.

However, there is a documented lack of confidence among clinicians, including GPs and emergency department personnel, in addressing these disorders. While the NSW Government has improved access to online training, clinicians require ongoing supervision and access to case conferencing provided by specialists at a tertiary level.

Training of a broad base of clinicians will be particularly important to effectively develop and implement prevention and early intervention programs, which are now under-developed in NSW. Prevention programs can reduce risk and early identification and intervention of each episode of illness significantly enhances sustainable recovery and reduces cost. Preventive programs need to include comprehensive family education about eating disorders, early warning signs and positive behaviours to reduce risk.

An eating disorder has a significant impact on all family members, including parents, partners and siblings. Long-term sustainable recovery requires a supportive family structure and, as such, providing education and support to develop resilience in each family member and the family as a unit is essential. Family members and carers can be essential partners with the treatment team and should be included as such, as well as being supported in their own right.

Actions

7.4.1 Ensure the statewide implementation of the NSW Service Plan for People with Eating Disorders 2013-2018 with priorities including: improved data collection; nurturing and disseminating a strong evidence base; workforce development; and promoting integrated and collaborative approaches.

7.4.2 Ensure that local mental health and wellbeing promotion activities (see *Building community resilience and wellbeing,* p. 25) and the basic training in mental health literacy provided to government employees and service providers (see *Build the capacity of services to respond therapeutically,* p. 51) include material about eating disorders.

7.4.3 Ensure that adequate training in the recognition, assessment, referral pathways and treatment of eating disorders is provided to all staff in mental health services.

7.4.4 Prioritise the development of community-based models of care for eating disorders from early intervention, to treatment, to recovery-focused services.

7.4.5 Advocate for the Commonwealth Government to fund uncapped or a minimum of 40 extra psychology sessions per calendar year for people diagnosed with an eating disorder under existing programs (such as Access to Allied Psychological Services – ATAPS – and Better Access) to enable them to access individual and group sessions.

7.4.6 Advocate for the Commonwealth Government to fund extra sessions with dietitians for people diagnosed with an eating disorder under existing programs (such as the Chronic Disease Management program) to enable them to access appropriate care.

7.5 Borderline personality disorder

It is estimated that borderline personality disorder (BPD) affects about 1 to 2 per cent of the population.[211]

People living with BPD often experience distressing emotional states, difficulty in relating to other people and self-harming behaviour. BPD is often misunderstood, which leads to negative attitudes, most significantly among some health professionals.[212] This is a barrier to people with BPD getting the care they need, resulting in their being marginalised within, or turned away from, existing service systems and mental health facilities. This effect is compounded by a paucity of resources and trained staff to meet their needs.

While the proportion of people living with BPD who access mental health services in NSW is not known, internationally the prevalence has been estimated at up to 23 per cent of outpatients and up to 43 per cent of inpatients.[213] People who experience severe BPD may also have symptoms of other mental illnesses, engage in more suicidal behaviours and experience higher rates of suicide.[214]

The difficulty in accessing appropriate services experienced by people living with BPD has broader implications. It is often the case that the intensity of mental health issues experienced by people with BPD is absorbed by carers in a way that also significantly affects the carer's mental health.[215]

These poor outcomes for those with BPD and those who support them must be addressed.

Interaction with services

The interactions with service providers of people living with BPD are characterised by chaotic personal circumstances, ambivalence towards treatments and supports, challenging interpersonal coping styles and a poor response to many traditional mental health treatments and interventions.[216]

People with BPD present to hospital emergency departments as well as to mental health and drug and alcohol services. Generally, inpatient health services provide crisis management which may include short-term admission for safety and assistance to reduce distress.[217] Recently, NSW Health has undertaken initiatives to improve the care of people with BPD. These include pilot projects, such as the Project Air Strategy for personality disorders in partnership with the University of Wollongong, to give clinicians the knowledge and skills to ensure people's experience of care, and what happens as a result of that care, is positive.[218] Though still a work in progress, new therapeutic approaches, through a combination of psychological therapy and medication for symptom relief, have achieved better outcomes. These approaches are articulated in the National Health and Medical Research Council's Clinical Practice Guideline for the Management of Borderline Personality Disorder (2012).[219]

Changing our approach

Despite these advances, there are still issues about the capacity of some mainstream mental health services to manage BPD and engage in the service redesign needed to respond better to this group of people.[220] Through appropriate care and treatment, we can redirect people from our hospital and emergency systems and provide care in the community.

The compassionate, holistic, person-centred approach to mental health is the way forward across the board. Services and staff members need to be oriented and educated to help people with BPD, recognising that specialist services are required for the most complex cases and to provide consultation support more broadly. This would include increased access to Commonwealth psychology services.

Carers, family members and the community are an important part of this equation. If the nature of the condition and its treatability are better understood, we are likely to reduce stigma and greatly improve access to services.

Actions

7.5.1 Ensure that Local Health Districts and community-based mental health services adopt and implement the Clinical Practice Guideline for the Management of Borderline Personality Disorder (2012).

7.5.2 Ensure that the local mental health and wellbeing promotion activities (see *Building community resilience and wellbeing,* p. 25) and the basic training in mental health literacy provided to government employees and service providers (see *Build the capacity of services to respond therapeutically,* p. 51) include material in relation to BPD.

7.5.3 Ensure that adequate training in the recognition, assessment and treatment of BPD is provided to all staff in mental health and drug and alcohol services.

7.5.4 Promote and progressively roll out community-based models of care for the treatment of BPD, such as that developed by the Project Air Strategy.

7.5.5 Advocate for the Commonwealth Government to fund extra psychology sessions per calendar year for people diagnosed with BPD under existing programs, such as Access to Allied Psychological Services (ATAPS) and Better Access, to enable people to access both individual and group sessions.

8. SUPPORTING REFORM

8.1 Investing in our workforce

Our workforce is the heart and soul of the mental health system. To support people who experience mental illness we need a mental health workforce of the right size and with the right characteristics to meet the demand for services, both in the community and in hospitals. We also need our mental health workforce to understand and support the philosophy of recovery and to have the skills and tools to provide services that are recovery focused.

However, workforce shortages in areas such as psychiatry, nursing, psychology and social work have already been identified, and are particularly severe in rural and remote areas.[221] Recent research indicates that a modest increase in the proportion of people seeking help for mental health difficulties, coupled with Australia's projected population growth, would produce a cumulative increase in the use of mental health services ranging from 135 per cent to 160 per cent for select mental health professions, over 15 years.[222] Our aim of course is to improve community mental health and wellbeing and prevent mental illness where possible and this should reduce growth in demand. Nevertheless, the research is indicative of the workforce challenges we must plan to meet.[223]

The mental health workforce

The mental health workforce comprises workers whose primary roles include early intervention, referral, treatment, care or support to people with a mental illness, in a mental health service or other health service environment, including community-managed mental health services.[224] These workers include[225]:

- Aboriginal mental health workers
- GPs
- mental health nurses
- occupational therapists
- peer workers
- psychologists
- psychiatrists
- social workers.

