PERFORMANCE AUDIT 29 AUGUST 2019

Mental health service planning for Aboriginal people in New South Wales

NEW SOUTH WALES AUDITOR-GENERAL'S REPORT

audit office
OF NEW SOUTH WALES

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auditoffice
OF NEW SOUTH WALES

GPO Box 12
Sydney NSW 2001

The Legislative Assembly
Parliament House
Sydney NSW 2000

The Legislative Council
Parliament House
Sydney NSW 2000

In accordance with section 38E of the *Public Finance and Audit Act 1983*, I present a report titled **'Mental health service planning for Aboriginal people in New South Wales'.**

Margaret Crawford
Auditor-General
29 August 2019

contents

Mental health service planning for Aboriginal people in New South Wales

Section one

Mental health service planning for Aboriginal people in New South Wales

Executive summary

Mental illness (including substance use disorders) is the main contributor to lower life expectancy and increased mortality in the Aboriginal population of New South Wales. It contributes to a higher burden of disease and premature death at rates that are 40 per cent higher than the next highest chronic disease group, cardiovascular disease.[1]

Aboriginal people have significantly higher rates of mental illness than non-Aboriginal people in New South Wales. They are more likely to present at emergency departments in crisis or acute phases of mental illness than the rest of the population and are more likely to be admitted to hospital for mental health treatments.[2]

In acknowledgement of the significant health disparities between Aboriginal and non-Aboriginal people, NSW Health implemented the NSW Aboriginal Health Plan 2013-2023 (the Aboriginal Health Plan). The overarching message of the Aboriginal Health Plan is 'to build respectful, trusting and effective partnerships with Aboriginal communities' and to implement 'integrated planning and service delivery' with sector partners. Through the Plan, NSW Health commits to providing culturally appropriate and 'holistic approaches to the health of Aboriginal people'.

The mental health sector is complex, involving Commonwealth, state and non-government service providers. In broad terms, NSW Health has responsibility to support patients requiring higher levels of clinical support for mental illnesses, while the Commonwealth and non-government organisations offer non-acute care such as assessments, referrals and early intervention treatments.

The NSW Health network includes 15 Local Health Districts and the Justice Health and Forensic Mental Health Network that provide care to patients during acute and severe phases of mental illness in hospitals, prisons and community service environments. This includes care to Aboriginal patients in the community at rates that are more than four times higher than the non-Aboriginal population. Community services are usually provided as follow-up after acute admissions or interactions with hospital services. The environments where NSW Health delivers mental health care include:

- hospital emergency departments, for short-term assessment and referral
- inpatient hospital care for patients in acute and sub-acute phases of mental illness
- mental health outpatient services in the community, such as support with medications
- custodial mental health services in adult prisons and juvenile justice centres.

The NSW Government is reforming its mental health funding model to incrementally shift the balance from hospital care to enhanced community care. In 2018–19, the NSW Government committed $400 million over four years into early intervention and specialist community mental health teams.

[1] Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011 (unaudited).
[2] Australian Institute of Health and Welfare data 2016–17 (unaudited).

This audit assessed the effectiveness of NSW Health's planning and coordination of mental health services and service pathways for Aboriginal people in New South Wales. We addressed the audit objective by answering three questions:

1. Is NSW Health using evidence to plan and inform the availability of mental health services for Aboriginal people in New South Wales?
2. Is NSW Health collaborating with partners to create accessible mental health service pathways for Aboriginal people?
3. Is NSW Health collaborating with partners to ensure the appropriateness and quality of mental health services for Aboriginal people?

Conclusion

NSW Health is not meeting the objectives of the NSW Aboriginal Health Plan, to form effective partnerships with Aboriginal Community Controlled Health Services and Aboriginal communities to plan, design and deliver mental health services.

There is limited evidence that existing partnerships between NSW Health and Aboriginal communities meet its own commitment to use the 'knowledge and expertise of the Aboriginal community (to) guide the health system at every level, including (for) the identification of key issues, the development of policy solutions, the structuring and delivery of services'[3] and the development of culturally appropriate models of mental health care.

NSW Health is planning and coordinating its resources to support Aboriginal people in acute phases of mental illness in hospital environments. However, it is not effectively planning for the supply and delivery of sufficient mental health services to assist Aboriginal patients to manage mental illness in community environments. Existing planning approaches, data and systems are insufficient to guide the $400 million investment into community mental health services announced in the 2018–19 Budget.

NSW Health is not consistently forming partnerships to ensure coordinated care for patients as they move between mental health services. There is no policy to guide this process and practices are not systematised or widespread.

In this report, the term 'Aboriginal people' is used to describe both Aboriginal and Torres Strait Islander peoples. The Audit Office of NSW acknowledges the diversity of traditional countries and Aboriginal language groups across the state of New South Wales.

1. Key findings

NSW Health does not have a clear picture of the mental health service use patterns of Aboriginal people

NSW Health does not have a clear picture of the mental health service use patterns of Aboriginal people prior to them presenting at hospitals in acute phases of mental illness. Data are not sufficiently detailed to show which services Aboriginal people are accessing in the community, or whether they are accessing services before they reach crisis.

Without information about the nature and extent of Aboriginal service use patterns with preventative mental health services, NSW Health is not able to target necessary resources and treatments to assist Aboriginal patients to manage their mental illnesses and avoid crises.

Executives from 11 of 15 Local Health Districts report that mental health data and information are insufficient for their mental health service planning requirements. The main deficiency is an inability to aggregate data from Commonwealth and non-government services with NSW Health data.

[3] NSW Health, The Aboriginal Health Plan 2013-2023.

New South Wales is not the only jurisdiction with limited data about the full picture of Aboriginal mental health service use in community environments. Other states and territories are similarly challenged in aggregating mental health data from multiple sources. While NSW Health has adequate data to describe its own mental health service use patterns, a lack of consistent data from Commonwealth funded services and the non-government sector, means that NSW Health's knowledge about the service use patterns of Aboriginal patients is incomplete.

In the absence of complete data, there is limited evidence that NSW Health has taken other steps to understand the service use behaviours of Aboriginal patients in the community. For example, less than half of all Local Health Districts have developed forums to seek the views of Aboriginal stakeholders about the types of mental health services that are best suited to address the needs of local Aboriginal communities. In addition, there is no consistency in the methods that Local Health Districts use to collect information from each region.

Planning is not sufficiently targeted to ensure mental health services are available in locations where they are needed

NSW Health does not have a policy or formula to guide the distribution of mental health services across locations. Mental health services are funded by both state and Commonwealth governments and while all Local Health Districts engage in some form of joint service planning with Commonwealth providers, there is insufficient guidance or policy to ensure the equitable distribution of mental health services across geographic areas and townships. There is no oversight or service mapping to ensure that NSW Health and Commonwealth services are in the locations where they are required.

As a result, some regional towns have limited mental health service options, while other townships have extensive service profiles. Some townships with limited service options have proportionally high Aboriginal populations. While mental health services may be available in neighbouring townships within travelling distance, transport options are limited in some regions, and the costs and time of travel can be a barrier to service access.

NSW Health is not targeting sufficient resources to support Aboriginal mental health patients to stay well at home and avoid hospitalisation

The New South Wales mental health service profile does not include sufficient outreach services to support Aboriginal patients with complex needs to avoid crisis situations. The high numbers of Aboriginal people presenting at emergency departments in mental health crises, highlights insufficiencies in the community mental health service profile.

Aboriginal people are more likely to access emergency services in circumstances of mental health crisis than non-Aboriginal people. The statewide proportions of Aboriginal people presenting at emergency departments for mental health treatments have been increasing over time. While Aboriginal people make up just under three per cent of the New South Wales population, in 2017–18 they accounted for nearly 11 per cent of emergency department presentations for mental health reasons. In regional and rural areas, the proportions were higher at 21 per cent.

Executives from 11 of the 15 Local Health Districts and staff from all surveyed non-government organisations report a system-wide lack of mental health services with the cultural and clinical expertise to support the high numbers of Aboriginal patients requiring specialist support in community environments.

Mental health teams in Local Health Districts lack staff numbers to meet patient demand in the community. While they have the clinical expertise to support Aboriginal people with complex mental health needs, most staffing is directed to hospital mental health services and follow-up for patients after discharge.

A range of non-government organisations provide a significant component of the early intervention, community mental health service profile. Most are non-Aboriginal organisations receiving Commonwealth funding to deliver counselling and social supports to a predominantly non-Aboriginal clientele who voluntarily come to appointments at community mental health centres. These services offer Western counselling models of mental health care that are not widely accessed or utilised by Aboriginal people with mental illnesses.

NSW Health provides some funding to Aboriginal Community Controlled Health Services to provide mental health services. These non-government organisations have the cultural and clinical capability to support Aboriginal patients with complex mental health needs, but most advise that they lack the level of staffing and resources to meet community demand.

There is limited case coordination as patients move from one service to the next

NSW Health does not have a policy directive or protocol to identify the circumstances when a patient requires a mental health case coordinator to manage their care. NSW Health also lacks policy to identify or nominate a lead case coordinator for patients accessing multiple mental health services. Case coordination is important for Aboriginal patients requiring multidisciplinary health services to assist in the management of their mental illness, including support with medications. A case coordinator assists in the management of care and the transfer of care from one service type to another.

Case coordination and information sharing across organisations is not routine, systematised or reported in all Local Health Districts. Six of the 15 Local Health Districts have some form of system for joint case review and information sharing, while the other Districts have limited systems for communicating about patients who require or access multiple mental health services.

Mental health patients lack certainty about which agency is responsible to manage their support and care. Some mental health patients require significant assistance to access services. For example, patients with symptoms such as paranoia, poor insight into their illness, or social withdrawal can find it very difficult to access services voluntarily.

In instances where patient treatment is mandated under the *Mental Health Act 2007 (NSW)*, responsibility for case management is clear. The Mental Health Review Tribunal or a Magistrate nominates an entity to provide medication and therapy, counselling, management, rehabilitation and other services for people subject to a Community Treatment Order. This is a legal order whereby a person must accept medication and support services while living in the community.

Case management leadership is also explicit when NSW Health manages its own Aboriginal patients as they transition from long term hospital stays to community residential care. NSW Health is the lead agency with responsibility to manage these transitions through its 'Pathways to Community Living Initiative'. Since 2015, 20 Aboriginal people have been transitioned to community residential care through this program.

NSW Health provides limited support to assist Aboriginal people with mental illness on release from prison

Aboriginal people diagnosed with mental illness are not consistently supported by Justice Health to transition to the community with prescribed medications, a discharge summary or a referral to a mental health service after release from prison. Justice Health staff in larger prisons with more than 100 inmates have difficulty following up on patients. When inmates are released from prison without notice, usually straight from court, there is no pre-planning to support their release. In some instances, communication with Corrective Services staff is not occurring and Justice Health are not aware of pending court dates. In other instances, Justice Health staff report that they have competing work priorities and are unable to follow-up on patients after release. That said, in respect of Justice Health's role:

- there is no key performance indicator (KPI) requiring Justice Health to report on the numbers of patients receiving discharge summaries and medications within seven days of their release
- Justice Health has not directed resources to support the transition of adults to community mental health services post release
- patient medical records and discharge summaries are held for two weeks at the prison where the patient was released. After the two-week period, patient records are not available to external medical agencies to ensure continuity of medications and care in the community.

