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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Mental health and suicide prevention

2022-2024 Needs Assessment
2022 Annual Review

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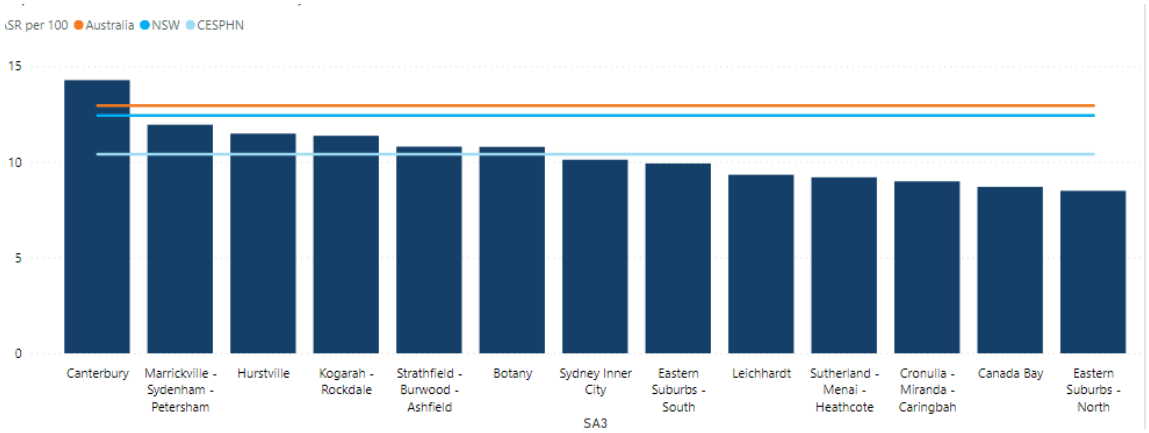
Prevalence of mental health issues and suicide

Psychological distress

Psychological distress is an indication of mental health and wellbeing based on self-reported levels of fatigue, depression, nervousness and anxiety. Whilst a person with high levels of psychological distress may not necessarily be diagnosed with a mental illness, it may have a negative impact on a person's wellbeing.

In 2017-18, the rate of people experiencing high or very high psychological distress in the CESPHN region was 10.4 age-standardised rate (ASR) per 100 people, which is below the NSW rate (12.4 ASR per 100) and the national rate (12.9 ASR per 100).(1) Within the CESPHN region, Canterbury SA3 had the highest age-standardised rate of psychological distress (14.3 per 100 population), followed by Marrickville-Sydenham-Petersham SA3 (12.0 per 100), Hurstville SA3 (11.5 per 100). Canterbury SA3 is the only SA3 in our region that had estimated rates of psychological distress higher than the NSW and Australian rates.

Figure 1: Persons 18 years and over with high or very high psychological distress by SA3, 2017-18



Source: PHIDU, 2021

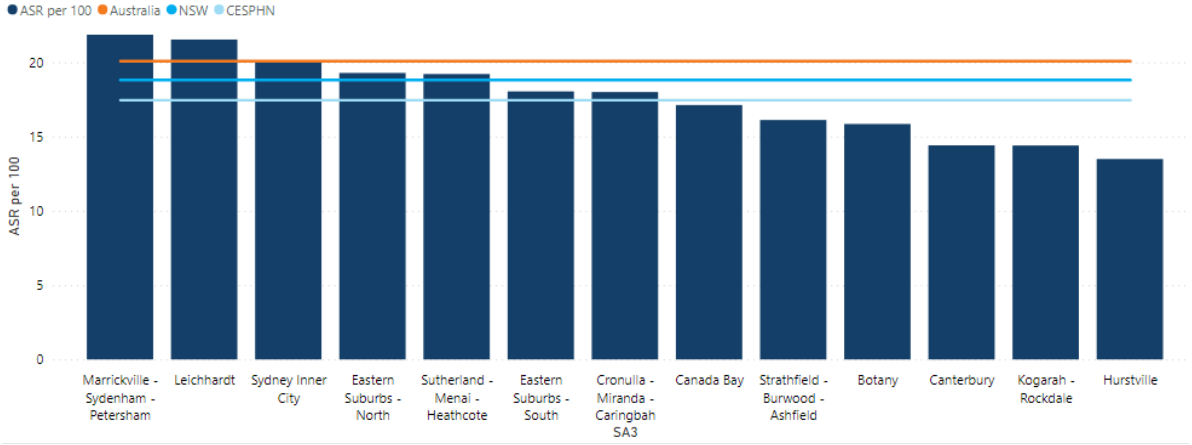
Mental health in adults

In 2017-18, the estimated prevalence of mental health and behavioural problems in the CESPHN region was 17.5 per 100 (ASR), which is lower than the NSW (18.8 per 100) and national (20.1 per 100) rates.(1)