Data compiled by the Australian Institute of Health and Welfare in 2011 indicates the mental health workforce in NSW is made up as follows:

- 12.6 full time equivalent (FTE) psychiatrists per 100,000 population, compared to 12.9 nationally[226]
- 72.3 FTE mental health nurses per 100,000 population, compared to 77.0 nationally[227]
- 88.3 FTE psychologists per 100,000 population, compared to 84.2 nationally.[228]

However, there is no comprehensive data in NSW about the numbers of workers across all fields of practice who work primarily in mental health.

A 2010 Audit Office report found it was difficult to determine the precise size and nature of the NSW mental health workforce because the data on mental health funding and workforce were 'inconsistent and in places inaccurate'. This reduced the state's 'capacity to plan its services and workforces effectively'.[229]

The report found that compared with most Australian states and territories, the NSW workforce is 'more concentrated in acute hospitals for adult patients and is marginally smaller for its population'.[230] It also found that the NSW public sector community mental health workforce had not grown as much as forecast, and that the state's ability to intervene early, support recovery and provide continuity of care was impaired as a result.[231]

A significant gap in our understanding of the mental health sector and its workforce is the lack of data on the contribution of the community-managed sector to mental health service provision, and the size of the community-managed mental health sector workforce.[232] Available data suggests Australia has about 800 such organisations working in mental health, with a total workforce of more than 12,000 full time equivalent employees.[233]

National initiatives

At a national level, the Mental Health Workforce Study begun in 2013 by Health Workforce Australia (HWA) aims to examine in detail how the size and composition of the workforce affects the delivery of services, to support workforce planning. Its first stage was to pull together existing data collections on mental health workforces.

HWA's work, which transitioned to the Commonwealth Department of Health in 2014 following the closure of HWA, is expected to enhance the National Mental Health Workforce Strategy which aims to `develop and support a well-led, high performing and sustainable mental health workforce delivering quality recovery-focused mental health services'.[234] This national strategy provides a framework for NSW investment in its mental health workforce.

How we need to change

We need to build a vibrant professional community mental health workforce that eases the pressure on acute crisis services and enables consumers to find care and support closer to home. Mental health services should be provided by a skilled, multi-disciplinary workforce that is supported by continuing education. New service models, based in the community, are emerging quickly and will continue to do so as the reforms set out in this Plan are implemented. Workforce planning will need to keep pace with these developments, and new approaches will be required to supply the people and the skills to build a recovery-oriented mental health sector.

An expansion of the present model will not be sufficient to meet the demands on the mental health system. We need a new way of arranging our workforce to make the most of their precious, professional skills. This will require:

- the development of new workforce models, including the rapid growth of the peer workforce
- strategies to ensure the most efficient use of the scarce specialist clinical workforce, including relieving them of non-clinical work
- the development of new service delivery and associated workforce capacity approaches grounded in community-based care and recovery-oriented practice.

To meet demand, we might also need to think more innovatively about what constitutes our workforce. As noted elsewhere, we need to better integrate and support GPs as critical components of our mental health system. But GPs are not always available and there are others who could play a greater role. For example,

the Pharmaceutical Society of Australia[235] has published a framework for pharmacists as partners in mental health care which sets out the vast potential of their role in providing direct services to consumers. Allied Health Professions Australia has also recognised that 'allied health professionals outside the traditional dedicated mental health workforce need to be trained in mental health issues so they are able to contribute to the early detection, care and treatment of people with mental illness'.[236]

Actions

8.1.1 NSW Health, in consultation with the NSW Mental Health Commission, will develop a NSW Mental Health Workforce Plan. This will include:

- the peer workforce (see *Peer workforce* for further detail, p. 100)
- the community-managed workforce
- the Aboriginal mental health workforce
- training and workforce support for the mental health workforce including recovery-oriented practice and trauma-informed care
- training and workforce support for mainstream service providers and frontline workers, including to better support responses to crisis, including suicide.

8.2 Peer workforce

People with lived experience of mental illness hold expertise that is incredibly valuable. Employing people with lived experience in peer worker roles to support others brings a tremendous range of benefits. Peer workers know what it is like to experience mental illness and can share experiences of personal recovery with consumers. People who are living well with mental illness represent hope that is often missing in people's lives.

Peer workers, consumer advocates and consumer representatives have been employed by the public mental health sector for 20 years but they do not always encounter positive acceptance. Stigma and discrimination, sometimes subtle and sometimes obvious, can cause a divide between the peer workforce and other staff. Formal structures, policies and procedures that support the peer workforce and provide a development pathway are needed if government services are to realise their full potential.

At present, the peer workforce in NSW is small, under-supported and under-resourced. There had been limited recognition of the peer workforce as a profession requiring a standard training qualification until the Certificate IV Mental Health Peer Work qualification and associated units were endorsed by the National Skills Standards Council in May 2012.

As noted separately in this Plan, Australia has a poor record of employment of people with a mental illness and this is reflected in the number of people with mental illness who rely on the Disability Support Pension.[237] Peer work can be an important pathway for people with mental illness to enter or re-enter the workforce but should not be seen as the only pathway to employment or the only benefit of a peer workforce.

Frameworks, guidelines and strategies

The peer workforce in NSW comprises people who work in public mental health services or community-managed organisations. At present, there is little or no employment of peer workers outside the mental health system.

The Commonwealth Government has committed to expanding and strengthening the peer workforce. Health Workforce Australia in 2013 completed a study of the mental health peer workforce and its findings are expected to assist in building a sustainable, well supported peer workforce in NSW.

An example of how this can be achieved is the Commonwealth-funded Personal Helpers and Mentors program which formally recognised the need to ensure consumer peer worker roles were incorporated in the funding guidelines when the program was developed. A minimum of one full-time equivalent staff member for each team was mandatory.[238] Until this point, the incorporation of peer workers as an integral part of a team was not common practice and was thought to be a very progressive move.

Within the NSW public sector, mental health consumer workers are individuals with lived experience of mental illness, employed to support consumers through peer support, positive role modelling, education, advocacy, facilitating self-advocacy and providing information and opportunities for consumers to participate.

The Mental Health Consumer Workers Committee, with the support of the NSW Consumer Advisory Group – Mental Health, developed the Framework for the NSW Public Mental Health Consumer Workforce. This

guides workforce development for consumer workers within public mental health services, and encourages and supports the growth of the consumer workforce across NSW public mental health services. It has been endorsed in principle by NSW Health's Mental Health Program Council.