NSW Health does not have an Aboriginal mental health policy to guide a complex service sector

The NSW Aboriginal Mental Health and Well Being Policy 2006-2010 expired in 2010. For almost a decade, NSW Health has operated without a directive for planning Aboriginal mental health care and integrating culturally appropriate Aboriginal models of mental health care into mainstream services.

While NSW Health has implemented policies that provide some direction for Aboriginal mental health care, none provide an overarching planning framework or a clear policy directive to address the unique needs that Aboriginal patients have for appropriate, culturally informed mental health services. Some policies advise on Aboriginal workforce planning and others contain information about partnership approaches to Aboriginal health care. They include:

- The NSW Aboriginal Health Plan 2013-2023; to guide health partnerships between NSW Health and Aboriginal communities to ensure services are targeted to the specific requirements of Aboriginal patients.
- The Mental Health Strategic Framework; to guide the delivery of services to all mental health patients, Aboriginal and non-Aboriginal.
- NSW Good Health - Great Jobs: Aboriginal Workforce Strategic Framework 2016-2020.
- The Aboriginal Health Impact Statement; requiring NSW Health Staff to report on the ways it will incorporate the health needs of Aboriginal people in the development of new and revised policies, programs and strategies.
- Respecting the Difference: an Aboriginal Cultural Training Framework for NSW Health.

NSW Health advises that they are in the process of developing a new Aboriginal mental health policy, though there is no timeframe for its completion.

2. Recommendations

By December 2020, in partnership with Aboriginal mental health clinicians and policy experts, NSW Health should:

1. Research, develop and publish evidence-based models of culturally appropriate Aboriginal mental health care for use in Local Health Districts.

2. Finalise and publish an Aboriginal mental health policy framework that includes:

    - a timeline and plan for full implementation of the Framework and a communication strategy to improve the visibility and priority of Aboriginal mental health care across the mental health sector
    - methods, roles and responsibilities for collecting detailed information and data about Aboriginal service use and service demand by location
    - a process for Local Health Districts to map services with Primary Health Networks and non-government providers to identify service gaps and duplications and plan for the equitable distribution of services across locations
    - a strategy to increase services for Aboriginal patients requiring high levels of clinical support in the community and clarification of mental health case management roles and responsibilities to ensure accountability and continuity of patient care across the different service providers and service types
    - actions to increase the numbers and types of Aboriginal workers across all levels and positions in the mental health workforce
    - new key performance indicators and performance reporting on follow-up actions that:
        - support information sharing and referrals of Aboriginal people to community-based mental health services
        - ensure follow-up actions to support mental health patients on release from prison so that they receive seven days of medication, referrals and discharge summaries.

1. Introduction

1.1 Prevalence of mental illness in Aboriginal populations

Mental illness (including substance use disorders) is the leading cause of chronic disease and the top contributor to lower life expectancy and increased mortality amongst the Aboriginal population of New South Wales. It contributes to disease burden and premature death at rates that are 40 per cent higher than the next highest chronic disease group, cardiovascular disease.[4]

While Aboriginal people make up just under three per cent of the New South Wales population, in 2017–18 they accounted for nearly 11 per cent of emergency department presentations for mental health reasons. In regional and rural areas, the proportions were higher, at 21 per cent.[5]

In New South Wales, Aboriginal people have higher rates of hospitalisation and premature death due to reasons of mental illness than the rest of the population. Between July 2013 and June 2015, Aboriginal people were hospitalised for mental health reasons at rates of 30 per 1,000 persons, compared with 18 per 1,000 for the non-Aboriginal population.[6] During the years 2011 to 2015, the suicide rate of Aboriginal people was 1.4 times that of the non-Aboriginal population of New South Wales.[7]

Mental illness is a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. Mental illness can be a lifelong condition that requires different levels of management over time. People with mental illness can have acute phases when intensive support is required, and more stable periods when less support is needed.

Common mental illnesses are anxiety and depression. Less common are illnesses where psychosis may be present such as schizophrenia and bipolar disorder. During an acute episode of psychosis, a person may experience hallucinations or delusions. Drug and alcohol addictive behaviours also fall into the category of mental illness.

Since 2013, acute hospital admissions of Aboriginal people have steadily increased for nearly all categories of mental illness diagnosis (Exhibit 1).

Exhibit 1: Acute hospital admissions of Aboriginal people in New South Wales, by diagnosis type, 2013 to 2018

Diagnosis type	2013	2014	2015	2016	2017	2018
Mood disorder	349	329	350	391	427	432
Anxiety	428	430	439	430	529	478
Injury / Overdose	161	203	177	270	247	169
Organic	26	13	11	10	18	13
Other	106	204	348	284	468	525
Personality disorder	139	156	209	267	330	365
Psychosis	925	1,030	1,278	1,434	1,552	1,440
Substance	231	259	270	296	257	278
Total	**2,365**	**2,624**	**3,082**	**3,382**	**3,828**	**3,700**

Source: NSW Ministry of Health.

[4] Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011 (unaudited).
[5] Ministry of Health data: Mental health-related emergency department presentations in public hospitals 2017–18.
[6] Aboriginal and Torres Strait Islander Health Performance Framework 2017 report: New South Wales (unaudited).
[7] Aboriginal and Torres Strait Islander Health Performance Framework 2017 report: New South Wales (unaudited).

Poor mental health has impacts on other health outcomes. For example, paranoia or social withdrawal can prevent people from seeking health services for other health conditions. Poor mental health can interfere with a person's ability to adhere to medication regimens. These can include medications for chronic health conditions such as diabetes and cardiovascular disease.

Mental illness in custodial environments

Aboriginal people are significantly overrepresented in prisons, constituting approximately 25 per cent of the adult prison population of New South Wales. They are more than 13 times more likely to be incarcerated than non-Aboriginal people. According to Justice Health patient surveys, 80 per cent of incarcerated Aboriginal women and 66 per cent of incarcerated Aboriginal men had been diagnosed with a mental illness in 2015, compared to 78 per cent of female and 63 per cent of male inmates in the general prison population. Diagnoses included schizophrenia, psychosis, alcohol and drug dependence, and post-traumatic stress disorder.

In 2015–16, Aboriginal young people were 24 times more likely to be in juvenile detention in New South Wales than non-Aboriginal young people. These rates have been escalating since 2009–10, when the rate of Aboriginal young people in custody was 19 times that of other young people.

Rates of mental illness amongst Aboriginal young people in custody are higher than rates of non-Aboriginal detainees. In 2015–16, 87 per cent of Aboriginal young people in juvenile detention had a diagnosed mental illness compared with 79 per cent of all other young people. Diagnoses include psychological, behavioural, attentional and substance use disorders.

1.2 Responsibility for delivering mental health services

The New South Wales mental health service network

NSW Health delivers a range of mental health services in a complex sector that also includes Commonwealth and non-government mental health providers. NSW Health delivers mental health services in:

- hospital emergency departments for short-term assessment and referral to services including inpatient hospital care
- inpatient hospital care for patients in acute and sub-acute phases of illness
- mental health outpatient services including medication support services, crisis or mobile assessments and outreach treatments in the community
- custodial mental health services in adult prisons and juvenile justice centres for the general prison population
- specialised mental health services for Justice Health patients requiring psychiatric inpatient care in forensic hospitals and other hospital care for self-harm or addictions.

NSW Health is a multi-tiered agency with the Ministry of Health (the Ministry) operating as a ‘system manager’, providing guidance, monitoring and support to a network of health services. The Ministry purchases services through service agreements with Local Health Districts and other service providers. The Ministry is responsible for developing and implementing mental health policies and collecting, collating and publishing information that informs decisions about the type and locations of mental health services across the State.

For the day to day running of mental health services and more detailed planning, the Ministry devolves responsibility to Local Health Districts. Local Health Districts are statutory corporations responsible for managing public hospitals and other health services in defined areas across New South Wales. There are eight Local Health Districts in the greater Sydney metropolitan region and seven in rural and regional New South Wales. Local Health Districts have responsibility to provide care to patients during acute phases of mental illness in hospitals and community service environments.

The Justice Health and Forensic Mental Health Network (Justice Health) is a statewide health service for adults and juveniles in custody. Justice Health provides services for over 30,000 patients annually. There are 17 psychiatry clinics providing services in approximately half of the New South Wales prisons. The remaining prisons use video conferencing to connect patients with psychiatry services.

The cost of mental health care

In 2018–19 the NSW Government Budget committed $2.1 billion to mental health services and infrastructure. This funding supports close to 60 inpatient facilities providing over 2,800 acute, non-acute and sub-acute beds across NSW Health.

NSW Government funding supports over 250 public community mental health centres. These include government and non-government mental health services, as well as those delivered as part of housing or domestic violence support. Fifty-one per cent of the centres are in metropolitan regions, 43 per cent are rural and regional, and six per cent are located within speciality networks such as Justice Health.

In New South Wales, the cost of providing specialised psychiatric units or public psychiatric hospitals was around $1.0 billion in 2016–17. This includes $750 million on acute hospital services, and $250 million on non-acute hospital services. The total expenditure on community mental health services in the same year was $561 million.

Supporting mental health patients in emergency departments and inpatient mental health facilities is significantly more expensive to the State than providing services in the community (Exhibit 2).

Exhibit 2: Average cost to New South Wales of different mental health services per person

Service	Average cost per person/day
Inpatient mental health care, per patient day	$1,132
Emergency department, per presentation	$1,514
Community mental health care, per treatment day	$243

Source: Audit Office analysis using unaudited data from the Australian Institute of Health and Welfare.

New South Wales is reforming the mental health care model from bed-based services to an enhanced community service profile. Funding is being moved to early intervention services, with $440 million committed over four years for community mental health teams and psychosocial supports.

The mental health budgeted expenditure also includes $700 million to support a statewide Mental Health Infrastructure Program. This will update existing infrastructure and build new services to respond to demand.

Since 2011–12, the NSW Government has more than doubled the annual funding for the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) from $12.2 million to $25.0 million in 2017–18. Subsidies for longer stay patients in not-for-profit accommodation have been increased and rural and isolated patients travelling for specialised allied health clinics are now eligible for IPTAAS travel and accommodation subsidies.

The role of Commonwealth and non-government organisations in the mental health service sector

Commonwealth funding supports non-government organisations to provide community-based mental health services. In addition, Commonwealth Medicare funding supports General Practitioners (GPs) to deliver mental health assessments, treatments and case management in primary health clinics across New South Wales. Primary health services can be the first point of access for Aboriginal people seeking mental health assessment and treatment.

Non-government organisations provide a significant component of the community-based early intervention services including psychosocial support programs.

Aboriginal Community Controlled Health Services (ACCHSs) are part of the non-government sector, receiving a mix of Commonwealth and state government funding. ACCHSs provide primary health GP services and social and emotional well-being services to Aboriginal people across New South Wales. ACCHSs deliver mental health services to Aboriginal people with complex needs. Some ACCHSs offer social and emotional support through outreach services into patient homes.

Drug and alcohol service types can be divided into two main categories in New South Wales: community therapeutic support services and residential or inpatient rehabilitation services. These services are funded and delivered by Commonwealth, state and non-government organisations.

1.3 Standards for assessing Aboriginal mental health care

The NSW Aboriginal Health Plan 2013-2023 is NSW Health's framework to achieve improvements in Aboriginal health, ensuring services are culturally appropriate and responsive to the needs of Aboriginal communities.