The SA3s with the highest estimated prevalence of mental health and behavioural problems were Marrickville-Sydenham-Petersham SA3 (21.9 per 100) followed by Leichhardt SA3 (21.5 per 100), and Sydney Inner City SA3 (20.1 per 100). Females had higher prevalence rates of mental and behavioural problems in comparison to males across all SA3s in the CESPHN region.(1)

This indicator is based on a person self-reporting that they were told by a doctor or nurse that they had mental health and behavioural problems that were current and long term. It therefore does not capture persons who have not sought help for their mental health.

Figure 2: Persons 18 years and over with mental and behavioural problems by SA3, 2017-18



Source: PHIDU, 2021

The 2021 Census reported the number of people with selected long-term health conditions, across the CESPHN region a total of 102,526 responded that they had a mental health condition (including depression or anxiety). This accounted for 6.6% of the CESPHN population and 5.9% of long-term health condition responses; the highest proportion for specific, identified long-term health conditions.

Within the CESPHN region, Marrickville-Sydenham-Petersham SA3 had the highest proportion of the population respond that they had a mental health condition (11.7%), followed by Leichhardt SA3 (8.9%) and Sydney Inner City SA3 (8.7%). (2)

Table 1: Number and proportion of population with mental health condition by SA3, CESPHN region, 2021

SA3	People with mental health condition	Proportion of people in SA3 with mental health condition
Botany	3,313	5.6%
Canada Bay	4,689	5.4%
Canterbury	6,683	4.7%
Cronulla-Miranda-Caringbah	7,684	6.5%
Eastern Suburbs – North	7,298	5.7%
Eastern Suburbs – South	8,694	6.5%
Hurstville	6,614	5.0%
Kogarah-Rockdale	7,505	5.1%
Leichhardt	5,029	8.9%
Lord Howe Island	10	2.2%
Marrickville-Sydenham-Petersham	6,427	11.7%
Strathfield-Burwood-Ashfield	10,914	6.8%
Sutherland-Menai-Heathcote	8,667	7.8%
Sydney Inner City	18,999	8.7%
CESPHN	**102,526**	**6.6%**

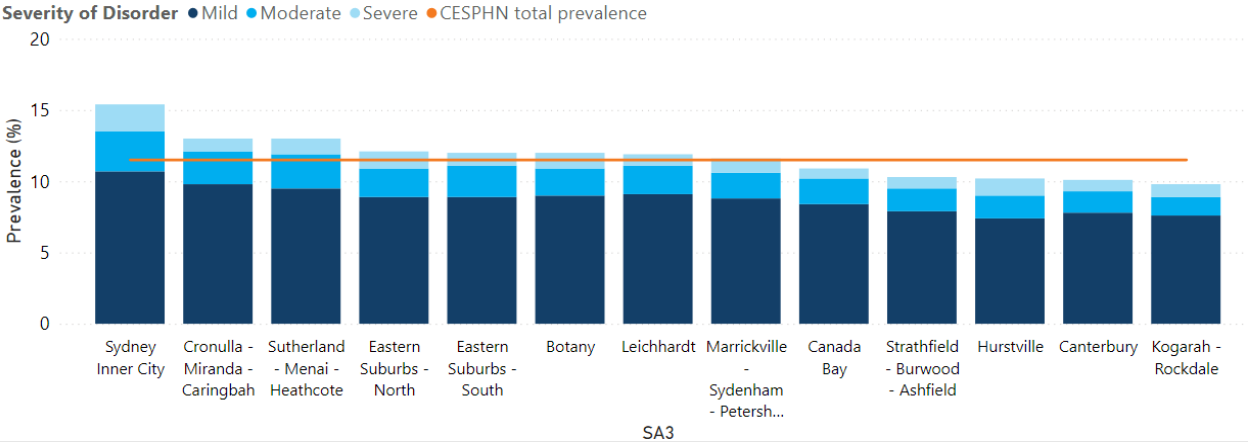
Source: ABS, 2022

Mental health in children and young people

The synthetic prevalence estimate of mental health issues among 4-17 year-olds in the CESPHN region is 11.8%, which is lower than the national rate (14.1%) across all severity levels.(3) However, there are SA3 areas where the prevalence estimates are higher:

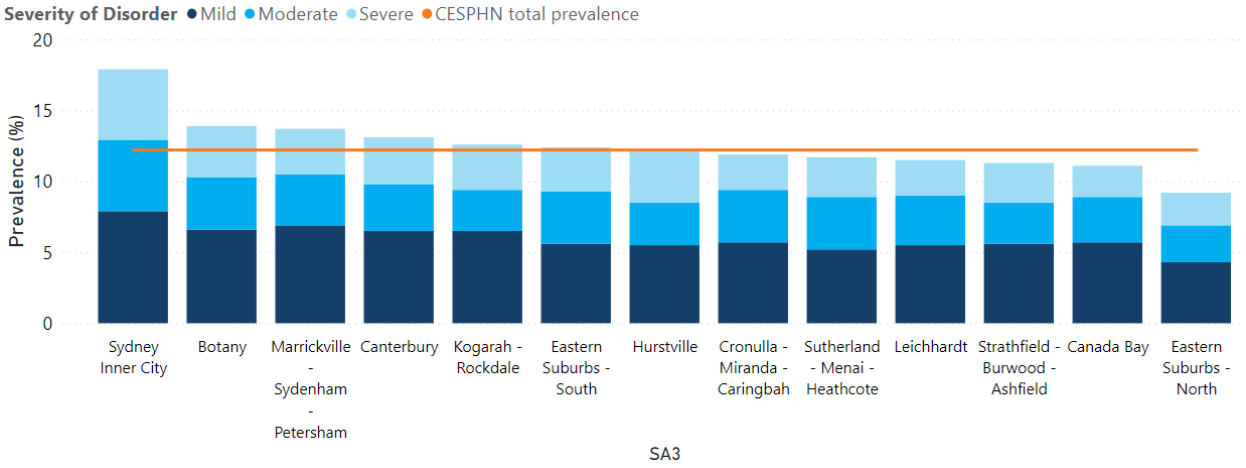
- For children aged 4-11 years old:
  - Sydney Inner City (15.4%), Cronulla-Miranda-Caringbah (13.0%) and Sutherland-Menai-Heathcote (12.9%) had higher prevalence estimates than the CESPHN rate (11.5%)
- For young people 12-17 years old:
  - Sydney Inner City (18.0%), Botany (14.0%), and Marrickville-Sydenham-Petersham (13.7%) had higher prevalence estimates than the CESPHN rate (12.2%)
- Children and young people aged 4-17 years old with moderate mental health issues:
  - Sydney Inner City (3.7%), Cronulla-Miranda-Caringbah (2.9%) and Sutherland-Menai-Heathcote (2.9%) had higher prevalence estimates than the CESPHN rate (2.5%)
- Children and young people aged 4-17 years old with severe mental health issues:
  - Sydney Inner City (3.1%), Hurstville (2.3%) and Botany (2.1%) had higher prevalence estimates than the CESPHN rate (1.8%).

Figure 3: Prevalence of mental health illness in children aged 4-11 years, by severity of disorder and SA3, June 2013 to April 2014



Source: Young Minds Matter, 2018

Figure 4: Prevalence of mental health illness in young people aged 12-17 years, by severity of disorder and SA3, June 2013 to April 2014

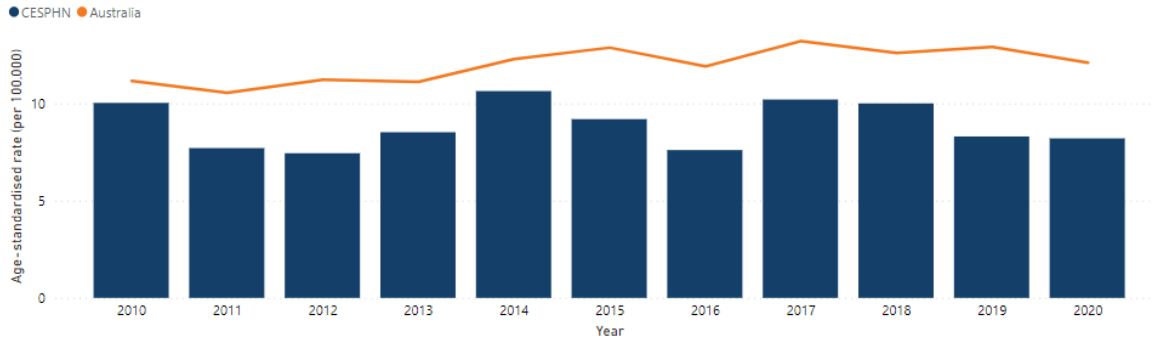


Source: Young Minds Matter, 2018

Suicide

In 2020, there were 145 deaths by suicide within the CESPHN region, this is a decrease of 2.1% from the previous year. Suicide rates in the CESPHN region continue to fluctuate, in 2020 the ASR of suicide was 8.2 per 100,000 people, the fourth lowest of all reported PHNs.(4)