Developing the peer workforce

Peer worker roles are integral to the concept of lived experience at all levels – including peer support to consumers and carers, peer mentoring, peer leadership, policy development and research. People with lived experience of mental illness should be part of all workforces that deliver services to client groups with a significant number of people who experience mental illness.

Further action is required to build a supportive infrastructure to ensure the peer workforce is embedded in the culture of service delivery to people who experience mental illness. Services and agencies need to consider how to attract a mix of peer leaders and new staff, create support structures, develop career pathways and support training and development specific to this workforce. This would include access to training such as the Certificate IV in Mental Health Peer Work within the first year of paid employment for all peer workers with government and community-managed organisations. Peer workers should also have access to formal supervision or mentoring by a person with lived experience.

Creating training, development and supervisory structures for an emerging workforce can challenge services in relation to the initial investment. This should be seen as an opportunity for sharing resources across the sector, not a deterrent.

Actions

8.2.1 NSW Health will implement the Framework for the NSW Public Mental Health Consumer Workforce

8.2.2 In developing the NSW Mental Health Workforce Plan, as described in *Investing in our workforce*, p. 97, NSW Health, in consultation with the NSW Mental Health Commission, will incorporate the needs of the peer workforce informed by the lived experience of people with mental illness. This would include:

- education, training and accreditation of peer workers
- the full spectrum of roles that peer workers may fill (such as educators, support workers, advocates and managers)
- recognition and integration of peer workers as team members in the delivery of mental health services
- the governance structures that will be required to support peer workers in the workplace, including pathways for career progression.

8.2.3 Family and Community Services will develop peer worker roles in its front-line services. This could be through a partnership with one or more community-managed organisations which have a developed peer workforce.

8.2.4 Benchmarks must also be set to stipulate peer worker numbers across the public mental health system, the community-managed sector and the broader government service sector, including housing, disability and justice.

8.3 Developing the community-managed sector

NSW needs a strong and resilient community-managed organisation (CMO) sector if it is to build an integrated and professional range of alternatives to hospital care. The development of this sector will, as noted elsewhere in this Plan, also allow NSW Health to make best use of scarce specialist clinical skills.

But the CMO sector faces a period of seismic change in NSW and across Australia with governments looking increasingly towards service delivery options that are open to tender and involve community-managed and private-sector operators. In NSW many CMOs are preparing for a shift from a grants-based, government-funding scheme to competitive tendering arrangements being established through NSW Health's Grants Management Improvement Program. Many are also adjusting to the new individualised packaging and brokering system under the National Disability Insurance Scheme.

The reforms raise real questions about the community-managed mental health sector's readiness for these changes. The survival and growth of the sector will depend on its capacity to adopt business models that fit with the new contestable and customer driven environment and on the continued professionalisation and accreditation of its workforce.

Community-managed sector profile

With the exception of NSW, every Australian jurisdiction recorded an increase in its CMO mental health spending between 2007 and 2011.[239] NSW has left its CMO sector to develop in a largely unsystematic, peripheral and ad hoc way.

There are almost 250 mental health CMOs in NSW and they deliver about 347 different programs.[240] Some of these organisations are new but many have decades of experience and expertise in supporting people with mental illness. However, there is a significant gap in our understanding of the contribution of the CMO sector to service provision, and the size of the CMO mental health sector workforce.[241]

Most mental health CMOs provide psychosocial rehabilitation and support. These are essential complementary services to clinical treatment that aid the recovery of people with a lived experience of mental illness. CMO psychosocial rehabilitation and support services include programs funded either by the NSW or Commonwealth governments, such as the Housing and Accommodation Support Initiative, the Day to Day Living in the Community program, and Personal Helpers and Mentors. There are also CMO programs that support the families and carers of those living with mental illness.

Embedding change

As described in *Shift to community*, p. 55, some Local Health Districts may either partially or fully devolve public community mental health services to the community-managed sector.

If we are to bring community-based services to the fore, we must determine:

- which community mental health service components can be delivered through the community-managed sector and which, if any, must be retained by public sector agencies
- the number and types of community services needed in each locality and the size of the workforce needed to deliver those services.

The CMO sector in NSW has already done some mapping of the level and mix of mental health services that should be available in each region, in line with the broader aims of the National Mental Health Services Planning Framework.

An effective community-based mental health system requires a range of services in the following areas, according to the Mental Health Co-ordinating Council[242]:

- accommodation support and outreach
- employment and education
- leisure and recreation
- family support and carer programs
- self-help and peer support
- helpline and counselling services, and
- information, advocacy and promotion.

This will clearly require a substantial workforce with a diverse range of skills. It is also important that standards of service are not lowered where government mental health care functions are transferred to community-managed organisations.

The National Practice Standards for the Mental Health Workforce 2013[243] and the National Mental Health Core Capabilities[244], which are being developed, will have implications for standards to be met by the community mental health workforce and its continued professionalisation and accreditation.

Some mental health CMOs are large enough to take care of their own workforce development needs. But smaller ones are unlikely to be able to meet workforce development needs without state funding support. Commonwealth funding is available through the National Disability Insurance Agency for the workforce undertaking the role of disability support workers, but it is mostly unavailable for psychosocial support workers in agencies funded by NSW Health. In any event, mental health/psychosocial training is required to meet state government structural changes to the way in which mental health services will be delivered in the future.

Shared-care models

There are some isolated examples of effective shared-care models in which CMOs work in co-ordinated and comprehensive partnerships with Local Health Districts, GPs, psychiatrists and allied health professionals. Examples include step-down units, the *headspace* model and the LikeMind integrated mental health service pilot sites for adults that are being developed by Uniting Care Mental Health in Seven Hills and Penrith. These models allow for the CMO to undertake holistic consumer assessments, including clinical and risk assessment. Further, defined clinical pathways can be developed among the CMO, Local Health Districts, other government agencies, private practitioners such as GPs and allied health professionals.

These types of co-ordinated and comprehensive partnerships need to become the norm. But if they are to work effectively, the roles, skills and resources of CMOs need to be supported and expanded. Their staff may need training in assessments of health, mental health and day-to-day functioning. Clinical governance frameworks will be required and clinical pathways for shared care will need to be defined. CMOs will also need to ensure they have the resources to manage and support clinical staff, to engage and retain staff, to

deliver quality services and to ensure that the journey towards recovery for people with mental illness, their families and carers is as smooth as possible.

At present, health care professionals are unable to move and transfer their entitlements between the public and CMO sectors in the same way they can move across the public health system. This could be assisted by some CMOs becoming Affiliated Health Organisations, which would allow for the transfer of staff entitlements. The removal of barriers to health care professionals moving between the public and CMO mental health sectors would allow the necessary expansion of the CMO sector, ultimately benefiting the people who use these services.