The Aboriginal Health Plan requires NSW Health to form partnerships with other organisations to ensure that health services are integrated, coordinated and leading to continuity of patient care. The Aboriginal Health Plan emphasises the need for partnerships with Aboriginal people to develop culturally appropriate therapeutic environments. The strategic directions of the Aboriginal Health Plan are:

1. building trust through partnerships
2. implementing what works and building the evidence
3. ensuring integrated planning and service delivery
4. strengthening the Aboriginal workforce
5. providing culturally safe work environments and health services
6. strengthening performance monitoring, management and accountability.

Appropriate mental health care for Aboriginal people

Aboriginal people face significant barriers in accessing mental health services. A key factor influencing the level of access to mental health care is the cultural appropriateness of care.

Most publicly funded mental health care in New South Wales is based on Western therapeutic models. Services are short term and generally provide support during a crisis situation.

With the exception of the Aboriginal Community Controlled Health Services, the mental health sector is predominantly staffed by non-Aboriginal people.

As part of this audit, we sought advice from Aboriginal mental health clinicians and policy makers about what constitutes appropriate mental health care for Aboriginal people. They advised that appropriate mental health care for Aboriginal people is:

1. culturally safe, allowing Aboriginal people to draw strength from their identity, culture and community
2. person centred and focussed on individual needs
3. delivered by culturally competent staff with no bias
4. holistic, trauma-informed and focussed on early intervention where possible
5. delivered in places that are appropriate including outreach to homes and communities
6. welcoming of the involvement of local Aboriginal community and connected to local knowledge and expertise including totems and kinship structures.

Throughout this report, assessments about the 'appropriateness' of NSW Health mental health care are based on these six principles and the strategic directions of the NSW Aboriginal Health Plan 2013-2023 that apply to appropriate Aboriginal health care at Appendix two. Section Four of this report describes appropriate care in more detail.

1.4 About this audit

The audit objective was to assess the effectiveness of NSW Health's planning and coordination of mental health services and service pathways for Aboriginal people in New South Wales.

We addressed the audit objective by answering three questions:

1. Is NSW Health using evidence to plan and inform the availability of mental health services for Aboriginal people in New South Wales?
2. Is NSW Health collaborating with partners to create accessible mental health service pathways for Aboriginal people?
3. Is NSW Health collaborating with partners to ensure the appropriateness and quality of mental health services for Aboriginal people?

More information about the audit approach is at Appendix three.

2. Mental health service planning

2.1 Planning mental health services for Aboriginal people in New South Wales

The Ministry of Health (the Ministry) uses a range of data and planning tools to predict mental health service demand and estimate the mix of acute, sub-acute and community-based mental health services at a population level across the State.

The Ministry assesses population requirements for statewide hospital services and community mental health services at regional and Local Health District levels using a data analysis tool, the National Mental Health Services Planning Framework (National Framework). Embedded within the tool are formulae to match population requirements with psychosocial and clinical services.

Each Local Health District undertakes its own internal planning process to determine District-level mental health service needs. This planning process includes the development of a Clinical Services Plan that informs annual funding negotiations. Nine of the 15 Local Health Districts also utilise the National Framework to assist in planning.

Funding negotiations between the Ministry and Local Health Districts are based on assessments of population and changes in service demand patterns. Funding formulae are used to estimate expected population growth, demographics (aging, chronic disease prevalence), population estimates of Aboriginality, and scaling to increase equity across Local Health Districts. The equity adjustor is not used for mental health services but is being trialled in drug and alcohol services.

Annual funding is also allocated to support planned infrastructure developments, inter-District patient flows, NSW Health priorities and known service gaps. The Ministry assesses Local Health District funding requests, New South Wales activity data and the National Framework before approving funding allocations.

Data are not sufficiently detailed to inform service planning for Aboriginal people

NSW Health's existing data systems and tools do not provide a sufficient level of detail to identify the mental health service profile or service requirements of Aboriginal people in New South Wales.

Despite a higher burden of mental illness, NSW Health does not have a clear picture of the service use patterns of Aboriginal people prior to them presenting in emergency departments in mental health crises. NSW Health data are not sufficiently detailed to show which services Aboriginal people are accessing in the community, or whether they are accessing services before they reach crises.

Executives from 11 of 15 Local Health Districts report that existing data are insufficient for their mental health service planning requirements. The main deficiency is an inability to aggregate data from Commonwealth and non-government services with NSW Health data. NSW Health lacks the data tools that can generate system-wide information about Aboriginal service use patterns.

Similarly, the National Framework does not generate data on the mental health service trends for sub-population groups such as Aboriginal populations. Work is underway to improve the Framework through a Commonwealth funded project. This work is designed to aggregate mental health data across the different provider groups and sub-population groups, with a timeline for completion in 2021.

New South Wales is not the only jurisdiction with limited data about Aboriginal mental health service use patterns. While State governments collect their own mental health data, identifying and reporting on trends in regional or rural areas can be limited by small population numbers. Furthermore, State governments have limited control over the consistency or quality of data from other service providers including non-government organisations and Commonwealth funded services.

In the absence of complete data, there is limited evidence that NSW Health has engaged alternate strategies to understand the service use behaviours of Aboriginal patients across the State. As the central agency with responsibility to ensure appropriate statewide mental health planning, the Ministry of Health has not initiated activity to guide this process.

Of the 15 Local Health Districts, only two reported that they had forums to seek feedback on mental health service use from Aboriginal stakeholders. These Districts have Aboriginal advisory groups and surveys to assess their service population reach. However, these actions are not consistently applied across Local Health Districts, with three Districts reporting no systems at all for understanding their local Aboriginal communities' needs.

Both quantitative and qualitative data are needed so that NSW Health can assess the nature and extent of Aboriginal interactions with preventative mental health services and target appropriate treatments to address problems before they become acute. NSW Health lacks the evidence to understand the preferred service models and options for Aboriginal patients. This lack of information limits the ability of NSW Health to provide appropriate community mental health services.

As NSW Health reforms its mental health resource model, evidence is required to target resources to the population groups and service areas where there is greatest need.

Implementing quality improvement initiatives for data collection and reporting related to Aboriginal people is a goal of the Aboriginal Health Plan. While NSW Health has undertaken some work in other health conditions, there has not been similar progress for mental health service data.

There is uneven distribution of mental health services, with duplicate services in some areas and no service in others

NSW Health does not have a policy or formula to guide the distribution of mental health services across the State.

Mental health services are not available in all townships across New South Wales. According to most regional and rural Local Health Districts and service providers, there is an uneven distribution of mental health services in their District. Some regional townships with proportionally high Aboriginal populations have very limited access to mental health services, while other townships have duplicate services that operate in close proximity.

For example, Brewarrina is a township with over 1,650 residents. Aboriginal people make up more than 60 per cent of the population. Brewarrina has a small hospital and limited community mental health services. A visiting NSW Health clinician provides mental health services for two days each fortnight.

In the nearby town of Bourke there are over 1,900 residents and Aboriginal people constitute 37 per cent of the population. In Bourke, a NSW Health team provides community mental health services for adults, children, adolescents and the elderly. Week day services are available for people who need counselling and support for moderate and severe mental illness in community settings.

NSW Health does not have complete control over the mental health service profile in each township or region. The Commonwealth funds additional services across New South Wales. While all Local Health Districts engage in some form of joint service planning with Commonwealth Primary Health Networks, there is insufficient guidance for the equitable distribution of mental health services for Aboriginal people across New South Wales.

Most Local Health Districts have executive-level meetings to plan services with Primary Health Networks. However, in many Districts, these are informal meetings with no agenda for mental health service mapping and equitable distribution of mental health services. Executives from 9 of 15 Local Health Districts report informal or minimal Aboriginal mental health service planning.

The Fifth National Mental Health and Suicide Prevention Plan encourages state and Commonwealth health entities to work collaboratively on joint regional plans for mental health services. Some Local Health Districts are engaged in collaborative activity with Commonwealth services to develop joint regional suicide prevention plans. However, this activity is not occurring in all regions and there is no consistency in practice.

Exhibit 3: Case study on joint regional service planning

Shared investment models for mental health and drug and alcohol services

In acknowledgement of the need for a regional approach to service planning, a group of Commonwealth and State health providers have come together to work out ways to share resources.

Funding for mental health and drug and alcohol services is provided by different Commonwealth and state government departments. The distribution of these funds and resources is not always well coordinated by location. Some regions are better resourced with multiple service providers and sources of funding, while others are lacking.

The goal of this collaboration is to identify service gaps and duplications in their region and devise ways to coordinate resources so they can be distributed efficiently and effectively. Together they are mapping service availability and service funding, with the aim of developing a shared investment model that will deliver an optimal and equitable distribution of mental health and drug and alcohol services across the region.

The group is investing in economic and systems modelling tools to support evidence-based decision making and guide future funding priorities. They have held an economic modelling session with partner organisations and external collaborators to identify target outcomes, potential interventions, and areas for investment.

In 2019 they launched the North Coast Collective. The collaboration is made up of the Local Health Districts of the Mid North Coast and Northern New South Wales, along with the North Coast Primary Health Network. The Collective also plans to work with Aboriginal Community Controlled Health Services. Governance is formalised via memoranda of understanding, and work has commenced to define roles and responsibilities and decision-making processes.

Source: Audit Office research.

Significant investments in community mental health are not sufficiently targeted to patients with complex mental health needs including Aboriginal patients

The NSW Government is reforming its mental health funding model to shift the balance from hospital care to enhanced community care. In 2018–19, the NSW Government committed $400 million over four years into early intervention and specialist community mental health teams.

The NSW Government funding reforms are predominantly focussed on resourcing early intervention services that aim to prevent future decline in mental health. However, these resources are not adequately targeted to meet existing demand from Aboriginal people. Aboriginal patients require culturally appropriate, clinical services to address multidisciplinary mental health needs. Local Health Districts in metropolitan, regional and rural areas describe this gap in the service profile. The service shortcomings include:

- a lack of support for patients requiring higher levels of clinical support to address complex mental illnesses in community settings
- insufficient 24-hour mental health support for people facing crises overnight or during the weekend (non-emergency department services)
- insufficient drug and alcohol support services
- a lack of ongoing psychological services to support beyond the crisis period
- mental health services that are not culturally appropriate.

While Local Health Districts provide care to Aboriginal patients in the community at rates that are four times higher than the non-Aboriginal population, resourcing is not at an appropriate level to meet demand. Increasing and costly presentations of Aboriginal people at emergency departments indicate the need to target resources to service profile shortcomings. These include a need for more services for patients with moderate to severe mental illness and more 24-hour mental health service options to assist people outside normal business hours.

Most non-government organisations are not funded to deliver clinical mental health services or to develop the organisational capacity to support patients with complex needs, including those in crisis or those requiring support with medications. While GPs provide clinical services in primary health clinics, their role is predominantly referral and the management of some medications. They are not funded to provide clinical outreach into patients' homes or therapeutic support and counselling.

Aboriginal Community Controlled Health Services (ACCHSs) deliver mental health services to Aboriginal people with complex needs. Some ACCHSs offer social and emotional support through outreach services into patient homes. ACCHSs have the cultural competence and the clinical expertise to support complex cases but are not sufficiently resourced to meet the levels of demand for patients in crisis or those requiring services outside normal business hours.

In the absence of appropriate community mental health resources, Aboriginal people are accessing emergency department services in high numbers.