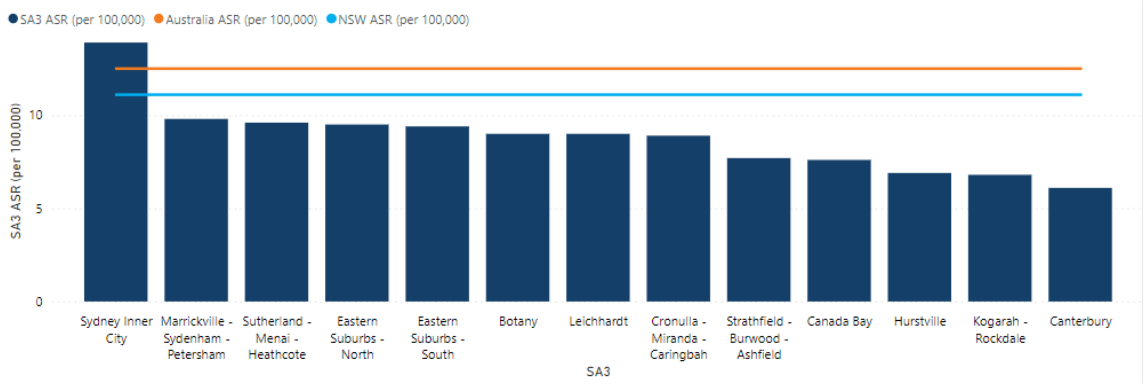
Figure 5: Suicide rate per 100,000 population, CESPHN region, 2020



Source: AIHW, 2022

Suicide data for 2016-2020 shows that Sydney Inner City SA3 had the highest rate of suicide within the CESPHN region (13.9 per 100,000 population) with rates higher than both NSW (11.1 per 100,000 population) and Australia (12.5 per 100,000 population), followed by Marrickville-Sydenham-Petersham SA3 (9.8 per 100,000 population) and Sutherland-Menai-Heathcote SA3 (9.6 per 100,000 population).(4)

Figure 6: Suicide rate by SA3, 2016-2020



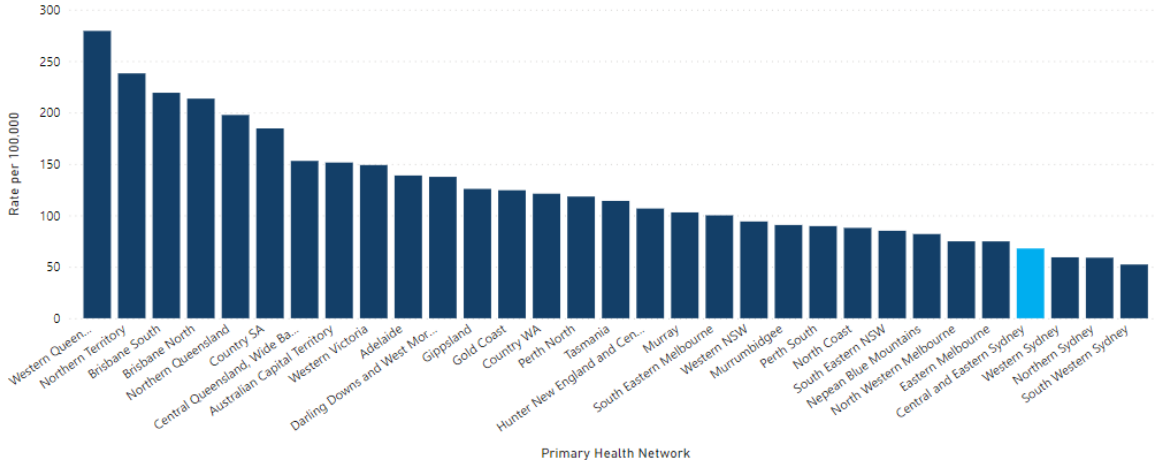
Source: AIHW, 2022

The NSW Suicide Monitoring System reported 918 suspected or confirmed deaths by suicide in NSW in 2021. This compares to the 946 suspected or confirmed deaths by suicide recorded in 2019.(5) From 1 January to 31 July 2022, there have been 586 suspected or confirmed deaths by suicide. This compares to 537 suspected or confirmed deaths by suicide recorded over the same period in 2021.(5)