Business models, innovation and data

With the rollout of the National Disability Insurance Scheme over the next five years and the NSW move to competitive tendering for services, it is clear that CMOs need to quickly review their business models and determine how they will operate and compete in this new environment. Larger organisations or consortium models are more likely to have the critical mass to cope with the challenges and to take advantage of opportunities.

An innovative CMO may have a range of activities and funding options including: Local Health District funding, Commonwealth funding via schemes such as the National Disability Insurance Scheme, shared care partnerships, accessing rebates under the Medicare Benefits Scheme for clinical services, fund-raising, social enterprise activities, and social benefit bonds, in which funds from the private sector are made available through government to deliver an outcome in the community.

CMOs also need to choose how to position their role for the future. Some may continue to focus on psychosocial rehabilitation and others will wish to widen their roles in community-mental health and be more closely integrated with public sector mental health services. It is likely that CMOs will need to be of a certain size to meet safety and quality requirements.

One of the valuable things about the CMO sector is its capacity to operate more flexibly and innovatively than government services tend to. As we move away from a grants environment to a contracting for service environment there is a risk that the sector could lose this flexibility and innovative capacity – but this is not inevitable.

State governments have an interest in ensuring that the relationship with CMOs is not simply transactional and that it can be transformational. Such a relationship would focus on outcomes, not only process-driven service agreements.[245]

Finally as noted in *Better use of technology*, p. 107, there are capacity limitations within the CMO sector in relation to data systems which affect its ability to adapt to the large-scale reforms of NSW Health's Grants Management Improvement Program and the National Disability Insurance Scheme, as well as any reporting standard changes. But work on this stalled because of funding issues and much is still to be done.

Actions

8.3.1 Strengthen the partnership between the public and CMO mental health sector, including arrangements for purchasing services, by reforming existing arrangements. NSW Health's Grant Management Improvement Program will be an important mechanism for some of this work.

8.3.2 The NSW Ministry of Health will establish a community-managed sector development plan which includes strategies to strengthen and expand the community sector workforce, and improve the management and collection of data. The plan should be modelled on the successful development work being undertaken in the disability sector and supported through National Disability Services.

8.3.3 Establish directions and priorities for education and training of the CMO workforce through the NSW mental health workforce plan (see also *Investing in our workforce*, p. 97).

8.3.4 Ensure that the NSW Initiative for Mental Health Leadership supports further development of community-sector leadership and sharing of knowledge more broadly across the community sector workforce (see also *Research and knowledge exchange*, p. 111).

8.4 Better use of technology

Providing the best mental health care in the 21st century means embracing new technologies to help deliver care and to expand access to it. It means harnessing new technology to promote self-agency and consumer choice (as discussed in *Promoting self-agency,* 26), and supporting our clinicians and service providers with new tools to improve care, data collection and information sharing.

For people who experience mental illness, online access to care and support has the potential to make a real difference. This is particularly true for people in rural and remote areas and for those who prefer not to use face-to-face professional services for cultural reasons or because of stigma. An overwhelming majority of Australians – 86 per cent – use the internet, with 44 per cent using it more than five times a day.[246] Ninety-five per cent of young people use the internet daily.[247] Young people are not only comfortable with the online world: it is a primary means of communication and a hub through which they plan their lives, connect, contribute, share and interact.[248]

New technologies are transforming health care and the delivery of human services more widely. One recent report suggests at least 8800 extra mental health professionals may be required to meet Australia's rising mental health care needs during the next 15 years, resulting in a cumulative cost of $9 billion[249] if we rely on today's methods only to bridge the gap in mental health care. The availability of new technologies that support consumers in their recovery will allow specialist mental health services to be more focused on people with severe and debilitating illness. In addition, better clinical information systems and decision-making supports will improve the quality of care and open up opportunities for sharing information among service providers to achieve more integrated care.

New technologies also provide possibilities for better collection, analysis and sharing of data.

A rapidly changing landscape

Australia is at the forefront in the development of e-mental health initiatives.[250] For people experiencing distress and mental illness, their families and carers, a growing array of quality online information, forums, support and counselling and self-help tools and apps is available. These include ReachOut.com, eheadspace, myCompass by the Black Dog Institute, Lifeline, Kids Helpline, MindSpot, beyondblue, MoodGYM, e-couch, Beacon 2.0, THIS WAY UP Clinic, to name a few.

While online supports are often discussed in economic terms – that is, the lower cost of online delivery – the more pertinent point is that many people prefer online information or support because it is convenient, fast and private.[251] Online services provide greater control for individuals than traditional services, can be easier to tailor and can be available at any time anywhere. For many of us, the first port of call for information or reassurance when we have a worry or query is the internet. As mentioned in *Promoting self-agency,* 26, many of us may never go further than the internet to seek care and, for some, online information and support may provide all we need. This is recognised in the NSW Government Information and Communications Technology Strategy which seeks to improve government services through convenient, real-time online-based tools, including mobile devices. This is discussed further in *Broader context of reforms*, p. 118.

There is good evidence that new technologies can be effective in improving mental health and wellbeing[252] [253], including among young people.[254] A review of randomised controlled trials found the internet to be an

effective medium for the delivery of interventions designed to reduce the symptoms of depression and anxiety in 88 per cent of the studies.[255]

But these online innovations are moving so quickly that we do not yet realise the full opportunity they present. In particular, online services are often emerging independently of existing service systems and are operating in parallel rather than in an integrated manner.[256] Where online services do integrate with traditional service delivery modes, it may be only on a small scale. The opportunity is to significantly scale up the integration of online services with traditional services delivered in community-managed, public sector and primary care settings. This would mean GPs, community workers, clinicians and other health professionals promoting and integrating online solutions into the care they provide. In this way, online services are not simply an adjunct or alternative to traditional services but a fully integrated part of a person's care.

E-health

For health workers, e-health is already transforming care and has the potential go much further. The term generally refers to the use of information and communications technologies to improve health care for individuals and communities. The 2013 Blueprint for eHealth in NSW highlights three core areas for e-health change:

- clinical care – new technologies that support the day-to-day requirements of clinical care, including decision support tools, and initiatives such as Personally Controlled Electronic Health Records (PCEHR) which are held by the patient and have the potential to connect primary, community and acute care
- corporate systems – includes technologies such as data collection and analytics tools to support performance management, planning and decision making
- infrastructure – includes the hardware, software, facilities and service components that support and enable e-health.[257]

Now forming part of HealthShare NSW, eHealth NSW will be established as a separate entity within NSW Health to provide statewide leadership on the shape, delivery and management of information and communication technologies led health care. eHealth NSW will connect clinicians and patients to health and medical resources and help create opportunities for clinicians and patients to work together and share decision making. This is in keeping with person-focused health delivery.