Key Performance Indicators influence service planning decisions

Local Health Districts offer a range of other health services along with mental health services. While Districts have discretion over their budgets, they prioritise the health services that have reporting obligations attached to performance and outcomes.

Districts are required to report annually against Key Performance Indicators (KPIs). Failure to meet targets or underperformance in these areas leads to financial penalties for Local Health Districts. Local Health Districts have 62 KPIs and 152 improvement measures across the full range of health services in each District. In order to avoid penalties, Local Health Districts prioritise resources for activity linked to KPIs. These activities include hospital services and hospital waiting times.

In the mental health service area, KPIs are attached to acute and sub-acute services; specifically, a seven day follow-up after hospital discharge, and a target to reduce unplanned readmissions within 28 days of discharge. Local Health District service agreements do not contain KPIs that drive mental health service activity beyond a month after a hospital admission. In addition, there is no KPI for community mental health services that are preventative and aimed at mitigating the need for a hospital admission such as community mental health outreach services. The lack of KPIs about community mental health care has relegated this service area in Local Health District priorities.

Limited funding to develop new therapeutic models of care for Aboriginal people

According to Local Health District executives, there is limited new funding for Aboriginal mental health services. Local Health District funding models do not have an identified stream to develop or resource Aboriginal-specific mental health services. While global health service budgets include a loading based on the proportion of Aboriginal people in each Local Health District, these funds are not tied to delivery of Aboriginal identified health care.

Local Health District executives have to weigh the costs and benefits of funding particular health options against other health priorities. Innovative approaches to Aboriginal mental health can be downstream on the priority list, when acute services such as emergency department and surgical services are competing for health funding.

Some Local Health Districts have allocated a small portion of their global budget for innovation funding. In one District, a competitive fund encourages different services to apply for funding to establish new health programs or models. However, this initiative is not specific to mental health services and applies to the widest range of health care.

Occasionally new initiatives are block funded via a new activity funding stream, generally for a 12-month period, before being rolled into Activity Based Funding allocations in subsequent years. When new initiatives are not funded, resources must be found from global budgets.

In limited instances, the Ministry has approved short-term pilot funding for new mental health initiatives such as the Aboriginal Getting on Track in Time (Got It!) program, but these are the exception rather than the rule.

NSW Health's primary entity for developing and sharing evidence-based models of care is the Agency for Clinical Innovation. The Agency for Clinical Innovation is yet to focus on researching and developing Aboriginal models of mental health care. It is in the early stages of developing a mental health project on trauma informed care. This project is aimed at all population groups and may have some relevance for Aboriginal populations.

Long waitlists for drug and alcohol services and dual diagnosis treatments

NSW Health's planning processes have not predicted or responded to increased service demand for drug and alcohol services in New South Wales. There are significant waitlists of up to four months for publicly funded drug and alcohol rehabilitation services. Aboriginal people and non-Aboriginal people are not receiving rehabilitation and counselling services in a timely manner. National drug monitoring data shows increasing levels of drug use in New South Wales, particularly in regional areas of the State. According to close to half of Local Health Districts and service providers, there are insufficient services in metropolitan, regional and rural areas. Services for Aboriginal women and young people are particularly lacking.

Within the Ministry and a number of Local Health Districts, oversight of mental health services is separate from drug and alcohol services, preventing joint service planning and resource sharing.

Higher than average bed numbers for acute patients but lower staff ratios for community patients

New South Wales has higher than average numbers of hospital beds for people with acute mental illnesses compared to other states and territories. However, New South Wales has a lower ratio of mental health workers to support people with mental illness in the community.

New South Wales has 36.8 community mental health workers per 100,000 people. Most other Australian jurisdictions have higher numbers of community mental health workers per 100,000 people. The national average of community mental health workers per 100,000 people is 45.1. New South Wales's lower than average numbers of community mental health workers limits service availability in the community, particularly for flexible models of delivery such as outreach services and those provided outside of normal business hours.

The Ministry acknowledges the imbalance in the mental health service profile and advises that it is working to incrementally shift the service balance over time. The NSW Government's health budget reform agenda is the main mechanism to move some mental health funds from acute inpatient services to community-based models of care.

2.2 Aboriginal mental health policy

Lack of policy to guide Aboriginal mental health practice and direction

The NSW Aboriginal Mental Health and Well Being Policy 2006-2010 is now more than nine years out of date. For almost a decade, the mental health workforce has operated without a statewide policy to guide or coordinate Aboriginal mental health care.

In 2013, NSW Health implemented the NSW Aboriginal Health Plan 2013-2023. The Aboriginal Health Plan is directed to all health service areas and aims to improve Aboriginal health outcomes through partnership approaches between health practitioners and Aboriginal people. The Aboriginal Health Plan does not provide specific guidance for the planning, design and provision of mental health services.

In 2018, NSW Health implemented the NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 for the broader population. This policy guides high level governance arrangements and overarching strategic directions for the mental health system.

Other plans and frameworks provide some guidance about Aboriginal policy and workforce numbers, though none provide a comprehensive approach to Aboriginal mental health. Some of these policies include:

- NSW Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016-2020
- The Aboriginal Health Impact Statement; requiring NSW Health staff to report on the ways it will incorporate the health needs of Aboriginal people in the development of new and revised policies, programs and strategies
- Respecting the Difference: an Aboriginal Cultural Training Framework for NSW Health.

With the expiry of the NSW Aboriginal Mental Health and Well Being Policy in 2010, the mental health workforce has lacked guidance in:

- data informed service planning so that the right mental health services are available for Aboriginal people in the locations where they are required
- protocols for case coordination and information sharing for the continuity of Aboriginal patient care
- evidence-based models of mental health care and assessment tools that are culturally appropriate and directed to the unique needs of Aboriginal patients.

An Aboriginal mental health clinician from one Local Health District described the lack of policy impacts on the workforce in the following terms:

> 'There's no overarching, strategic process that drives a plan for mental health. No advice cascading down from the executive. No formalised, coordinated approach to how we do business. No identification of what's working where and no standardising of practice across Districts. There's no literature review, no project plan, and no coordination. It's not sustainable. All practice is at the whim of individual clinicians. It's one-off, not written up and not used to provide an evidence base.'

NSW Health advises that they are developing a new Aboriginal mental health policy, though there is no timeframe for its completion.

2.3 Planning mental health services for Aboriginal people in prisons

Justice Health delivers mental health services to the general population of adults and juveniles in prisons as well as specialist mental health services in forensic and prison hospitals. Justice Health receives block funding from the Ministry based on prison population data. Growth funding is based on Corrective Services projections of future bed expansions.

The Justice Health service model is based on a core staff profile at each prison, generally a small number of nurses and a GP for a few hours a week. Those prisons with infrequent access to a GP use video conferencing for doctor and specialist services.

Insufficient data to inform and plan mental health services in prisons

Justice Health does not have sufficient data to effectively plan for patient mental health needs or predict future service requirements.

Justice Health has a hybrid medical record system (electronic and paper based) which does not include electronic management of patient medications. Patient health information is recorded on multiple systems including the Justice Health electronic Health System (JHeHS), paper files, the Patient Administration System (PAS), and other databases such as the Community Health Information Management Enterprise (CHIME).

While there are extensive individual patient files, Justice Health does not have reliable aggregate data on the mental health conditions or the medications of its patients across the New South Wales prison system. The most recent New South Wales data on patient mental health diagnoses and medications in prisons is from the Aboriginal Network Patient Health Survey conducted in 2015.

The multiple information management systems do not provide reliable information about the demand for mental health services in prisons, the needs of patient cohorts, and the broader patient medication profile across New South Wales. Justice Health is not able to aggregate patient information by frequency of patient interactions, treatment types, or prescribed medications. The limitations of patient information are further compromised by the fact that as many as 1,500 inmates per day are moved between the 39 adult prisons in New South Wales to be close to courts, or to assist with population management across the prison network.

Adults incarcerated in prisons and young people in custody do not have access to Medicare. Justice Health does not access patients' Medicare numbers or other linking information that could be used to track medical records information in the community. This impedes the ability of Justice Health to follow patient journeys or to evaluate the effectiveness of their services.

The complex and hybrid nature of this data management system seriously impedes the ability of Justice Health to share health information across the prison network and plan for current and future service demand.

More planning is required to improve wait times for health services in prisons

Wait times for health services in prisons can vary depending on the acuity of the patient and the size of the prison population. In one custodial facility, the current wait time for a mental health nurse is 88 days. In another custodial facility, the wait time is 170 days for semi-urgent mental health care. The longest reported wait time for non-urgent mental health care is over one year.

In large prisons with more than 100 inmates, wait times for non-urgent health services are generally longer than in smaller prisons, where patients are more likely to receive treatments within a matter of weeks. Justice Health policy specifies that patients with non-urgent medical needs require attention within 14 days to three months. While long wait times may not always breach policy guidelines, Justice Health staff report that long wait times are not optimum for patient health.

At each prison, Justice Health staff record the average wait times for health services with categories based on clinical priority (urgency and acuity). This information is aggregated centrally by Justice Health, but is not used to plan staffing ratios or resource levels across the prison network.

The ratios of nurses to patients differ significantly across New South Wales prisons. Some prisons have a full-time health nurse per 30 patients while other facilities have ratios that approach one nurse per 100 patients. This unequal distribution of services creates inequity of access across the prison network.

Justice Health does not have a fixed formula to guide its staffing ratios. There is no nurse to patient ratio in prison health centres. Justice Health advises that nurse staffing is calculated on the size of the prison, the acuity of patients and rural and remoteness factors.

3. Creating mental health care pathways

3.1 Coordinating mental health services for Aboriginal people in community environments

Navigating the mental health service system is difficult for service users and service providers alike. The mental health sector has been described as 'complex and fragmented' by New South Wales parliamentary inquiries and the Productivity Commission.

It is a feature of the mental health service system that patients access a range of services for treatment and monitoring. Local health clinics and GPs provide mental health services, as do hospitals, community treatment and counselling centres. These services are provided by a mix of Commonwealth, state and non-government services.

In order to facilitate access to treatment across this complex system, service providers make referrals and share information with other providers. Mental health case coordination is required for safety purposes. Without clear oversight of patient service use, people can fall through the gaps between referrals, or medications and services can be duplicated without the knowledge of treating clinicians.

Most services share information to assist in patient care, but the system lacks coherence

Information sharing and follow-up after mental health referral is not routine, systematised or reported across all Local Health Districts. Some Districts have extensive systems for joint case review and information sharing, while others have limited structures for sharing information about common patients across government and non-government organisations.

While the majority of government and non-government mental health providers have referral guidelines such as Transfer of Care protocols or information-sharing practices, according to 65 per cent of surveyed service providers, the current systems and guidelines are not sufficient to ensure coordinated patient care. Mental health staff advise that there is no guidance to identify or nominate a lead service provider amongst community mental health providers. Responsibility for community mental health case coordination is not always clear or known to providers or patients. With no lead organisation, patients are sometimes overlooked.

Local Health District staff in community mental health services are not required to form governance arrangements with other services for the transfer of patient care and for case coordination. In 2018, the Secretary of NSW Health wrote to all Local Health Districts to set out the expectation that they would form partnerships with Aboriginal Community Controlled Health Services to assist in coordinated health care. Despite this guidance, there continues to be inconsistent information sharing practices and limited joint case management between Local Health Districts and Aboriginal Community Controlled Health Services.

