



COORDINARE
Review of Low Intensity Mental Health
Services in SENSW - February 2026

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Executive Summary

Context

COORDINARE receives funding from the Commonwealth Department of Health, Disability and Ageing (DHDA) to commission low intensity mental health services to support people with, or at risk of, mild mental illness as part of a stepped care approach. Since June 2020, COORDINARE has commissioned Wellways to deliver NewAccess, a region wide low intensity service licenced and supported by BeyondBlue.

The Australian Government's 2024–25 Budget announced a new National Early Intervention Service (NEIS) to provide low intensity support to people at risk of, or experiencing, mild mental ill health or transient distress. This national approach now known as Medicare Mental Health Check-in commenced on 1 January 2026.

The introduction of Medicare Mental Health Check-in has resulted in a reduction to COORDINARE's Mental Health Care Flexible Funding from 2026–27. In addition, the Commonwealth has directed PHNs to review all existing low intensity mental health services to assess whether they should continue, be refocused, or be decommissioned to avoid duplication with the national service.

This shift has significant implications for the low intensity service landscape. COORDINARE has undertaken a review to determine the most effective commissioning approach that maintains access, avoids duplication, and meets the needs of our region.

Findings

The review focused on the current low intensity service, regional needs and opportunities to implement new models. Consultation and feedback were collected through focus groups with current providers and online surveys with consumers of existing low intensity services. This was supplemented by an exploration of the evidence and population needs.

Key findings include:

- Key components of existing low intensity services will be duplicated with the rollout of Medicare Mental Health Check In nationally from May 2026.
- The revised commonwealth guidelines for low intensity support highlight the importance of commissioning services which complement existing low intensity service offerings, and target populations who face barriers to access.
- Across PHNs and globally, there are several other examples of low intensity service provision, including community led programs targeting priority populations.
- Local stakeholders highlighted the need for more flexible, community based, culturally tailored models that better meet the needs of people who face digital, cultural and literacy barriers to accessing existing services.

Background

COORDINARE receives funding from the Commonwealth Department of Health, Disability and Ageing (DHDA) to commission low intensity mental health services to support people with, or at risk of, mild mental illness as part of a stepped care approach to mental health service delivery. Since June 2020, COORDINARE has commissioned Wellways to deliver the “NewAccess” program, a region wide low intensity mental health service licenced and supported by BeyondBlue.

The Australian Government’s 2024-25 Budget announced funding for a new National Early Intervention Service to provide low-intensity mental health support to people at risk of or experiencing mild mental ill-health or transient distress.

The new national service (now known as Medicare Mental Health Check in) Launched in January 2026 with a phased approach as follows:

- 1 January 2026: psychoeducational materials to help help-seekers, their families and carers understand and manage their mental health
- 30 March 2026: guided LiCBT delivered by skilled and trained professionals via phone or video (guided LiCBT) from 30 March 2026
- 30 May 2026: self-guided LiCBT to support help-seekers who are able and willing to engage with self-guided resources and tools free evidence based online tools from 30 May 2026.

The implementation of Medicare Mental Health Check in resulted in a reduction of COORDINARE’S Mental Health Care Flexible Funding from 2026-27. In addition, the Commonwealth requested that PHNs review existing low intensity mental health services to determine if services can continue, be re-focused, or decommissioned to ensure no duplication of services with the NEIS.

Commonwealth Guidance

The Australian Government has released revised 2026 guidance for the delivery of Low Intensity Mental Health services by PHNs. These guidelines highlight the PHN’s responsibility to plan for the provision of low intensity mental health services as part of a stepped care approach, with a focus on commissioning services for consumers who cannot access mainstream services or for whom these services do not meet their needs.

According to the guidance, Low intensity mental health services are evidence-based psychological services designed to target people with or at risk of mild mental ill-health and are designed to be accessed:

- Quickly, without the need for a formal referral
- Easily, through a range of modalities
- Efficiently, typically involving a small number of services, and short sessions

The guidance identifies the following groups as those who may benefit from these services:

- People in rural and remote areas (including those affected by drought or other natural disasters)
- First Nations peoples
- Older Australians
- Children and youth
- People who may be experiencing social or economic disadvantages
- LGBTIQ+ people
- Culturally and linguistically diverse individuals
- Underserved groups experiencing barriers to accessing mainstream services or for whom these services are not suitable for their needs
- Other people not mentioned who may not be able to access services under mainstream services or for whom these services are not suitable for their needs.