Self-harm hospitalisation

In 2020-21, there were 1,130 self-harm hospitalisations in the CESPHN region giving a rate of 67.8 per 100,000 population, down from 71.1 per 100,000 in 2019-20. Fifty-nine percent of self-harm hospitalisations in 2020-21 were for females.(4)

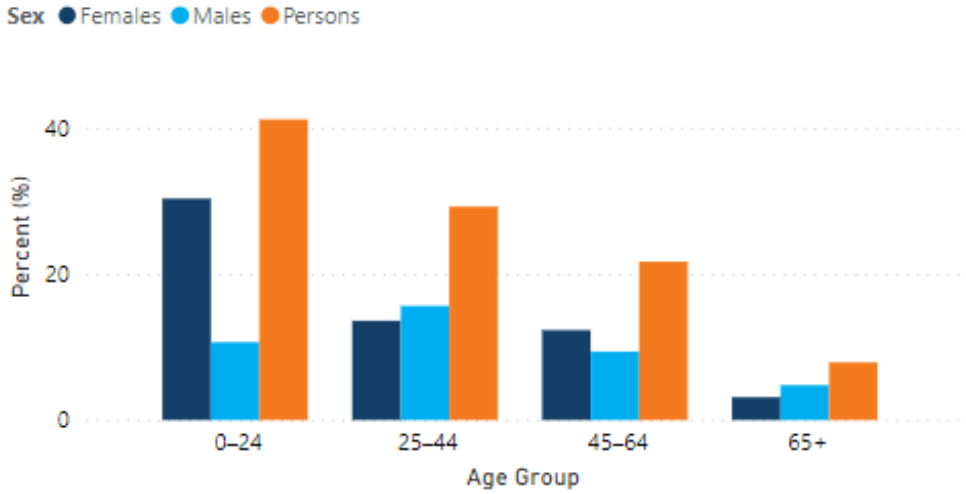
Figure 7: Self harm rate by PHN, 2020-21



Source: AIHW, 2022

Individuals in the 0-24 year age group had the highest proportion of self-harm hospitalisations in the CESPHN region (41.2%), followed by 25-44 year-olds (29.2%).(4)

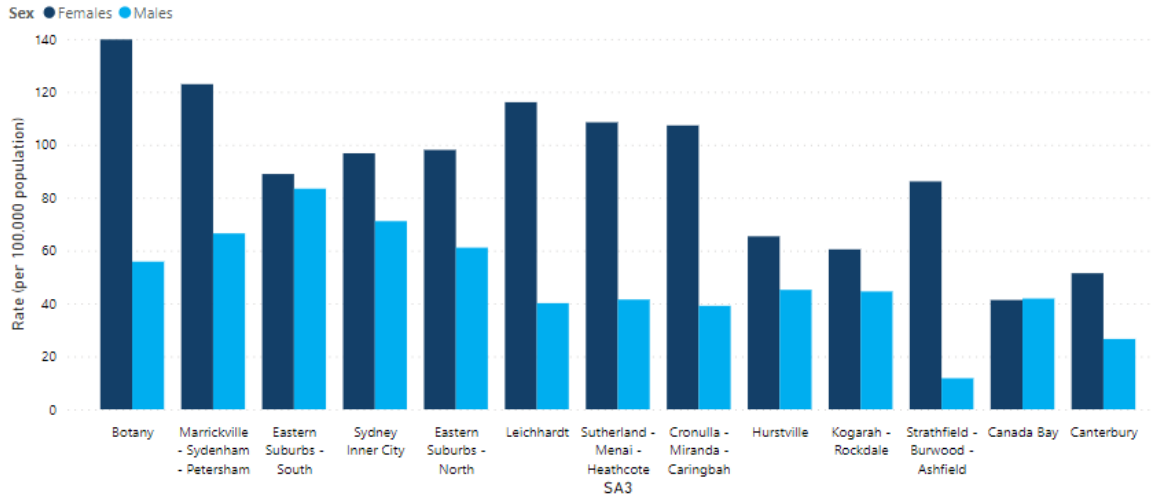
Figure 8: Self-harm hospitalisations by age group and gender, CESPHN, 2020-21



Source: AIHW, 2022

Females in the Botany SA3 had the highest self-harm hospitalisation rates (139.8 per 100,000 population) within the CESPHN region, followed by Marrickville-Sydenham-Petersham SA3 (122.9per 100,000 population). Across all SA3s, females had higher rates of self-harm hospitalisations than males, with the exception of Canada Bay, where rates were comparable across sexes.(4)