Some Aboriginal patients require high levels of support to manage their mental illness in the community. Different government and non-government service providers may be managing treatments and medications of Aboriginal patients, but governance arrangements and oversight of mental health treatment plans may be unclear to clinicians in different services.

In some regions, Local Health Districts and non-government providers have developed memoranda of understanding to guide case coordination. Others have established working groups where prescribed health bodies share information about clients accessing multiple services.

There is a risk in relying on local leadership initiatives. Working groups can be disbanded, key staff can leave services, and memoranda can become outdated. Without formalised guidelines or policy directives for case management, leadership can be diminished over time and patients can be lost to care.

Exhibit 4: Case study on coordinated care

Joint case management with an Aboriginal Medical Service

A government and a non-government provider of mental health services in South Western Sydney are working together to deliver better care coordination for patients attending both services. These services have developed a collaborative model for joint case management.

Staff from both services meet for monthly case reviews to discuss the needs of shared patients and to coordinate treatment plans and referral pathways. These meetings help clinicians to reduce duplication and ensure patients are getting the right support for their mental health, physical, and social needs.

The participating providers are the South Western Sydney Local Health District and the Tharawal Aboriginal Corporation, an Aboriginal Community Controlled Health Service in South Western Sydney.

These services also have a shared model of care. Clinicians from the District's Community Mental Health team deliver an outreach service at the Aboriginal Medical Service, with a psychologist and psychiatrist providing assessment, review and treatment for Aboriginal clients. The Aboriginal Medical Service is a venue that provides a culturally safe environment and is a preferred location for some service users.

The two organisations maintain regular communication at all levels, from the executive staff level to frontline staff. The group have developed terms of reference to guide their responsibilities and activities, and the partnership is formalised via a Service Agreement.

Source: NSW Audit Office research.

Effective transfer of care occurs when activities are mandated or monitored

In instances where patient treatment is mandated under the *Mental Health Act 2007 (NSW)*, responsibility for case management is clear. The Mental Health Review Tribunal or a Magistrate nominates an entity to provide medication and therapy, counselling, management, rehabilitation and other services for people subject to a Community Treatment Order. This is a legal order whereby a person must accept medication and support services while living in the community.

Local Health District staff advise that people subject to the Community Treatment Orders are receiving coordinated care.

In instances where NSW Health has attached performance reporting or Key Performance Indicators (KPIs) to activities, information sharing is occurring and there is evidence of transfer of care. For example, NSW Health entities are meeting performance targets requiring seven-day follow-ups for patients recently discharged from inpatient hospitals to care in the community.

There has been some progress in coordinating mental health and drug and alcohol care, but more is needed to shift attitudes and improve cooperation

Some people with mental health conditions have comorbid dependencies on drugs and alcohol. In general, health services do not provide concurrent treatment for these conditions. Historically, mental health and drug and alcohol services have operated as separate entities in the Ministry and many Local Health Districts. The administrative separation of mental health and drug and alcohol services has created barriers to integrated treatment for Aboriginal patients with a dual diagnosis. A small number of Local Health Districts are making progress towards integrating drug and alcohol services with mental health care.

NSW Health's NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 supports an integrated approach to drug and alcohol and mental health services. A goal of the framework is to align mental health with drug and alcohol services to provide comprehensive assessment and integrated treatment planning. Over the past decade, a colocation model has gone some way to coordinating mental health care with drug and alcohol services.

NSW Health has participated in an integrated service model that combines Commonwealth funded primary health care and State funded community health care in 27 locations across New South Wales. The colocation service model of HealthOne assists in communication and coordination across health and allied health services. HealthOne NSW brings Commonwealth funded general practice and State funded primary and community health care services together. Other health and social care providers may also be involved in the HealthOne NSW model, for example pharmacists, private allied health professionals, other government agencies and non-government organisations.

While there has been some progress in integrated care models, more needs to be done across all Local Health Districts to coordinate services for people with comorbidities.

Access to Aboriginal mental health specialist programs is limited to trials in selected locations

NSW Health has partnered with Commonwealth funded services and non-government organisations to provide a limited number of specialist Aboriginal mental health programs and interventions. These programs are available in limited locations as trials or as early stage roll outs.

A tailored version of the Getting on Track In Time (Got It!) program is being trialled for Aboriginal children in one Local Health District. The mid-term review of the Aboriginal Health Plan lists this program as planned for statewide implementation, but there is no evidence that this has progressed. This early intervention program aims to help children connect with their culture and develop emotional resilience, to prevent future mental health and behavioural issues. It is targeted to Aboriginal children aged four to eight years old who display behavioural concerns and emerging conduct problems. The program is a combined care model with services offered by Child and Adolescent Mental Health Services in partnership with the Department of Education and an Aboriginal Medical Service.

Where specialised programs are shown to have positive impacts and outcomes, all efforts should be made to expand them to other sites where the benefits can be shared.

Multiple service providers create choice for clients, but in some regions, competition for clients is reducing information sharing

Confidentiality is an essential component of appropriate mental health care. In small townships where many local people are known to each other it can be difficult to maintain anonymity. Townships with multiple mental health services allow people to select one where they feel anonymous. While Aboriginal clients may prefer to access the local Aboriginal Community Controlled Health Service for most health treatments, clinicians advise that some people avoid these services when seeking treatment for mental illness. Aboriginal stakeholders report significant stigma associated with mental illnesses.

The Commonwealth and State governments have increased funding to non-government mental health service providers as part of a move towards a commissioned model of service provision and enhanced early intervention services in the community. This has led to an over-supply of services in some regional areas and under-supply in others. Government and non-government services report that some community providers compete for clients and this competition has led to poor information sharing and referral practices.

Referral pathways and information sharing is more likely to be compromised in regions where there is insufficient mental health service mapping and unbalanced mental health service profiles.

3.2 Coordinating mental health care for Aboriginal people in custodial environments

Intake processes are not providing timely access to mental health services

When a person first arrives at a custodial facility, they undergo a lengthy intake process. A Corrective Services officer completes several identification and security assessments and records any known information about an inmate's mental health. Corrective Services must advise Justice Health staff immediately if an inmate has:

- immediate health concerns
- drug or alcohol issues
- a Mandatory Notification Form (MNF) in relation to self-harm or suicide
- been detained under the *Mental Health Act 2007*
- a specific court or Parole Board request for psychiatric and/or medical attention.

Justice Health staff also complete an assessment of the patient on intake and list any medications and pre-existing conditions that are disclosed during the process. In urgent cases, when the patient has symptoms of acute mental illness or significant distress, Justice Health may use video conferencing to connect with a psychiatrist or a GP for further assessment and potential medication prescriptions.

If the patient's needs are not urgent, Justice Health lists known medications on the patient's file and waitlists the patient for further assessment. Prescriptions for medications are not filled until Justice Health receives a response to their 'Request for Information' from external health providers. This process usually takes 24 to 48 hours but can take significantly longer, depending on the external health provider. In the case of young people in custody, timeframes are also impacted by the requirement for a parent or caregiver to consent to administer medications. Once the information arrives, the patient must wait for an available appointment with a GP or specialist before the medication can be prescribed. Interim medications or services can be provided at any stage via telephone orders to a General Practitioner.

For some patients, there can be significant delays in receiving appropriate treatments and medications for mental illness. The factors that impact on access to treatment include:

- whether the patient disclosed medications during the intake screening process
- information sharing with external services
- the wait times for mental health services at the custodial facility
- the acuity of the patient
- patient movements around the prison network at the discretion of Corrective Services
- access to patients in the custodial environment.

While more acute patients are likely to receive timely care, less acute patients can be waiting for a follow-up health appointment for weeks or months.

Poor access to patients exacerbates wait times for non-acute health services in prisons

Factors outside the control of Justice Health can exacerbate wait times for health services. Justice Health relies on Corrective Services staff to bring patients to health appointments. Justice Health has no authority to require that patients be brought to the health centre. Factors that can impede access to health services include security lock downs, poor communication or cooperation between Corrective Services and Justice Health staff, and the movement of inmates for security or operational reasons.

According to Justice Health staff from 75 per cent of surveyed custodial centres, the factor that is most likely to improve Aboriginal mental health care is greater access to patients.

Justice Health is working with Corrective Services to improve access to patients through benchmarking activities.

Adults with mental illnesses are unlikely to be supported on release from large prisons

On release from larger prisons with more than 100 inmates, Aboriginal people with mental illness diagnoses are not always supported to transition to the community with prescribed medications, a discharge summary or a referral to a mental health service.

According to Justice Health staff at one prison, the 'majority' of mental health patients do not receive medications on release from large prisons, including reception prisons where people are on remand and waiting to be sentenced. Staff at one prison estimated that 50 per cent of patients are released with no medications. At another prison, staff reported that as many as 90 per cent of patients are not provided with medications or discharge summary reports on release. The reasons for poor transitional support on release include:

- some inmates are released without notice, usually straight from court and there is no pre-planning to support release
- while Justice Health is mandated to complete patient discharge summaries, compliance is inconsistent. There is no key performance indicator (KPI) requiring Justice Health to report on numbers of patients with a discharge summary and medications within seven days of release
- Justice Health staff have limited capacity to support the transition of adults to community mental health services and there is limited funding for this role
- patient records are held for two weeks at the prison where the patient was released. After the two-week period, records are not always available to external medical agencies.

Justice Health does follow information sharing protocols when patients are released from prison on Community Treatment Orders.

Mental health support is available on release from small prisons and juvenile justice centres

Aboriginal adults released from smaller prisons with less than 100 inmates are supported on transition to the community with medications and discharge summaries. Even in cases where patients are released without notice, Justice Health staff are able to follow-up due to a manageable caseload.

Young people released from Juvenile Justice facilities have access to support services provided by the Community Integration Team. This is a voluntary program offering three months of support for young people as they transition to the community on release. Justice Health staff prepare post-release medications and discharge summaries and the Community Integration Team assist in connecting young people to mental health or drug and alcohol services in the community.

Exhibit 5: Case study on coordinated care

In-reach to correctional centres and post-release planning

An Aboriginal Family Health Worker on the New South Wales South Coast is providing fortnightly in-reach and holistic case management to Aboriginal women in custody. The service is available for Aboriginal women at three correctional centres in Sydney and their family members. The service is also available to women who have contact with the legal system in the community.

The Health Worker assists women to overcome challenges including access to mental health services, drug and alcohol services, family violence or housing services or any other matters where support is required. The Health Worker develops post-release plans for women approaching release and makes connections and referrals to community-based services to support women following release.

In 2017–18 the Health Worker supported over 300 women by providing referrals, advocacy and support in accessing programs, services and crisis intervention as needed. The service provides a culturally safe avenue for Aboriginal women to develop support networks to assist in the transition from prison to the community.

Since 2013, Justice Health have provided funding for this initiative to the South Coast Women's Health and Welfare Aboriginal Corporation, Waminda. This partnership is formalised via a memorandum of understanding.

Source: NSW Audit Office research.

4. Providing appropriate mental health care

In May 2019, the Audit Office of New South Wales invited Aboriginal mental health clinicians and policy experts from government and non-government organisations to attend a one-day workshop. Workshop attendees advised on factors that improve the quality and appropriateness of mental health care for Aboriginal people in New South Wales. They described appropriate mental health care as:

- culturally safe, allowing Aboriginal people to draw strength in their identity, culture and community
- person centred and focussed on individual needs
- delivered by culturally competent staff with no bias
- holistic, trauma-informed and focussed on early intervention where possible
- delivered in places that are appropriate including outreach to homes and communities
- welcoming of the involvement of local Aboriginal community and connected to local knowledge and expertise including totems and kinship structures.