An example of an existing initiative is Health*e*Net, which NSW has developed to connect the electronic medical records held by public hospital and community services with the PCEHR, a national initiative that gives patients an electronic record they control, with GPs expected to be the primary contributors of information.

Mental Health Emergency Care – Rural Access Program

This program provides specialist mental health support to people in rural and remote areas. It began in 2008 and uses video technology to conduct assessments and provide advice to health and emergency staff who are supporting a person experiencing a mental health emergency. It also allows for broader support for rural and remote hospital staff to receive training in assessment and management of behavioural consequences of acute mental illness, enables support for police and ambulance staff in decisions about transporting a person with a mental illness for acute hospital care and allows for collaboration with GPs.

Within the community-managed mental health sector, work has been done to integrate information systems to standardise national mental health data collection for the community-managed sector. This is a significant step towards an integrated information technology approach.

For the potential of information and communications technology to be realised for the community-managed sector, a considered and integrated approach will be required from government. An approach that supports community-managed partners to meet their information and communications technology requirements efficiently will benefit not only community-managed agencies but government through a reduction of duplicated systems and the potential for better, standardised data and performance reporting.

Actions

8.4.1 Ensure that NSW Government information and communications technology planning considers the needs and benefits for mental health consumers, carers and service providers of new technology, and include planning for mental health in the priorities of eHealth NSW.

8.4.2 Develop a statewide strategy for the provision and continual improvement of technology infrastructure for the mental health sector and to promote the integration of new technologies with traditional service arrangements.

8.4.3 Scope opportunities for new technologies to improve care through better information sharing among service providers.

8.4.4 Develop and implement a training program for health care leaders, clinicians and front-line staff on emerging technologies in e-mental health. In particular, education and training will need to focus on how evidence-based decision supports can be incorporated into everyday practice within a collaborative, recovery-focused care context.

8.4.5 Explore the use of e-mental health systems to enhance the capabilities of primary health and other service sectors to appropriately identify, support, and refer on people experiencing mental illness to mental health services. This could include trialling real-time mental health assessments and surveys in general practice waiting rooms via tablets which can immediately refer the person to relevant online resources and guide the GP's consultation with the individual.

8.4.6 Closely monitor and review the evidence supporting e-mental health and publish regular updates relevant to NSW.

8.4.7 The NSW Mental Health Commission will partner with ReachOut.com by Inspire Foundation, the Black Dog Institute and the Brain and Mind Research Institute to explore an approach that integrates technology-based services with primary health care providers and traditional clinical services in a stepped-care framework. They will work with NSW Health to develop, implement and evaluate a trial to examine whether the integration of technology services can increase the scalability, effectiveness and outcomes of mental health care.

8.5 Research and knowledge exchange

To support the reforms set out in this Plan, it is critical that we have a robust evidence base to guide decision making and the development and design of services and programs. Both the Commonwealth and NSW governments play a role in this.

The Commonwealth has substantial investment in health and medical research, much of which is high-level discovery research. NSW has committed to building an evidence base through the routine evaluation of its programs in the NSW Government Evaluation Framework.

The framework calls evaluation 'a key tool to support evidence-based policy and decision making in government to learn and adapt to changing environments and as a tool for communicating and sharing valuable information'.[258] However, the NSW Government's interest extends beyond this to directing limited funds towards translational research for novel and innovative approaches that support:

- the delivery of better services, treatment and technology to improve the lived experience of those with a mental illness and keep people well in the community
- better preventive efforts to improve the mental health and wellbeing of the people of NSW.

Collaborative research framework

There has recently been a focus on reviewing the frameworks governing investment by the Commonwealth[259] and NSW[260] governments in health and medical research that has emphasised the need for greater integration between research and practice. NSW has indicated its desire for a more collaborative, research hubs-based approach that allows for collaborative research environments and strong research leadership, as well as the capacity to share physical facilities, operational support and expensive equipment.

Within this context, the NSW Mental Health Commission was asked on its establishment to develop a Research Framework for Mental Health in NSW. The proposed framework developed by the Commission and currently subject to consultation seeks to develop an inclusive and collaborative approach rather than a competitive one.

This framework confirms that the overarching aims of NSW-funded mental health research are to:

- improve the lived experience of those with a mental illness and keep people well in the community
- accelerate the translation of research into practice
- support and attract a robust research capacity and infrastructure for NSW.

The key principles underpinning the framework are:

- engagement of consumers and carers at all stages of research, including its translation into practice and policy
- prioritising research that supports prevention, early intervention and keeping people well in the community with a flexible approach that would adapt as opportunities and knowledge change. Priority setting will take into account under-researched areas and disadvantaged communities where clear inequities exist, while also building on our existing strengths
- fostering knowledge exchange and the successful translation of research into practice.

Knowledge sharing

Although a number of mechanisms for managing and sharing information already exist, including A Blueprint for eHealth in NSW and the NSW Government Information and Communications Technology Strategy, these primarily look to establish common standards for and approaches to information management across government.

While these initiatives are important, knowledge exchange must go beyond this to include a sharing of experiences and insights, not only data. While innovation in one place may not work in another, sharing of innovation can illustrate what is possible and provide a platform on which to build innovation and reform, rather than starting from scratch.

The NSW Mental Health Commission and NSW Health are members of an international mental health forum whose focus is leadership development and capability and exchange for senior policy, consumer, clinical, service and research leaders. A similar forum established in NSW would enable a full exchange of ideas in mental health. It would need to operate across the public and community-sector health and draw in housing, education, community services, justice and local government.

It would also need to work in partnership with agencies that have a role in knowledge exchange, including the Agency for Clinical Innovation, the Clinical Excellence Commission, the Bureau of Health Information, the Health Education and Training Institute, and InforMH, a NSW Ministry of Health entity which collects and reports mental health data.

Actions

8.5.1 The NSW Mental Health Commission will establish a research co-ordination unit to oversee the implementation of the Research Framework for Mental Health in NSW.

8.5.2 Establish a model for developing and supporting consumer researchers that takes the principles of recovery into account.

8.5.3 Establish effective mechanisms within NSW, between NSW and the Commonwealth, and between NSW and other states, to ensure NSW's research activity improves knowledge sharing, maximises opportunities to leverage from the broader research field and minimises duplication of effort.

8.5.4 The NSW Mental Health Commission will establish a NSW Initiative for Mental Health Leadership, built on the International Initiative for Mental Health Leadership model, to strengthen reform capability of mental health in NSW through:

- knowledge exchange
- innovation sharing
- transfer and adaptation of successful policy and service design
- use of comparative data to drive service improvement
- problem solving
- support for change management
- leadership development and networking.