Services that are in scope for PHN commissioned activities must be evidence-based and could include:

- Face-to-face low intensity psychological services delivered 1:1 or in a group.
- Psychological services or coaching provided to support and supplement services provided online
- Activities to promote mainstream services such as walk-in centres, website and phone services to consumers and health professionals as a source of low intensity mental health services.

Activities that are not considered to be in scope for PHN commissioned low intensity mental health services include those which:

- Are not supported by evidence.
- Do not provide a structured form of counselling or psychological intervention to address a mental health problem or ill-health.
- Primarily provide social support services or lifestyle interventions (psychosocial supports).
- Duplicate other services including those provided by the state and territory government, through the Medicare Benefits Schedule or through other national initiatives.
- Duplicate the suite of existing Commonwealth-funded nationally available digital mental health services including those accessed through Medicare Mental Health Centres and the National Early Intervention Service; and/or
- Are relatively high cost compared to other available services. A good benchmark for this is the cost of services under the Medicare Benefits Schedule Better Access initiative.

Community wellbeing activities aimed at improving connectedness, lifestyle or resilience, such as exercise, yoga or relaxation, are not considered to be low intensity mental health services. These types of activities are generally seen as being out of scope of the Flexible Funding pool.

Population and Service Needs

Regional Context and prevalence

The South Eastern NSW PHN covers a wide catchment area. It encompasses two local health districts (Illawarra Shoalhaven and Southern NSW), 12 local government areas/territories, and a population of over 645,000. Approximately 5% of the population in the region identify as Aboriginal and Torres- Strait Islander.

The Population Health Profile shows that there are differences in mental health need in the region. For example, Shellharbour, Shoalhaven, Eurobodalla, and Wollongong have the highest estimated prevalence of people living with high or very high psychological distress. Goulburn Mulwaree also has a high need, with the highest estimated prevalence of mental and behavioural problems within the region.

Low Intensity service availability and demand

Based on modelling from the National Mental Health Service Planning Framework (NMHSPF), it is estimated that approximately 54,822 people across the SENSW catchment may be experiencing mild mental health disorders or mild mental health needs (using 2024-25 data). This estimate is derived from national prevalence modelling produced by the AIHW in partnership with the University of Queensland and represents a whole of population estimate for the region.

It is important to note that NMHSPF estimates are indicative only. The NMHSPF models an idealised service system based on population need, rather than reflecting the current configuration, capacity, or utilisation of local services. These figures are synthetic, conceptual estimates informed by available national data and do not represent real time service use, dynamic system pressures, or existing service coverage across the region. As such, in this report, this estimate informs strategic planning and relative scale and will be combined with other information such as local service data, stakeholder insights, and lived experience evidence.

From May 2026, Medicare Mental Health Check in will be available region wide. There is the potential for a large proportion of the population to access this service given its scale and national promotion.

The COORDINARE needs assessment identifies several service gaps and considerations related to low Intensity service delivery, including:

- a lack of early intervention services, low uptake of e-mental health options, low mental health literacy, and poor community awareness of digital and low-intensity services.
- The need to build community capacity around early identification and support for mental health consumers especially during early and/or mild stages of distress/ disorders along with having resources to enable initial interventions
- Need for interventions and service models to be based on consumer's unique and individual needs and circumstances with the availability of a degree of flexibility to suit the consumer

Barriers to accessing services

For some individuals, telehealth and digital services work well. In these cases, Medicare Mental Health Check In may be a suitable low intensity service. However, according to the needs assessment, digital and telehealth services are not always suitable due to:

- trust issues,
- capacity/confidence to use telehealth.
- Complexity in need,
- older age
- language and cultural barriers
- lack of access to internet/technology

Priority populations

The needs assessment highlights several groups as having higher vulnerability or lower access to mental health supports in our region, including

- Aboriginal and Torres Strait Islander peoples
- Culturally and linguistically diverse (CALD) communities
- Males
- LGBTIQ+ individuals
- Children under 12 years
- People with disability or complex needs
- Perinatal populations
- Drought-affected farming communities

It is worth noting that many of these groups align with the groups the commonwealth has specifically outlined in the Low Intensity program guidance.