The definition of 'appropriate' mental health care for Aboriginal people throughout this report is based on this advice.

Aboriginal people access emergency services at much higher rates than non-Aboriginal people

The choices that people make in relation to health service options provide some insight into the suitability and appropriateness of the service to their needs.

Aboriginal people have different mental health service use patterns than non-Aboriginal people. Aboriginal people are much more likely to be in a crisis situation before receiving mental health services, usually in an emergency department of a hospital.

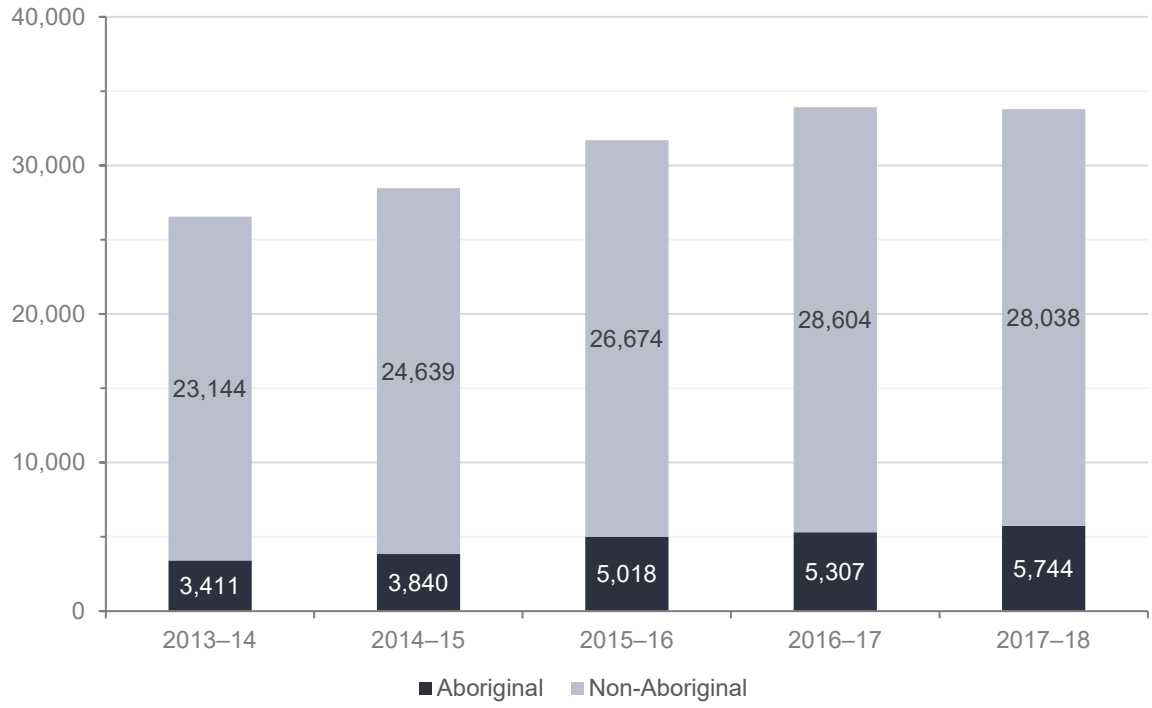
Aboriginal people make up three per cent of the total New South Wales population, but they constitute 11 per cent of emergency department presentations for mental health treatments. In regional areas, Aboriginal people make up 20.5 per cent of presentations at emergency departments for mental health reasons.

A number of factors help to explain Aboriginal mental health service usage patterns. According to government and non-government mental health organisations:

- emergency department services are better known to Aboriginal people than other mental health services
- community-based models of care are not appropriate for Aboriginal people
- Aboriginal people are reluctant to access community-based mental health services to prevent crisis situations
- community mental health services are not available for Aboriginal people after hours and during the weekend, so emergency services are the only option.

The statewide proportions of Aboriginal people presenting at emergency departments for mental health treatments has been increasing over time (Exhibit 6).

Exhibit 6: Numbers of Aboriginal and non-Aboriginal presentations at emergency departments for mental health reasons in New South Wales from 2013–14 to 2017–18



Source: Audit Office analysis of NSW Health Emergency Department data.

Partnerships with Aboriginal communities improve the appropriateness and accessibility of services

When asked about the factors that are most likely to improve the appropriateness of mental health services for Aboriginal people, the most common response from frontline service staff was 'relationships and partnerships with the local community'.

Aboriginal Community Controlled Health Services have strong links into their local communities. While some Local Health Districts have close working relationships with Aboriginal Community Controlled Health Services, partnerships are not operating in all Districts.

NSW Health has developed a partnership with the peak body for Aboriginal health in New South Wales, the Aboriginal Health and Medical Research Council. This partnership aims to achieve improvements in the health and wellbeing of Aboriginal people.

Executives from nine of 15 Local Health Districts have some form of communication or system to seek feedback from Aboriginal stakeholders. Some have committees with Aboriginal health staff, others conduct forums with Aboriginal community members. However, these forums are not always formalised, or leading to service changes. Local Health District executives identified a number of limitations to their feedback processes with Aboriginal stakeholders including:

- the structures and models are not designed for positive engagement and generally focus on what is not working
- the structures or relationships are not engaging a wide or diverse group of Aboriginal stakeholders
- there is a lack of funding for evaluations.

All Local Health Districts measure service engagement using the 'Your Experience of Service' survey. This is a national measure of health services by consumers. It is designed to gather information about consumers' experience of care. Answers from the survey are intended to be used to build a better service experience for consumers.

Aboriginal artwork and imagery enhance hospital environments, but models of care do not reflect Aboriginal culture or practices

Local Health Districts have imagery, signage and symbols to reflect Aboriginal people and culture. Some have worked in partnership with local elders to develop design concepts for artistic works on mental health service infrastructure. These artistic representations include totems and other cultural imagery to acknowledge local Aboriginal histories and culture. In some instances, the process of developing the local art works has enhanced community knowledge about the mental health services in the region.

While visual representations of Aboriginal culture can send welcoming messages to the Aboriginal community, there is limited evidence that models of mental health care have been designed to reflect the cultural and healing requirements of Aboriginal patients. Aboriginal clinicians and policy experts describe the limitations to existing models of mental health care as:

- not person-centred or designed to address the individual circumstances of each patient
- not holistic or trauma informed
- too Westernised and unobservant of Aboriginal culture
- not cognisant of Aboriginal history and trauma.

Despite consultations with Aboriginal stakeholders, most mental health care in hospitals and the community is designed on a Western biomedical model of care.

In recognition of the need for culturally appropriate care, the Ministry recently published a training resource entitled Working with Aboriginal People: Enhancing Clinical Practice in Mental Health Care. This resource is not a policy directive. It is intended to assist clinicians to provide culturally informed care.

The New South Wales mental health workforce lacks culturally informed mental health assessment tools and models of mental health care. In instances where Aboriginal models of care have been implemented, they are a one-off initiative or a short-term trial. The case study at Exhibit 7 is one example of a healing initiative with high levels of attendance by Aboriginal people. There is no plan to expand this type of service model on an ongoing basis, or to trial other culturally informed models of mental health care for Aboriginal people.

Exhibit 7: Case study on culturally appropriate care

Culturally appropriate care: traditional healing clinics

Several Local Health Districts have organised visits from traditional Aboriginal healing services to enhance mainstream mental health service models.

Traditional healing services provide an opportunity for patients to experience holistic healing based on Aboriginal culture and knowledge systems. These services attract a high level of engagement from Aboriginal people.

The Western NSW Local Health District has offered traditional Aboriginal healing clinics on several occasions since 2016. In early 2019 they arranged for healing services to be offered within the mental health and drug and alcohol services in Western NSW. Many participants provided positive feedback on the experience and expressed interest in attending future healing clinics.

The clinics were open to both Aboriginal and non-Aboriginal patients. All appointments were fully booked. The healers visited three services in Orange and Dubbo and saw around 60 patients.

Source: NSW Audit Office research.

Limited research into culturally informed models of Aboriginal mental health care

There is a significant gap in knowledge and evidence about culturally appropriate models of Aboriginal mental health care in New South Wales. The Ministry has not led research or development activity that would generate models of Aboriginal mental health care that are evidence based and evaluated. While there is a trial of an early childhood program in a metropolitan Local Health District and occasional funding directed to traditional healing programs, there is no overarching plan to develop an evidence base for appropriate Aboriginal mental health care.

While Local Health Districts can participate in trialling and evaluating health models, a more centralised level of research activity at the Ministry level is required to fill this knowledge gap. This includes analysis of health population data and research into existing models of mental health care for indigenous peoples nationally and internationally.

The NSW Health Population Health Research Strategy 2018-2022 aims to generate and use research and evaluation to improve health equity and the effectiveness of health interventions across New South Wales. There is no evidence of research into models of Aboriginal mental health care as part of this Strategy.

NSW Health's Agency for Clinical Innovation is not working on Aboriginal models of mental health care. While in the early stages of a mental health project on trauma informed care, there is no specific focus on Aboriginal populations.

Aboriginal staff improve mental health care but there are insufficient staff in most services

According to NSW Health executives, the factors that are most likely to improve mental health care for Aboriginal people are increases in Aboriginal staff and enhanced cultural support for service users. Frontline staff identify similar factors for improving care, in particular:

- better coordination of services with social supports in the community
- enhanced community engagement to reduce fear about mental health services
- increases to Aboriginal health staff.

Aboriginal staff make up less than one per cent of the New South Wales mental health workforce. Executives at all Local Health Districts report that there are insufficient Aboriginal mental health staff in their District. According to the most recent available data from NSW Health, only three of the 15 Local Health Districts met Aboriginal workforce population targets in 2016 (Exhibit 8).

Exhibit 8: Aboriginal Mental Health Worker (AMHW) staff numbers and targets 2016

Local Health District	Indigenous population estimate as at 30 June 2015	Target number (1 AMHW / 1000 population)	Aboriginal Mental Health Workers and Clinical Leaders (including vacancies)	Target met or not	Percentage met (%)
Hunter New England	51,840	51.8	9	no	17.4
Western NSW	32,442	32.4	21	no	64.8
South Western Sydney	16,781	16.8	17	yes	101.2
Western Sydney	15,168	15.2	2	no	13.2
Northern NSW	14,798	14.8	6	no	40.5
Illawarra Shoalhaven	13,772	13.8	4	no	28.9
Mid North Coast	13,232	13.2	7	no	53.0
Central Coast	12,148	12.1	2	no	16.5

Local Health District	Indigenous population estimate as at 30 June 2015	Target number (1 AMHW / 1000 population)	Aboriginal Mental Health Workers and Clinical Leaders (including vacancies)	Target met or not	Percentage met (%)
Murrumbidgee	12,106	12.1	13	yes	107.0
Nepean Blue Mountains	11,723	11.7	3	no	26.0
South Eastern Sydney	8,566	8.6	5	no	58.1
Southern NSW	7,461	7.5	5	no	66.7
Sydney	6,848	6.8	2	no	29.4
Far West	3,799	3.8	9	yes	236.0
Northern Sydney	3,200	3.2	3	no	93.8
Total	**223,884**	**223.8**	**108**		

Source: NSW Health.