9. GOVERNANCE OF MENTAL HEALTH WITHIN NSW HEALTH

Who has a role in mental health?

It is becoming increasingly critical that we have a clear and shared understanding of who is in charge of mental health, and of our core expectations.

Mental illness has until very recently been viewed in our community as something quite separate from a person's general health and other aspects of their life.

That separateness has been echoed in the systems that have grown up in NSW to offer mental health care, which have existed in parallel with our broader system of public health care – particularly in the ways they are planned, managed and governed.

There is a need to promote a broader, integrated approach to planning, development, and governance across the whole of the public health system that is fully inclusive of mental health.

The Mental Health Drug and Alcohol Office within the Ministry of Health, created in 2006, raised the profile of mental health and has seen NSW lead national mental health projects, but it has operated separately to other health policy and planning functions.

NSW Health has, since 2013, been pursuing the better alignment of mental health to the wider governance and accountability arrangements of the NSW health system. These efforts seek to make mental health central to the accountabilities not just of the NSW Health 'Pillar' agencies (including the Clinical Excellence Commission, the Agency for Clinical Innovation and the Bureau of Health Information), but also of the Ministry's Population and Public Health Division activities, and of NSW Kids and Families, a statutory authority which champions the interests of children across the health system and the wider community. Clearer inclusion of mental health within the ambit of the Pillars and other central NSW Health divisions will ensure that mental health can benefit from innovations and practices across the NSW health system.

To support these aims the NSW Mental Health Commission has initiated:

- with the Agency for Clinical Innovation, the establishment of a mental health clinical network
- with the Bureau of Health Information, the development of what will become a regular public report about mental health service performance in NSW.

The Local Health Districts

As Local Health District (LHD) boards and chief executives are given more responsibility to design and run health services, in line with NSW Government policy, the capacity of LHDs to act independently, partnering with Commonwealth, community-managed and private providers as well as other NSW agencies to innovate and drive efficiency, will be the engine room of mental health reform.

But it may also raise ambiguities in terms of responsibility for planning, forecasting need, and ensuring an agreed level of service is always available to people who need it. With the authority to act, LHDs also assume the accountability to deliver.

The accountability of Local Health Districts

In preparing this Plan, the NSW Mental Health Commission approached eight LHD chief executives for baseline information on their mental health services and also conducted site visits. Generally the Commission met with the LHD executive, the mental health executive, other key staff and local community-managed service providers, and toured facilities and services. The Commission has also had contact with other LHDs and they have been helpful in providing information.

The feedback provided by the LHDs deepened the Commission's understanding of the challenges facing mental health services and also highlighted areas of best practice and initiatives which are working well.

Based on these consultations, the Commission observed that:

Planning and forecasting need

- LHDs received little guidance about how they should plan their mental health services and ensure their accountability. In the absence of this advice, some developed their own clinical service plans without external input regarding treatment goals or evidence-based models of care.
- Mental health service configuration is not contemporary. There are high levels of inpatient care with insufficient enhancement to community care over many years. The result is an inadequate response to more severe mental illness in the community, which frequently does not embody ideas of recovery and trauma-informed practice.
- The scope of services that the LHD is expected to provide with the funding it receives is unclear, and is further complicated by parallel Commonwealth and NSW funding streams without joint planning.
- Specialist state-wide mental health services hosted by a number of LHDs – including the Transcultural Mental Health Centre and the NSW Aboriginal Mental Health Workforce Program – require support and attention from the Ministry and the LHD executive, if they are to adequately perform their state-wide role and not be vulnerable to the LHD budget pressures.

Innovating and driving efficiency

- There were many local examples of modern, innovative practice. However these were isolated and there appeared to be no mechanism to share and scale up these local initiatives across NSW.
- Increased integration is required. This includes training staff to work in partnership with other organisations, co-location of services, cooperative agreements and joint appointments. New specialist capacity may be needed to initiate and successfully manage multiple clinical and business relationships.

Ensuring the transparency of mental health spending

Our observations, in engaging with LHDs, were that, although funds for mental health are ostensibly quarantined, in practice they may be diverted to other areas within LHDs. The current difficult financial environment within the health sector and Government more generally has amplified the risk that mental health services may not receive their funding allocation, and this is particularly true for community mental health services. A lack of transparency in mental health funding within many LHDs makes this difficult to challenge when it occurs.

In addition, we were advised that some LHD mental health directors do not have control over their budgets and are unable to approve the recruitment of staff. Approval to recruit is not always forthcoming or is substantially delayed. This results in a workforce shortfall, especially across community-based services, and in effect also diverts funding away from mental health.

Mental health budgets can be depleted in a number of ways including:

- charging excessive or duplicated fees for corporate services
- charging excessive levies for items such as information technology, financial services and executive salaries
- requiring unreasonable efficiency or productivity savings
- imposing unreasonable revenue targets
- instituting unreasonable salary caps and position freezes, and delaying advertisement of vacancies
- using the deletion of vacant positions to divert funds to other LHD programs
- restricting spending to generate cash savings, in order to offset budget issues in other programs and in the overall LHD financial position.

The Commission believes that steps are required in some LHDs to preserve and stabilise existing mental health service and state-wide specialty mental health service budgets by eliminating any excessive extraction of overheads and levies from LHD mental health budgets.

Funding is critical to the reform agenda

This is not a new issue. There have been long-standing calls for mental health funding to be quarantined and successive commitments to ensure that this is so. Indeed, bi-partisan concern for the protection of mental health budgets was central to Parliament's support for the establishment of the Mental Health Commission of NSW.

In an environment where available funding currently falls short of the needs of reform, it is imperative that the 2013-2014 $1.45 billion mental health services budget allocated in the Budget Papers and supported by the NSW Parliament are deployed as intended. Moreover, the thrust of current reforms is to give priority to community based services. While this will require increased funding to these services over time, it will be critical to ensure that existing mental health funding is transparent and acquitted appropriately.

The Ministry of Health has acknowledged during the consultation process that improving the transparency and governance of mental health spending is essential in order to ensure the promise of reform is fulfilled.

NSW Health is clear that greater devolution of the health system does not mean that Government should not have a clear sense of the outcomes that it wants to achieve, and the resources that it is investing, as well as the extent to which it is meeting its aims.

In line with NSW Health's devolution journey, to make a reality of the measures in the Plan, LHDs will be required to increase their focus on mental health service innovation and reform. This will require commitment from LHD boards and chief executives to seeing through the implementation of the reform priorities and ensuring that LHD directors of mental health have the necessary authority to act, including having certainty around the mental health budget.