Figure 9: Self-harm hospitalisations rate by gender, by SA3, 2020-21



Source: AIHW, 2022

Vulnerable groups

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

- Children and young people
- Refugees settling

- Parents experiencing perinatal mental health issues
- Older people including residents of aged care facilities
- Aboriginal and Torres Strait Islander peoples (herein referred to as Aboriginal people)
- People from culturally and linguistically diverse (CALD) backgrounds, including newly arrived in the region
- People who are homeless or at risk of homelessness
- Lesbian, gay, bisexual, trans, queer and intersex (LGBTQ+) people
- Intersex people
- People with an intellectual disability
- People living with complex mental health and co-existing complex physical health needs
- People living in regions that are highly disadvantaged
- People with co-existing drug and alcohol issues
- Family and carers of people experiencing mental ill health
- Neurologically divergent people
- Veterans.

Many people will fit into multiple vulnerable groups.

Mental health service utilisation

The data presented in this section largely relates to 2019-20 or earlier which does not give a complete picture of the impact of the COVID-19 pandemic and subsequent restrictions. At the local level we have limited data, although some noticeable changes have been:

- Increased wait times for people accessing mental health care
- A 20% increase in referrals to the commissioned Psychological Support Services (PSS) program for people wanting to access psychological therapies; with referrals increasing 14% between 2019-20 and 2021-22.
- Increase in demand for headspace centre services, and an increase in frequency and duration of interventions required.

Service navigation

Service navigation plays a critical role in the stepped care approach to mental health to ensure people experiencing mental health issues receive the right care, at the right place, at the right time. Community and stakeholder consultations have raised that service navigation is a continuing issue for people experiencing mental ill health and their carers. It was noted that Community Pharmacy staff, if appropriately trained, could play a role in directing people to the appropriate level of care.

The National Intake and Assessment Phone Line (Head to Health) also plays a service navigation role, ensuring people are linked into the right level of support to meet their needs. CESPHN has mapped all commissioned mental health and AOD services by IAR level and have embarked on a more extensive mapping of primary mental health services within the region. This will support the role out of GP upskilling in the use of the IAR-DST in supporting referral pathways and service navigation.

Challenges with service navigation include access issues due to service eligibility, vulnerabilities during transitions between services, and lack of awareness of the most appropriate service available. These points are further explored in the service gaps section of this chapter.

CESPHN funded programs

CESPHN has implemented a stepped care approach to commissioning mental health services by ensuring services are available for all levels of mental health needs, from low intensity to severe and complex needs.

Low intensity services

Access to low intensity services earlier in the mental health trajectory can improve longer term mental health and wellbeing and reduce the need for higher intensity interventions. These services are designed to be accessed quickly, without need for formal referral and involve few short sessions. CESPHN commissions the following low intensity services:

- NewAccess Coaching
- Mindfulness Program
- headspace Centres
- Residential Aged Care Facilities – Mental Health Education Program
- Expressive Therapy for children in-school pilot program

Moderate intensity services

Access to moderate intensity services aims to address mild to moderate symptoms and distress where individuals meet criteria for a diagnosis. Individuals, whose symptoms will have typically been present for 6 months or more, may also be experiencing complexity around risk, functioning or co-existing conditions but not at very severe levels. These services are structured, reasonably frequent and intensive interventions. CESPHN commissions the following moderate intensity services:

- Psychological Support Services
- Cognitive Behavioural Therapy (CBT) Group for people with Autism Spectrum Disorder
- Emotional Wellbeing for Older Persons.
- Head to Health Pop Up clinics
- Head to Health satellite in Canterbury due to open January 2023
- Tresillian groups

High intensity services

These services include periods of intense intervention that may involve multi-disciplinary support. CESPHN commissions the following high intensity services:

- Connect and Thrive – Commonwealth Psychosocial Support (CPS) Program
- Continuity of Support (CoS) Program
- Telehealth Psychiatry Service
- Dialectical Behaviour Therapy (DBT) Group Therapy
- GP Mental Health Shared Care Program
- Service Navigation for Psychosocial Services
- Keeping the Body in Mind – Primary
- Primary Integrated Care Supports (PICS) Program
- Youth Enhanced Services.

- Head to Health Pop Up Clinics

Suicide prevention services

These services support people who have attempted suicide or experienced a suicidal crisis. CESPHN commissions the following suicide prevention services:

- The Way Back Support Service (in collaboration with the NSW Ministry of Health)
- Psychological Support Services (PSS) Suicide Prevention Service (SPS).