NSW Health is working to increase the number of Aboriginal staff across its health workforce through targets for all Local Health Districts. The Ministry has allocated $1.0 million in ongoing enhancement for the Aboriginal mental health workforce in 2018–19, including enhancement of the Statewide Coordination Unit that oversees the development of the Aboriginal mental health workforce.

Some Local Health Districts identify positions that are exclusively available to Aboriginal applicants. There is no statewide policy or direction about Aboriginal designated 'identified positions'. Aboriginal identified positions are developed at the discretion of Local Health District executives. The numbers and types of identified positions vary from District to District.

Mental health peer workers are being employed across Local Health Districts. Peer support workers have a lived experience of mental illness and provide a non-clinical support role. There are eight positions across New South Wales and one Aboriginal identified position. A statewide mental health peer support committee does not have any identified Aboriginal members.

The Aboriginal Mental Health Worker Training Program is successful in increasing the Aboriginal workforce

As part of a strategy to enhance the Aboriginal mental health workforce, NSW Health has developed an Aboriginal Mental Health Worker Training Program. This program trains and employs Aboriginal people as mental health professionals. Since the commencement of the program in 2007, 83 Aboriginal people have graduated with the qualification. This program is enhancing the numbers of qualified Aboriginal clinicians in the mental health workforce.

Some Local Health Districts automatically transition graduates of the program into permanent employment positions. This is regardless of whether there is a mental health clinical position available. However, not all Districts offer permanency following graduation. While all graduates can continue working in Local Health Districts when they complete their traineeships, in some Districts, graduates are required to apply for jobs to secure permanent positions. Some are motivated to seek employment elsewhere if permanent employment is not guaranteed.

Partnerships with Aboriginal Community Controlled Health Services strengthen service pathways, but Aboriginal staff are under pressure

Aboriginal Community Controlled Health Services offer primary health care services to local Aboriginal communities. As community controlled organisations, their role is to respond to community requirements for holistic, comprehensive and culturally appropriate health care. They have strong links into local Aboriginal communities. Reciprocal partnerships between NSW Health providers and Aboriginal Community Controlled Health Services strengthen pathways between services and Aboriginal service users.

Aboriginal Community Controlled Health Service staff are often called upon to assist Local Health Districts and other health services to connect with Aboriginal community members. They advise that in a sector with limited Aboriginal staff, they are under pressure to provide input on all matters related to Aboriginal people, including input on matters outside of their role description.

Room to improve Aboriginal clinical feedback channels in some Local Health Districts

Local Health Districts have their own processes for seeking feedback from Aboriginal clinicians. In some Local Health Districts, Aboriginal clinicians have direct channels of communication with the Chief Executive. In others, there is limited or no direct input from Aboriginal clinicians at the executive level.

Formalised communication channels can assist chief executives to give priority to issues affecting Aboriginal mental health. Regular meetings can help to escalate issues for timely resolution and address workforce barriers and service barriers as they occur.

Section two

Appendices

Appendix one – Response from agency

NSW GOVERNMENT | Health

Ms Margaret Crawford
Auditor-General of NSW
Audit Office of NSW
GPO Box 12
SYDNEY NSW 2001

Our ref H19/78664

Dear Ms Crawford Margaret

Aboriginal Mental Health Service Planning Performance Audit Report

Thank you for inviting NSW Health to provide comment on the recommendations made in your performance audit report on *Aboriginal Mental Health Service Planning.*

The recommendations made in the report are welcomed, as is the focus which the audit has given to the provision of appropriate models of care for Aboriginal people experiencing mental health illness. NSW Health's role in this area is complex, with a number of government agencies and other non-government organisations collaborating to provide services.

Within this context, please find attached a table detailing NSW Health's response to each recommendation. In addition, I would like to specifically highlight the following points to give completeness to the observations made in the audit report:

NSW Health invests resources to support all people experiencing mental illness to stay well at home and avoid hospitalisation

NSW Health remains focused on providing care to all people experiencing acute and severe phases of mental illness in hospital and community service environments. NSW Health funds a number of non-government providers to deliver community based psychosocial services to support people living with complex mental health issues. These services complement the role of Commonwealth and non-government organisations to provide non-acute care that supports people to stay well at home and avoid hospitalisation.

The services work in partnership with our Local Health Districts to support mental health recovery and include the *Housing Accommodation Support Initiative* (HASI) and *Community Living Supports* (CLS) programs.

Both HASI and CLS services have benchmarks to ensure Aboriginal people experiencing significant mental ill-health are receiving needed supports. These benchmarks are consistently exceeded for each program.

NSW Health has had great success in forming partnerships to meet the objectives of the NSW Aboriginal Health Plan

A range of partnerships are in place which support the delivery of initiatives across all strategic directions of the *NSW Aboriginal Health Plan 2013–2023.* NSW Health and the Aboriginal Health and Medical Research Council (AH&MRC) share a strong relationship which is grounded in the *NSW Aboriginal Health Partnership Agreement 2015–2025* and regularly collaborate on joint projects. This Agreement provides a guiding framework for engaging Aboriginal people in planning, delivering and evaluating health services.

NSW Ministry of Health
ABN 92 697 899 630
100 Christie Street, St Leonards NSW 2065
Locked Mail Bag 961, North Sydney NSW 2059
Tel (02) 9391 9000 Fax (02) 9391 9101
Website: www.health.nsw.gov.au

The State-wide partnership is reflected at the local level with three-quarters of LHDs reporting a formal partnership with an Aboriginal Community Controlled Health Service (ACCHS). Partnerships between LHDs and ACCHS' vary in focus, with an example of an effective partnership supporting mental health service delivery being the *South Western Sydney LHD and Tharawal Aboriginal Medical Service Partnership Agreement 2016-2019*. This partnership has improved pathways to healthcare for Aboriginal patients in the region, evidenced through the results of the mid-term evaluation of the Aboriginal Health Plan which saw strengthened Executive-level engagement and collaboration between sectors.

NSW Health advocates for culturally appropriate models of care

NSW Health's *Centre for Aboriginal Health (CAH)* has developed and implemented a range of strategies and resources to build the cultural safety of the NSW Health system. These include the recently released guideline, *Communicating Positively: A guide to appropriate Aboriginal terminology*, the *Aboriginal Cultural Activities Guideline* and the *Aboriginal Health Impact Statement* which facilitates the systematic application of an 'Aboriginal health lens' to all policies, programs and strategies. In addition the CAH is currently piloting the *NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool* which will embed Aboriginal-specific actions from Version 2 of the National Safety and Quality Health Service Standards and the six strategic directions from the NSW Aboriginal Health Plan into service delivery.

Case coordination as patients move between services is not solely a NSW Health responsibility

The Commonwealth's Primary Health Network, other primary health care providers and non-government organisations all have important roles in providing ongoing support to people accessing mental health services.

NSW Health will always endeavour to improve our care pathways and relationships to ensure smooth transitions when this intersect of service providers occurs. The *NSW Aboriginal Mental Health Workforce State-wide Coordination Unit* and the *Aboriginal Mental Health Coordinator Project* within the Aboriginal Health and Medical Council have been established by NSW Health specifically to improve referral pathways.

You will note that the NSW Health policy directive *Transfer of Care from Mental Health Inpatient Services* (PD2016_056) includes accountabilities to promote safe and effective transition of all mental health consumers between inpatient treatment settings and also from the hospital to the community.

This Policy Directive and the related procedures provide direction and guidance for the delivery of services, but do not replace the need to exercise clinical judgement for each presentation and recognition of the current workplace environment to maintain safety and continuity of care.

NSW Health can only report reliably on mental health service use patterns of Aboriginal people who access our facilities.

NSW Health collects reliable data that allows Local Health Districts to plan services that we are directly responsible for. However, it is also acknowledged that NSW Health is part of a broader system with Commonwealth and non-government organisations who have important roles in the delivery of mental health services.

We will continue to work with these partners to improve communication with data systems operating outside of NSW Health's jurisdiction. In doing so, it is important to remain conscious that there are complexities and sensitivities in relation to the patient information that is collected and this may limit the breadth of data able to be shared across services. Patient data serves different purposes and requires a high level of privacy and confidentially to ensure that the people NSW feel secure that their data is used in appropriate ways.

NSW Health provides a suite of services to assist Aboriginal people with mental illness on release from prison

Through the Justice Health and Forensic Mental Health Network, NSW Health has issued a suite of policies and procedures that articulate the procedures to be followed to support patients being released from custody with mental illness.

For high acuity patients there are a number of specialist programs that assist with the release process, including:

- The *Integrated Care Service* (ICS) works to identify people within the custodial setting living with one or more chronic or complex health issues, including mental health issues. Participants are assigned a Care Coordinator who assists in managing their care throughout their journey in custody and prior to release, the ICS work closely with Corrective Services and community health care to identify and refer patients to appropriate services on release. These services include but are not limited to Aboriginal Medical Services, community mental health teams and general practitioners. It is noted that 28% of the current participants identify as Aboriginal.
- The *Aboriginal Chronic Care Program* (ACCP) is part of our ICS, and includes Aboriginal Health Workers (AHW) spread across correctional centres in NSW.
- The *Connections* program is a drug and alcohol program in the adult setting with about 30% of participants identifying as Aboriginal and over 60% reporting mental health problems. Participants are assertively engaged to coordinate release planning and post release engagement to community health care providers on release.
- In the adolescent setting our *Community Integration Team* (CIT) works with young people to assertively coordinate their ongoing care following release. The young people supported are those with mental health and/or drug and alcohol problems, with approximately 50% of participants identifying as Aboriginal.

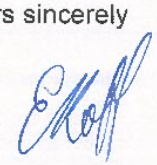
A new NSW Health Aboriginal Mental Health and Wellbeing policy will be launched in 2019

NSW Health is committed to ensuring that Aboriginal people have a voice in planning and policy decisions that will affect Aboriginal communities. We are proud that the revised Aboriginal Mental Health and Wellbeing Policy has been developed with extensive community and sector consultation. However, we are also aware that developing programs and policy using true co-design does take considerable amount of time, which has caused delay to the release of the policy.

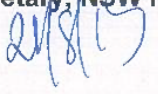
The Aboriginal Mental Health and Wellbeing Policy is now ready for publication and will be launched at the 2019 Aboriginal Mental Health and Wellbeing Forum in November 2019.

I appreciate the collaborative approach taken by the audit team through working closely with the Ministry, the Justice Health and Forensic Mental Health Network, Local Health Districts and our partnering stakeholders over the course of the audit.