Actions

To establish new governance and accountability mechanisms for mental health service delivery the NSW Government, in consultation with the Commission, will establish formal governance and accountability arrangements to oversee the implementation of this Plan and its alignment with other reform activity across the NSW Government.

As part of these governance and accountability arrangements, NSW Health and the Commission will develop:

9.1 A new outcomes agenda for mental health services in NSW. This will include a set of clear key performance indicators (KPIs) for LHDs under the NSW Health Performance Framework, including in relation to community mental health services. These should also be reported publicly, increasing the transparency of mental health spending, and the extent to which services are meeting need. For example, KPIs might include budgets and expenditure, staffing levels and vacancy rates in each LHD. These KPIs will also be implemented with community-managed organisations where relevant.

9.2 Clearer service and performance agreements, which include clear performance parameters, between the Ministry and LHDs.

9.3 Clearer purchasing arrangements particularly in relation to community mental health care and community alternatives to inpatient care and including the liaison between specialist mental health services and general health services both hospital-based and in the community.

9.4 Mechanisms for more robust mental health budget transparency, including acquittal and reporting processes, including considering the role of audit and risk committees.

9.5 Strengthened stakeholder engagement, particularly of people with a lived experience of mental illness, their families and carers, around mental health service planning and review by LHDs.

If, within two years, the Commission is not satisfied that progress against these actions is sufficient, it retains the authority under the *Mental Health Commission Act 2012* to report and make further recommendations to Government, for example around providing the NSW Mental Health Commission with independent audit powers and/or regarding the implementation of alternative funding models.

10. BROADER CONTEXT OF REFORMS

This Strategic Plan for Mental Health in NSW comes at a dynamic time in the development of health and social policy, at state and national levels. Major policy revisions, based on new philosophies about individual autonomy and effective service provision, have the potential to dramatically change the way support is offered to people who experience mental illness, and to rewrite our shared understanding about community wellbeing.

These changes present valuable opportunities to embed mental health reforms within wider movements for change, enhancing their efficiency and the likelihood they will succeed in the longer term.

But as we look ahead at the directions for mental health in the next decade, many of these major policy transformations also make it more difficult for us to anticipate the shape of the future into which they must fit. Even smaller, incremental adjustments to funding or governance structures can, over time, change fundamentally the environment in which we are living and working.

It is imperative that we revisit this Plan at regular intervals during its 10-year horizon, to check and adjust the directions set out here so that they achieve the improvements we expect.

This section outlines some of the most important existing policy directions of the NSW and Commonwealth governments, and how they may affect our thinking and practice in mental health and wellbeing.

National Disability Insurance Scheme

Under the National Disability Insurance Scheme (NDIS), people with a psychiatric disability will be offered support if their impairment affects their communication, social interaction, learning, mobility, self-care or self-management and the impairment affects or is likely to affect the person's capacity for social or economic participation.

For people with severe mental illness, the NDIS acknowledges their experience that severe psychological symptoms can be just as disabling as physical illness. The scheme’s emphasis on people’s level of functioning rather than their diagnosis is in line with thinking that mental health is part of a person’s overall wellbeing.

The NSW rollout of the NDIS has started in the Hunter region. A range of reviews is under way to look at how to improve the scheme’s implementation. These reviews acknowledge that some things remain unclear, including how the scheme will apply to people whose mental illness causes disability.

At this time, it is not yet certain what level of mental health support will be included in an NDIS package. It also appears some people will fall through the gap as Commonwealth-funded mental health support services, such as the Personal Helpers and Mentors service, provide services to a broader group than would be eligible for the NDIS. While present participants have a guarantee that they will not be worse off, these services will not be available to new people unless they are eligible for the NDIS. This is a real concern for people living with a mental illness and is likely to place extra pressure on Local Health Districts.

These issues need to be closely monitored and the Mental Health Commission of NSW has partnered with the Mental Health Co-ordinating Council to provide a project worker in the Hunter NDIS site to influence and learn from the early implementation of NDIS and how it applies to people who experience mental illness.

Another issue relates to governance at the intersection between mental health and disability, particularly in complex areas such as the criminal justice system. At present, NSW Health and Ageing, Disability and Home Care have a highly developed partnership in this area. But Ageing, Disability and Home Care will cease to exist after the NDIS is introduced. From a service perspective, NSW Health will need to develop partnerships with community-managed and private disability service providers and the National Disability Insurance Agency.

But with whom will NSW Health partner on strategic issues to ensure there are appropriately accountable services and models of care to meet the needs of clients with complex needs? As in other states, these matters are still being considered by government agencies, including Family and Community Services and NSW Health, as part of the NDIS implementation work.

The ultimate outcome in NSW may be assisted by proposed reforms under the *NSW Disability Inclusion Act 2014* which specifically acknowledges psychosocial disability as a disability for the purposes of the legislation, in a similar manner to the NDIS.

Activity-based funding

Historically, mental health services have been block funded, with each service usually receiving last year's funding plus or minus a little. This way of funding public hospital services is being progressively phased out and is replaced by activity-based funding (ABF). The model takes into account the number of episodes of care and the mix of services– with more funding for more complex patients and more expensive episodes.

The price paid for each activity is set by the Independent Hospital Pricing Authority (IHPA), which is developing a new classification for mental health, the Australian Mental Health Care Classification. It is likely this classification will include all public hospital settings except the emergency department. Work to develop this classification and funding model is due to begin in 2014 with the goal of having a new system ready for trialling in 2015-16.

Activity-based funding offers the potential of more transparency about funding and will assist in preventing funding intended for mental health being directed elsewhere.

A new funding model offers the opportunity to achieve a better balance of investment in services across the inpatient, community and community-managed settings. However, if not implemented correctly, this funding change could result in the extra resources going to the hospital sector, where evidence suggests they will not achieve the same outcome. It will be important for NSW to work with IHPA to ensure the new model does not work against a recovery approach or against the development of community-based models of care, including early intervention.

Other national activity

The 4th National Mental Health Plan 2009-2014 contains five priority areas: social inclusion and recovery, prevention and early intervention, service access, co-ordination and continuity of care, quality improvement and innovation and accountability. The reforms set out in this Plan are aligned with these priorities. As the national plan enters its final year, NSW reforms have the potential to reinvigorate improvements already under way.

The Commonwealth's creation of 17 Medicare Locals in NSW to support primary care at a local or regional level offers opportunities for improving mental health and resilience. The initiative, begun in 2011, funds GPs and other primary practitioners to respond to local needs, for example by establishing out-of-hours general practice clinics or offering a home visiting program.

Some Medicare Locals have developed mental health initiatives, for example funding a psychiatrist to be on call for GPs who are then supported to care for people in the community, even when a patient's mental health problem is more severe. This is consistent with the emphasis in this Plan on moving away from crisis care towards a more robust system of community supports.