After community consultation, three key groups emerged as facing additional barriers to accessing telehealth and digital online low intensity services in SENSW. These were:

- Children
- CALD communities, particularly those from non-English speaking backgrounds or who face cultural barriers to speaking about mental ill health
- Older people

Additional information about these groups and their needs are highlighted below

Children

Existing low intensity models including NewAccess, and Medicare Mental Health Check in are not available to children. RANZCP (2023) argue that current childhood mental health care services in Australia do not currently meet the needs of infants and young children. This report suggests that children benefit most from relational, developmentally appropriate, and family involved interventions, typically delivered face to face or through supported community based settings such as schools and family services. Where early, low intensity supports are unavailable or inaccessible, children are more likely to experience delayed intervention, increasing the risk of symptom escalation and later need for higher intensity services.

Outside of the Strong Foundations program in the Shoalhaven, COORDINARE does not currently commission child specific low intensity mental health services for children under 12 across the region. In Wollongong, the ISLHD Medicare Mental Health Kids Hub will provide support for children aged 0–12 experiencing mild to moderate developmental, emotional, relational or behavioural challenges once fully operational; however, this model does not address gaps across the broader PHN catchment and is unlikely to meet the full scale of demand.

[Family Mental health support services](#) (FMHSS) provide early intervention support to children and young people at risk of mental illness and their families, however a scan of these services across the catchment show that currently there are no funded providers for these services in Goulburn, Yass, Upper Lachlan, Eurobodalla, and Bega Valley.

Multiple indicators highlight significant developmental vulnerability and unmet need among children in South Eastern NSW. As reported in the COORDINARE population health profile, in the Bega Valley, 28.1% of children are developmentally vulnerable on one or more domains, and 15% are vulnerable on two or more domains. Elevated rates of vulnerability are also evident in Eurobodalla, Shellharbour and Upper Lachlan. Family-level risk factors that are known to contribute to poorer child mental health outcomes are also concentrated in these areas, with Eurobodalla recording the highest proportions of single-parent families (30.09%) and families with children under 15 where no parent is employed (14%), alongside similarly high rates in Shoalhaven, Shellharbour, Goulburn and Bega Valley.

While national mental health prevalence data for children under 12 is limited, Lawrence et al. (2023) produced synthetic estimates of mental disorder prevalence in children by combining Young Minds Matter survey data with the 2021 Australian Census. These modelled estimates indicate substantial numbers of children aged 4–11 across all SA3 areas in the SENSW PHN who are likely to experience mild mental health conditions and could benefit from early, low-intensity intervention (see Figure 1). While these estimates should be interpreted with caution, when considered alongside strong local qualitative evidence from clinicians and communities, they reinforce the need for accessible, child-focused low-intensity mental health services across the catchment.

Figure 1: Modelled estimates based on Young Minds Matter synthetic prevalence data for children aged 4–11 (extracted from Lawrence, D., Bartlett, J., Buckingham, W., Hielscher, E., Diminic, S., & Whiteford, H. (2023). *Regional estimates of child and adolescent mental disorders [Data set]*. Curtin University. <https://doi.org/10.25917/2JYB-PY41>)

Sa3 Area	Estimated population	Estimated Prevalence (mild)	Estimated Prevalence (moderate)	Estimated Prevalence (all)	Estimated demand for services (mild only)
Queanbeyan	6,902	760	263	2,324	380 (5.5%)
Snowy Mountains	1,677	190	64	582	95 (5.7%)
South Coast	5,974	484	218	1,739	242 (4.0%)
Goulburn/Mulwaree	3,722	425	162	1,300	212 (5.7%)

Young/Yass	4,239	518	149	1,533	259 (6.1%)
Dapto/Port Kembla	8,149	800	287	2,570	400 (4.9%)
Kiama/Shellharbour	9,974	1,011	324	3,165	505 (5.1%)
Wollongong	12,197	1,189	402	3,793	595 (4.9%)
Shoalhaven	9,355	963	374	3,042	482 (5.1%)
Southern Highlands	4,783	400	139	1,399	200 (4.2%)

Older people

Mental distress and mental health conditions are common in late life (Dijk and Mierau 2023). The 2020–2022 National Study of Mental Health and Wellbeing identified that 7.9% and 11.1% of men and women, respectively, aged 65 years and older have experienced a mental health condition in the past 12 months (not including dementias) (ABS 2020–2022).