The NSW Ministry of Health also funds Suicide Prevention Outreach Teams (SPOT) and Safe Havens in the following locations:

- SESLHD: SPOT is based in Sutherland with the Community Mental Health Team and the Safe Haven is located nearby the St George Hospital.
- SLHD: SPOT is based out of Canterbury Hospital and supporting Concord, Croydon, Canterbury and Bankstown areas and the Safe Haven is located in Newtown near RPA emergency department.
- SVHN: combined SPOT and Safe Haven are currently located at St. Vincent's Hospital, Darlinghurst, and will be located at the site of the Former Green Square Hotel once renovated, on the corner of Victoria and Liverpool St Darlinghurst
- SCHN: combined SPOT and Safe Haven is located at the Sydney Children's Hospital in Randwick.

NSW Health has commissioned the Standby Response Service to expand across the whole of NSW. This service provides post suicide support to anyone bereaved or impacted by suicide in the form of:

- Counselling
- Links to other support services
- Group Support
- Information and Resources
- Training and upskilling to groups and professionals.

Services are delivered to groups and/ or individuals by professionals trained in Suicide ASIST who have a tertiary background in psychology, social work, and counselling. Post Suicide Support is a consortium led by StandBy with Jesuit Social Services Support After Suicide, Roses in the Ocean and University of New England.

Table 2. Suicide prevention services across the care continuum, CESPHN region

Primary care Low intensity	Primary care moderate intensity	Primary care high intensity	Specialist acute	Hospital alternatives	Post discharge
Suicide Call Back Service Lifeline	PSS or Better Access Lifeline Being supported Suicide Call Back Service Alternatives to Suicide peer support group (if near Marrickville) headspace	PSS-Suicide Prevention Service (SPS) Alternatives to Suicide peer support group (if near Marrickville) Other non-SP specific MH services e.g., Connect and Thrive Safeguards	Mental Health Line Community Mental Health Teams SESLHD, SLHD, SVH and SCHN hospital emergency departments and Mental Health Units	Safe Havens SPOT Pop up Safe Space Summer Hill	Community Mental Health Teams PSS-SPS SPOT The Way Back Support Service

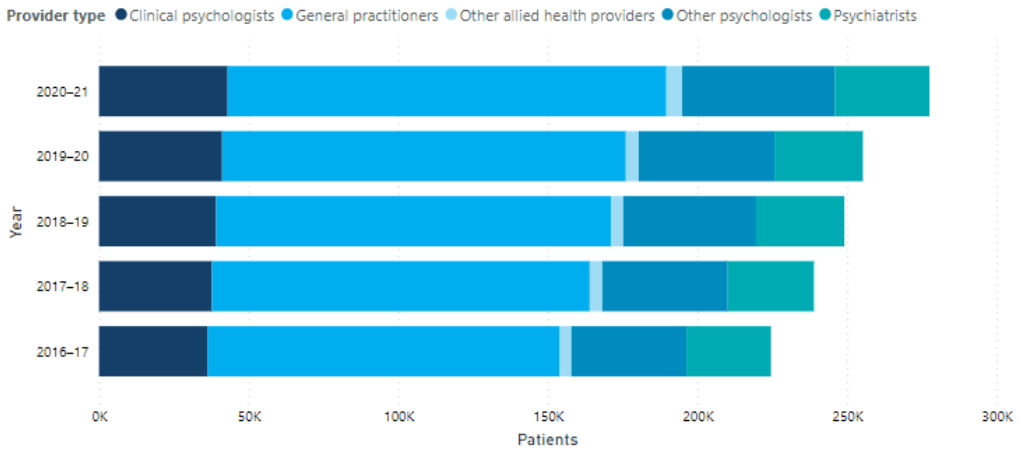
Source: Adapted from Central and Eastern Sydney Mental Health and Suicide Prevention Regional Planning

Medicare-subsidised mental health services

The 2022 RACGP's General Practice Health of the Nation report stated that 71% of GPs reported psychological conditions as one of the most common reasons for patient presentations, an increase from 61% in 2017.(6)

In 2020-21, there were 178,174 people (11.5% of the population) who accessed Medicare-subsidised mental health services in the CESPHN region. This is an increase of 30,606 people (20.7%) from 2016-17.(7)