Medicare Locals will be replaced in July 2015 by Primary Health Networks, which offer similar potential for greater co-ordination and partnership with the state Local Health Districts and Commonwealth-funded services.

NSW 2021: A plan to make NSW number one

NSW 2021 is the Government's 10-year plan to improve opportunities and quality of life for all, including the vulnerable and disadvantaged.

Four of the goals of the 2021 plan align directly with the priorities of this Strategic Plan for Mental Health in NSW:

- to keep people healthy and out of hospital
- to provide world-class clinical services with timely access and effective infrastructure
- to better protect the most vulnerable members of our community and break the cycle of disadvantage
- to increase opportunities for people with a disability by providing supports that meet their individual needs and realise their potential.

NSW 2021 is supported by 19 Regional Action Plans that seek to enhance community involvement and responsiveness to local needs and priorities. Delivery of these is supported by cross-government leadership structures led by the Department of Premier and Cabinet to ensure local partnerships result in system changes that benefit regions and the whole state. This commitment to localised action is reflected throughout this Strategic Plan and underpins all its proposed activities.

NSW 2021 also reflects the Government's commitment to accountability and transparency. It does this through the clear articulation of goals, priority actions and by specifying the lead minister and agency for each of the targets. It also commits to regular online updates and an annual performance reporting process that includes all performance data being subject to an independent audit before the report's release.

The plan provides the context within which this Strategic Plan for Mental Health in NSW will be delivered and will inform the development of the monitoring, review and reporting framework for its implementation. A range of NSW 2021 targets relate directly to the goals and actions of this Strategic Plan and the NSW Mental Health Commission will have regard to these in its monitoring and reporting on the implementation of this Plan.

NSW Government ICT Strategy

This sets out a plan to build capability across the public sector to deliver better, more customer-focused services, and to derive better value for the state's $2 billion annual investment in information and communications technology. The strategy, which is highly relevant to the delivery of person-centred mental health services, aims to support and develop:

- services any time anywhere – the delivery of convenient and real-time services to the community, increasingly through mobile devices
- community and industry collaboration – using digital channels to interact with the community and industry in policy development, priority setting and service improvement
- citizen-focused services – the delivery of the 'whole service' from the person's perspective, rather than that of government agencies
- information sharing – the ability of government to efficiently share and analyse information among departments
- financial and performance management – timely and consistent information about the financial, service and business performance of agencies to improve decision making and service delivery.

It also sets out six whole-of-government ICT investment principles, which include considering online open access to key data so the community can participate in policy development, as well as data sharing across government and with its key partners.

These developments are supported by initiatives to improve information sharing within government agencies such as the NSW Ministry of Health's Blueprint for eHealth in NSW, and between the state and Commonwealth through initiatives such as e-health records. Developments are also under way on information sharing among government and community-managed organisations and on the reporting to the public of information by government departments.

In addition, data linkage activities are being explored to complement existing initiatives such as the Centre for Health Record Linkage (CHeReL).These initiatives reflect the 'whole of person' and 'whole of government' approach at the core of this Strategic Plan.

NSW criminal justice strategy

Following the bringing together of police, the courts, juvenile justice and corrective services into a single cluster, the Department of Justice is finalising its NSW Criminal Justice Strategy: A plan for system transformation. This aims to create a more unified and responsive criminal justice system.

A key priority for this strategy will be the diversion of people with a mental illness into treatment and support and will draw together a number of programs in the justice sector, including:

- the development and implementation of the government response to the Law Reform Commission's reports on diversion and criminal responsibility for people with cognitive and mental health impairments
- early interventions for young people through schemes such as Youth on Track which is operating in Blacktown, Newcastle and the mid-North Coast.
- personalised support for adult offenders through programs such as the Court Referral of Eligible Defendants into Treatment (CREDIT) program (which is available at three local courts) and Life on Track which began in August 2013 at seven local courts.

The success of these efforts is intrinsically linked with the improved availability of community supports from mental health and related human services as described in this Strategic Plan for Mental Health in NSW. As such, the NSW Mental Health Commission will work closely with the Department of Justice to ensure alignment of directions and activities.

Looking ahead

Many more external policy changes will inevitably arise during the 10-year life of this Strategic Plan. They will be important in determining the implementation of the Plan but they will not change the ultimate goal – to improve the mental health and wellbeing of the people of NSW.

11. APPENDICES

11.1 Indicators

Indicator	Why this matters
Increase the proportion of the community that reports positive mental health and wellbeing	Mental health consists of two dimensions: mental health problems (measured by psychological distress) and mental wellbeing (measured by positive mental health which includes life satisfaction, positive relationships with others and purpose in life). Accordingly, mental health indicators that encompass both mental health problems and mental wellbeing are used to look at outcomes in this area.
Decrease the rate of psychological distress in the community	
Reduce the proportion of people with a mental illness experiencing discrimination and stigma	Reducing the discrimination and stigma associated with mental illness is an important component of improving the quality of life and wellbeing of people experiencing mental health problems. This relates to how a person with a lived experience is perceived by employers, work colleagues and the wider community.
Increase the rate of community participation among people with a mental illness	Community participation covers the extent to which a person is engaged in activities that support health and a good quality of life and allow individuals to contribute to their community. This includes work, education and participation in social activities and community life.
Increase the proportion of the workforce in mental health services who are peer workers	Peer workers are people who have a lived experience of mental illness. Using this experience they are able to support and work with others with a mental illness. Peer workers have a positive impact on practice and outcomes in mental health.
Increase the proportion of consumers with a positive experience of service delivery	Ensuring consumers have a positive experience of service delivery reflects the expectation that services are effective and address the needs and priorities of consumers.
Decrease the rate of suicide and suicidal behaviour	Reducing suicide and suicidal behaviour is essential given the devastating effect of suicide on carers, families and the community. The suicide rate is also a reflection of the mental health and wellbeing of the community.
Increase the proportion of NSW mental health spending allocated to community-based alternatives to hospital services	The development of community-based alternatives to hospital in the delivery of mental health care and support services is a critical element in rebalancing our system. NSW has the lowest per capita funding allocated to community-based services of any state or territory.

Indicator	Why this matters
Decrease the rate of involuntary treatment orders (inpatient and community) issued	A high rate of involuntary treatment orders (inpatient and community) is a marker of a system which is not intervening early or effectively. It indicates a need to rebalance the system and move away from a reliance on coercive forms of care, in inpatient and community settings.
Reduce the proportion of people in the prison population who have a previous experience of mental illness	People with a mental illness are disproportionately represented in custody. Diversion programs, interventions and support after release help reduce the number of people with a lived experience of mental illness re-entering custody.

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