Older people are also less likely to engage with low-intensity services delivered primarily through digital or telehealth platforms. An Australian study (Handley et al., 2014) on rural older people found that majority of study participants would not consider engaging with internet-delivered mental health services. Barriers identified including privacy concerns, mistrust, not believing the services would work, and broader barriers related to internet use more generally.

COORDINARE’s healthy ageing framework (2025) describes how getting older brings a range of significant life changes such as retiring, changes in relationships and living arrangements, becoming a carer, changes to physical and mental health and grief and loss. These changes can contribute to increased risk of mental illness and distress. The framework also notes that mental health support is not always tailored to the needs of older people, and not everyone has natural support networks.

According to our population health profile, compared to the rest of NSW the SENSWPHN catchment has a substantially higher proportion in the older age groups.

In particular, the Eurobodalla has a substantially higher proportion of older-aged persons over 65 across the catchment and NSW.

Social isolation especially among the elderly is a major risk factor and is estimated to further complicate the burdens of morbidity and mortality among elderly persons. While social isolation and loneliness can only be accurately measured by large scale qualitative surveys or wide population screening; figures for households with lone persons and persons aged 65 years and over living alone within private households can be used as a proxy of social isolation among older persons living in the community. Figure 2 outlines the number of people ages 65 years and living alone in each part of the catchment, alongside the overall % of the population aged 65 years and over.

Figure 2: *Living alone in the household: at risk of social isolation, 2021 (extracted from Ghosh A. 2019, Population Health Profile: South Eastern NSW. COORDINARE - South Eastern NSW PHN. [Last Updated: December 2025])*

Regions	Persons aged 65 years & over and living alone	% of resident population aged 65 years & over
Bega Valley	2,456	26.6%
Eurobodalla	2,840	24.2%
Goulburn Mulwaree	1,766	30.2%
Jervis Bay	4	10.0%
Kiama	1,208	21.5%
Queanbeyan-Palerang Regional	1,810	23.7%
Shellharbour	2,917	22.8%
Shoalhaven	6,774	24.6%
Snowy Monaro Regional	1,040	28.0%
Upper Lachlan Shire	483	25.9%
Wollongong	9,911	27.2%
Yass Valley	575	20.7%
SENSWPHN	31,784	25.4%
<i>Illawarra Shoalhaven</i>	<i>20,814</i>	<i>25.3%</i>
<i>Southern NSW</i>	<i>10,970</i>	<i>25.6%</i>
NSW	315,136	24.6%
Australia	993,465	25.5%

Culturally and Linguistically Diverse Communities (CALD)

As described in the 2024 SENSW PHN Needs Assessment focused on CALD primary care access (COORDINARE & Rubic Consulting, 2024), people from culturally and linguistically diverse (CALD) backgrounds face layered socioeconomic and health challenges, with more complex needs among those with refugee backgrounds. These groups experience higher rates of mental health conditions such as anxiety and post-traumatic stress disorder, often alongside other chronic health issues. Cultural beliefs, stigma, and experiences of discrimination further contribute to unmet mental health needs.

COORDINARE has heard through local consultation that barriers including language, affordability, accessibility, service appropriateness, and low health literacy reduce help seeking and limit engagement with mainstream mental health services. Temporary migrants are particularly disadvantaged due to their ineligibility for Medicare, further restricting access to affordable care.

As shown in the population Health Profile, within the SENSWPHN catchment, Wollongong and Queanbeyan have the highest concentrations of CALD communities, with around 10% of residents speaking a language other than English at home. Wollongong, followed by Shellharbour and Queanbeyan, also has the highest number of residents with limited English proficiency. The most spoken languages differ by sub-region, with Macedonian most common in Illawarra Shoalhaven and Punjabi in Southern NSW.