Yours sincerely



Elizabeth Koff
Secretary, NSW Health



Recommendation		Response	Comment
1	Research, develop and publish evidence-based models of culturally appropriate Aboriginal mental health care for use in Local Health Districts	Accept in principle	NSW Health has focused on ensuring that the mental health clinical support and models of care available to all people of NSW is of world class standard. NSW Health ensures that mental health services are culturally appropriate for by Aboriginal people by: • Ensuring that all program and policies that are developed have undertaking an *Aboriginal Impact Statement* assessment. • Continuing to implement and continuously improve the mandatory *Respecting the difference* training for all NSW Health employees • Achieving actions outlined in the *NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022* including actions specific to Aboriginal people • Fulfilling commitments in relation to the mental health and wellbeing of Aboriginal people outlined in the *Fifth National Mental Health and Suicide Prevention Plan* • Continuing to implement the *NSW Aboriginal Health Plan 2013-202;* and • Publication of the revised Aboriginal Mental Health and Wellbeing Policy. Further opportunities to strengthen NSW Health's efforts in this area will be researched and incorporated into planning for 2019-20.
2	Finalise and publish an Aboriginal mental health policy framework that includes: • A timeline and plan for full implementation of the Framework and a communication strategy to improve the visibility and priority of Aboriginal mental health care across the mental health sector • Methods, roles and responsibilities for collecting detailed information and data about Aboriginal service use and service demand by location • A process for Local Health Districts to map services with Primary Health Networks and on-government providers to identify service gaps and duplications and plan for the equitable distribution of services across locations • A process for Local Health Districts to map services with Primary Health Networks and non-government providers to identify service gaps and duplications and plan for the equitable distribution of services across locations	Accept in principle	The *NSW Health Aboriginal Mental Health and Wellbeing Policy,* which will replace the current policy, is on schedule to be launched in November 2019. The policy will provide overarching guidance to Local Health Districts and provide best practice examples. It will complement the existing *NSW Aboriginal Health Plan 2013-2023*, the *NSW Strategic Framework and Workforce Plan 2018-2022* and the *Fifth National Mental Health and Suicide Prevention Plan.* The policy has been developed with extensive community consultation. Any revision to consider additional content will require a similarly wide-reaching and planned consultation process. The individual points contained in the recommendation will be considered as appropriate after the launch of the new policy.

Recommendation	Response	Comment
Recommendation 2 continued • A strategy to increase services for Aboriginal patients requiring high levels of clinical support in the community and clarification of mental health case management roles and responsibilities to ensure accountability and continuity of patient care across the different service providers and service types • Actions to increase the numbers and types of Aboriginal workers across all levels and positions in the mental health workforce • New performance indicators and performance reporting on follow up actions that: – Support information sharing and referrals – ensure follow up actions to support mental health patients on release from prison so that they receive seven days of medication, referrals and discharge summaries		

Appendix two – The NSW Aboriginal Health Plan

Vision

Health equity for Aboriginal people, with strong, respected Aboriginal communities in New South Wales, whose families and individuals enjoy good health and wellbeing.

Goal

To work in partnership with Aboriginal people to achieve the highest level of health possible for individuals, families, and communities.

Partnership

The Aboriginal Health Plan recognises the importance of the NSW Aboriginal Health Partnership between the NSW Government and the Aboriginal Health & Medical Research Council (AH&MRC) at the State level, and the continued need for strong partnerships between Local Health Districts and Aboriginal Community Controlled Health Services (ACCHSs) at the local level.

Principles

The following underpinning principles are essential to achieve the Plan:

1. Trust and cultural respect.
2. Recognition of the cultural values and traditions of Aboriginal communities.
3. Wholistic approaches to the health of Aboriginal people.
4. The valuable and unique role of ACCHSs.
5. The participation of Aboriginal people at all levels of health service delivery and management.
6. Partnership with Aboriginal communities through ACCHSs and the AH&MRC.
7. Recognition of the contribution the health system can make to the social determinants of health.

Aboriginal health

'Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community...'.

Strategic directions

1. Building trust through partnerships.
2. Implementing what works and building the evidence.
3. Ensuring integrated planning and service delivery.
4. Strengthening the Aboriginal workforce.
5. Providing culturally safe work environments and health services.
6. Strengthening performance monitoring, management and accountability.

Strategic actions

To support achievement of these strategic directions, a range of actions have been identified for implementation by NSW Health and other stakeholders.

Implementation and evaluation

NSW Health is responsible for implementing the Plan and reporting on progress. The NSW Aboriginal Health Partnership will monitor progress and oversight evaluation.

Appendix three – About the audit

Audit objective

This audit assessed the effectiveness of NSW Health's planning and coordination of mental health services and service pathways for Aboriginal people in New South Wales.

Audit criteria

We addressed the audit objective by answering the following questions and criteria:

1. Is NSW Health using evidence to plan and inform the availability of mental health services for Aboriginal people in New South Wales?
    a) Mental health services are planned and established based on evidence that describes the mental health service requirements of Aboriginal people across New South Wales.
    b) Models of mental health care are based on evidence and engagement with Aboriginal stakeholders.
2. Is NSW Health collaborating with partners to create accessible mental health care service pathways for Aboriginal people?
    a) NSW Health forms partnerships with other mental health care providers to facilitate referral points and manage integrated pathways of mental health care.
    b) NSW Health shares information with mental health care service partners and other stakeholders to ensure continuity of mental health care for Aboriginal people transitioning from one service to another.
3. Is NSW Health collaborating with partners to ensure the appropriateness and quality of mental health services for Aboriginal people?
    a) NSW Health seeks and uses feedback from Aboriginal stakeholders to improve the quality and appropriateness of mental health services.
    b) NSW Health implements the findings and recommendations of mental health inquiries and evaluations to improve Aboriginal mental health services.
    c) NSW Health shares evidence-based approaches to Aboriginal mental health care with service providers.

Audit scope and focus

The audit focused on:

- all Local Health Districts, community and hospital based mental health services for children and adults
- NSW Justice Health & Forensic Mental Health Network including adult correctional environments, juvenile correctional environments, forensic mental health facilities
- treatment and services supporting comorbidities such as addiction where mental illness is a factor
- NSW Health monitoring systems, information, data, resources
- The NSW Aboriginal Health Plan 2013-2023.

Audit exclusions

The audit did not assess:

- programs for non-Aboriginal mental health service users
- school-based mental health services and programs
- programs exclusively focused on addiction without a mental health component
- specialist aged-care or gerontology programs for age-related brain conditions
- programs or services funded solely by Commonwealth or non-government funding
- the merits of decisions made by Ministers or Cabinet.

Audit approach

Our procedures included:

1. interviewing staff from audited agencies including:
    a) Ministry of Health
    b) Local Health District executives and services staff
    c) Justice Health executives and services staff
2. meeting with other organisations and services relevant to mental health, including:
    a) Aboriginal Community Controlled Health Services
    b) other non-government mental health and drug and alcohol service providers
3. reviewing documents relevant to mental health services, including:
    a) Aboriginal Health Plan evaluations and progress
    b) mental health service planning frameworks and funding guidelines
    c) mental health service delivery protocols and policies
    d) data on mental health service use in New South Wales.

The audit approach was complemented by quality assurance processes within the Audit Office to ensure compliance with professional standards.

Audit methodology

Our performance audit methodology is designed to satisfy Australian Audit Standard ASAE 3500 Performance Engagements and other professional standards. The standards require the audit team to comply with relevant ethical requirements and plan and perform the audit to obtain reasonable assurance and draw a conclusion on the audit objective. Our processes have also been designed to comply with requirements specified in the *Public Finance and Audit Act 1983* and the *Local Government Act 1993*.

Acknowledgements

We gratefully acknowledge the cooperation and assistance provided by the audited agencies throughout the audit. We acknowledge the contribution of Donna Stanley, the Aboriginal mental health consultant to this audit. Donna provided cultural advice, knowledge and expertise throughout the audit and facilitated a workshop of Aboriginal mental health and drug and alcohol stakeholders. We also thank all those from other NSW Government agencies and other stakeholders who met with us to discuss the audit.

Audit cost

The estimated cost of the audit, including travel and overheads, is $520,000.

Appendix four – Performance auditing

What are performance audits?

Performance audits determine whether State or local government entities carry out their activities effectively, and do so economically and efficiently and in compliance with all relevant laws.

The activities examined by a performance audit may include a government program, all or part of an audited entity, or more than one entity. They can also consider particular issues which affect the whole public sector and/or the whole local government sector. They cannot question the merits of government policy objectives.

The Auditor-General's mandate to undertake performance audits is set out in section 38B of the *Public Finance and Audit Act 1983* for state government entities, and in section 421D of the *Local Government Act 1993* for local government entities.

Why do we conduct performance audits?

Performance audits provide independent assurance to the NSW Parliament and the public.

Through their recommendations, performance audits seek to improve the value for money the community receives from government services.

Performance audits are selected at the discretion of the Auditor-General who seeks input from parliamentarians, state and local government entities, other interested stakeholders and Audit Office research.

How are performance audits selected?

When selecting and scoping topics, we aim to choose topics that reflect the interests of parliament in holding the government to account. Performance audits are selected at the discretion of the Auditor-General based on our own research, suggestions from the public, and consultation with parliamentarians, agency heads and key government stakeholders. Our three-year performance audit program is published on the website and is reviewed annually to ensure it continues to address significant issues of interest to parliament, aligns with government priorities, and reflects contemporary thinking on public sector management. Our program is sufficiently flexible to allow us to respond readily to any emerging issues.

What happens during the phases of a performance audit?

Performance audits have three key phases: planning, fieldwork and report writing.

During the planning phase, the audit team develops an understanding of the audit topic and responsible entities and defines the objective and scope of the audit.

The planning phase also identifies the audit criteria. These are standards of performance against which the audited entity, program or activities are assessed. Criteria may be based on relevant legislation, internal policies and procedures, industry standards, best practice, government targets, benchmarks or published guidelines.

At the completion of fieldwork, the audit team meets with management representatives to discuss all significant matters arising out of the audit. Following this, a draft performance audit report is prepared.

The audit team then meets with management representatives to check that facts presented in the draft report are accurate and to seek input in developing practical recommendations on areas of improvement.

A final report is then provided to the head of the audited entity who is invited to formally respond to the report. The report presented to the NSW Parliament includes any response from the head of the audited entity. The relevant minister and the Treasurer are also provided with a copy of the final report. In performance audits that involve multiple entities, there may be responses from more than one audited entity or from a nominated coordinating entity.

Who checks to see if recommendations have been implemented?

After the report is presented to the NSW Parliament, it is usual for the entity's audit committee to monitor progress with the implementation of recommendations.

In addition, it is the practice of Parliament's Public Accounts Committee to conduct reviews or hold inquiries into matters raised in performance audit reports. The reviews and inquiries are usually held 12 months after the report received by the NSW Parliament. These reports are available on the NSW Parliament website.

Who audits the auditors?

Our performance audits are subject to internal and external quality reviews against relevant Australian and international standards.

The Public Accounts Committee appoints an independent reviewer to report on compliance with auditing practices and standards every four years. The reviewer's report is presented to the NSW Parliament and available on its website.

Periodic peer reviews by other Audit Offices test our activities against relevant standards and better practice.

Each audit is subject to internal review prior to its release.

Who pays for performance audits?

No fee is charged for performance audits. Our performance audit services are funded by the NSW Parliament.

Further information and copies of reports

For further information, including copies of performance audit reports and a list of audits currently in-progress, please see our website www.audit.nsw.gov.au or contact us on 9275 7100.

Professional people with purpose

OUR VISION

Our insights inform and challenge government to improve outcomes for citizens.

OUR PURPOSE

To help parliament hold government accountable for its use of public resources.

OUR VALUES

Purpose – we have an impact, are accountable, and work as a team.

People – we trust and respect others and have a balanced approach to work.

Professionalism – we are recognised for our independence and integrity and the value we deliver.

auditoffice
OF NEW SOUTH WALES

audit.nsw.gov.au

Level 19, Darling Park Tower 2
201 Sussex Street
Sydney NSW 2000 Australia

PHONE +61 2 9275 7100
FAX +61 2 9275 7200

mail@audit.nsw.gov.au

Office hours: 8.30am-5.00pm

auditoffice
OF NEW SOUTH WALES

audit.nsw.gov.au