COORDINARE’s findings are supported by evidence, with a scoping review published in 2025 (Emmanuel et al.) highlighting persistent barriers to mental health service access among CALD communities. The most frequently reported barriers are stigma and shame, including fear of community judgement, loss of family reputation, and concerns about confidentiality, which often delay help seeking until symptoms become more severe. Engagement is further limited by language and communication barriers, low mental health literacy, and limited awareness of available services. These issues are compounded by complex service pathways, long wait times, and unclear referral processes, restricting access to early or preventive support.

At a system level, CALD communities report a lack of culturally competent practitioners, limited availability of bicultural or ethno-specific services, and models of care that do not reflect cultural beliefs, family structures, or preferred help seeking pathways. The literature consistently identifies the need for culturally responsive, supported entry point services, including culturally tailored mental health literacy initiatives, community based “soft entry” models, and face-to-face or blended delivery with supported navigation. While Emmanuel et al. (2025) do not examine low intensity services specifically, the barriers identified primarily affect engagement at early stages of help seeking, highlighting the relevance of targeted, low intensity service models for CALD communities.

Evidence review

Existing low intensity service models

Low Intensity service models in Australia have been influenced by international programs such as the “Improving Access to Psychological Therapies” (IAPT) program in the United Kingdom (Australian Government, 2026). IAPT promoted a standardised approach where therapists, known as Psychological Well-being Practitioners, receive year-long training in a national CBT curriculum. A similar model has been adapted as part of the delivery of Medicare Mental Health Check-in.

Engagement with digital models in regional and remote Australia

Engagement with low intensity mental health services is influenced by a range of interpersonal, service, and system level factors. While low intensity services are designed to reduce barriers to care, they do not benefit all populations equally, particularly when services are delivered digitally or via telehealth.

A study exploring rural and remote access to the online service “This Way Up” (Le et al., 2025) demonstrates that barriers to low intensity and digital mental health services extend beyond service availability and internet connectivity. While digital mental health has the potential to address geographic and workforce related access constraints, uptake in remote communities is limited due to low awareness of services, lack of clinician confidence and integration pathways, perceived unsuitability for some populations, and consumer concerns regarding privacy, effectiveness, and stigma. This study noted that clinicians act as key gatekeepers to accessing these kinds of services, and for clinicians, barriers include limited digital capability, time constraints, and uncertainty about referral pathways. These findings suggest that without complementary face-to-face options, navigation support for consumers and clinicians, digital low intensity services may not meet the needs of all regional and remote populations, particularly those with language, cognitive impairments, or more complex needs. COORDINARE must be mindful of these learnings to promote and increase the uptake of Medicare Mental Health Check in, as well any other commissioned services in the low intensity space.

Evidence for Non-Digital Low Intensity Mental Health Models

Across Australia, PHNs have successfully established nondigital, low intensity mental health services as core components of stepped care systems. These services are commonly integrated with other offerings to enable people to step up or down within the same service or local system, improving continuity of care and reducing fragmentation.

Many PHNs (including NWMPHN, WVPHN, EMPHN and NQPHN) have adopted integrated or hybrid commissioning approaches, often following extensive system redesign, codesign and community consultation. This has enabled low intensity services to function as preventative, early intervention supports rather than standalone or residual services.

Priority Populations Focus

Standalone low intensity services funded across other PHNs consistently target priority populations where barriers to access, stigma, or limited suitability of digital services are well recognised. These include:

- Older people
- Parents and people in the perinatal period
- Young children and families
- CALD communities
- Men
- People in rural, regional and isolated communities

Many PHNs commission multiple low intensity services tailored to different cohorts within their catchment.

Examples from across PHNs include face-to-face, brief, skills based and psychologically informed programs:

- Children and families (e.g. STAR4Kids, Resilient Kids, early intervention and parenting programs)
- Perinatal and parenting supports (e.g. Peach Tree, Gidget House, Sunshine Parenting, Circle of Security)
- Adult low intensity services (e.g. NewAccess, LIME, Connect)
- CALD and culturally responsive services (e.g. WHO PM+ delivered by World Wellness Group)
- Men, older people and residential aged care populations (e.g. Men’s Table, aged care embedded mental health services)

While funding sources vary, these programs align strongly with low intensity principles, including early intervention, short duration, group or brief individual delivery, and clear pathways to higher intensity care.

Broader and Emerging Practice

Internationally, effective low intensity systems emphasise:

- Colocation and integrated care, embedding supports in trusted, no stigmatising settings such as primary care, schools or community health services (Isaacs & Mitchell, 2024).
- Community hub outreach, using nontraditional venues to improve access and engagement, particularly in rural or underserved communities (World Health Organisation, 2022)

Consultation

COORDINARE consulted with a range of stakeholders between November 2025 and January 2026, including focus groups with the existing provider, and mental health hubs, a survey with consumers of the NewAccess service, consultations with COORDINARE’s Aboriginal Health Council, Clinical Councils, and Community Advisory Council, and a general community webpage with option for additional comment.

These consultation activities confirmed that low-intensity mental health services play a critical role in supporting early intervention, addressing accessibility gaps, and reducing escalation to higher-intensity care. While the NewAccess model demonstrates several strong elements and positive outcomes, system constraints, inequities in access, and limited integration reduce its overall reach and effectiveness, particularly for priority populations. There were also concerns highlighted about digital and telehealth models more broadly and their use by priority populations such as CALD communities, older people, children, and first nations communities.

What Is Working Well

We heard that NewAccess’s evidence-based design and use of structured low-intensity cognitive behavioural therapy (LiCBT) was highly valuable. Coaches and clinicians noted that the targeted, skills-based approach is highly effective for individuals who are motivated and ready to engage, with some reporting greater benefit than from unstructured “talk therapy.” The program’s use of locally based staff supports referral relationships and community trust, while broad eligibility criteria and flexible delivery modes are valued. Consumers highlighted the ability to combine face-to-face and telehealth sessions as supporting both engagement and accessibility, and the availability of TIS interpreting services was identified as an important enabler. Coaches were consistently described as caring, respectful, and non-judgemental.

The broader system also provides partial coverage for low-intensity needs, with some Mental health hubs accepting consumers with low Intensity needs into their service. Instead of ‘stepping down’ Mental Health Hubs generally continue to support people with lower-intensity needs for extended periods. GPs also raised their ability to provide low-intensity support directly.

Gaps and Challenges

Awareness of low intensity service offerings was low among many GPs, NDIS support coordinators, and advisory groups.

First Nations stakeholders reported limited awareness of existing services and low trust in telehealth-only models, expressing a strong preference for face-to-face, community-based services. We also heard that CALD consumers with low English literacy face major barriers with phone and online-based programs that rely on English forms or written materials. Children and older people were also identified as less well served by digital-only approaches and the existing service system.

Transport challenges in rural areas limit face-to-face service access, while poor internet access and low digital literacy can hinder telehealth engagement.

Stakeholders also noted that some existing models can be overly rigid, with fixed session numbers, duration, and timeframes limiting flexibility, re-engagement, and ongoing support. Both stakeholders and consumers expressed a desire for more flexible, individualised approaches and alternative modalities beyond CBT alone.

Implications for Future Low-Intensity Services

Overall, the findings suggest that digital-only low-intensity models are unlikely to meet regional need equitably. Stakeholders supported more flexible, relational, and community-based approaches, including group programs, peer-led models, outreach, and social prescribing. Strong integration with mental health hubs, general practice, and community services was seen as important to reduce fragmentation, strengthen step-up and step-down pathways, and improve continuity. Co-design with priority populations and community led delivery was also noted as an important consideration for the future commissioning of services.

Opportunities and Recommendations

The review identified clear opportunities to strengthen the reach, flexibility and equity of low intensity supports across the region to better align with commonwealth guidance and complement existing offerings in the community. Stakeholders emphasised the need for community based, culturally tailored models that better meet the needs of priority populations and will complement the national Medicare Mental Health Check in service. These suggestions are supported by evidence and population need.

The role for PHN commissioned low intensity services has changed with the introduction of Medicare Mental Health Check in. Where previously COORDINARE was required to fund broader low intensity support which could benefit people across the region, the introduction of Medicare Mental Health Check in provides an opportunity for COORDINARE to refocus this funding to more specifically support those in the community who miss out, including groups identified throughout this report like CALD communities, older people, and Children.

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