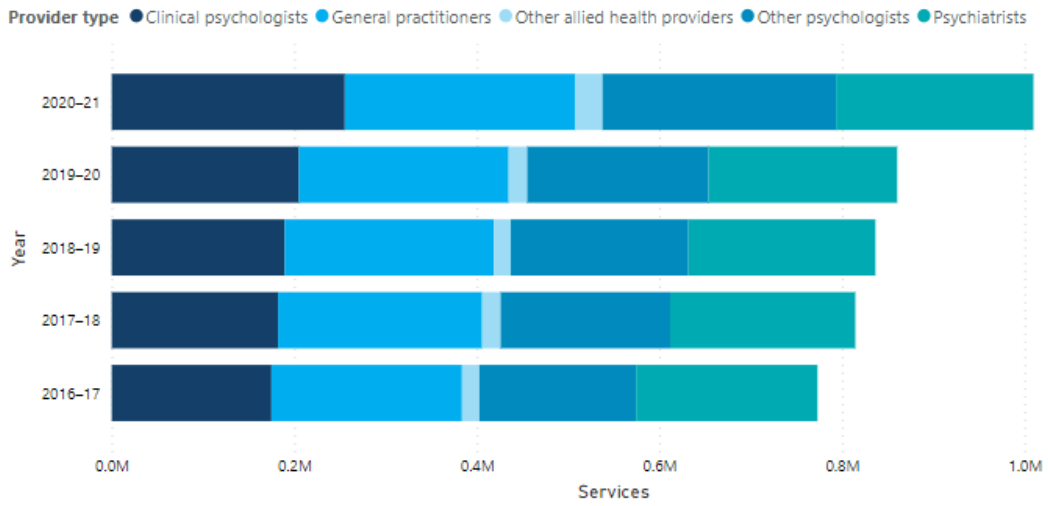
Figure 10: Number of people accessing Medicare-subsidised mental health services by service type, CESPHN region, 2016-17 to 2020-21



Source: AIHW, 2022

In the same period, there was a 30.6% increase in the number of services in the CESPHN region for all mental health providers (n=236,585). There was an increase in the number of services for each mental health provider type, with the increases ranging from 8.9% increase for psychiatrists to 56.5% increase for "*other allied health*". (7)

Figure 11: Number of Medicare-subsidised mental health services by service type, CESPHN region, 2016-17 to 2020-21

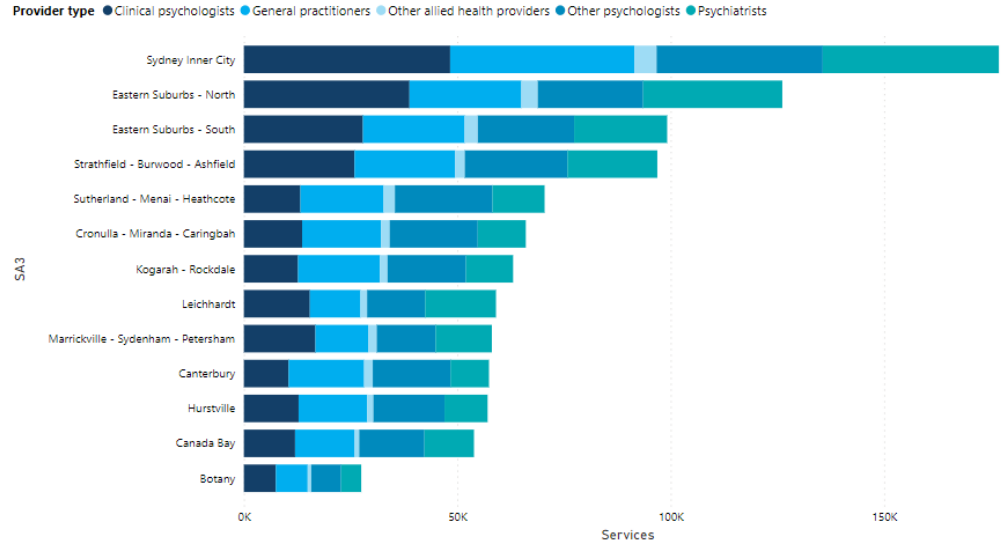


Source: AIHW, 2022

There are considerable variations in the number of Medicare-subsidised mental health services between SA3s. Sydney Inner City SA3 had the highest number of patients (45,028), followed by Eastern Suburbs-North SA3 (31,014) and Eastern Suburbs-South SA3 (26,385) across all service types. Botany SA3 had the lowest number of services (8,090). (7)

Approximately 50% of patients across all SA3s saw a general practitioner for Medicare-subsidised mental health services. (7)

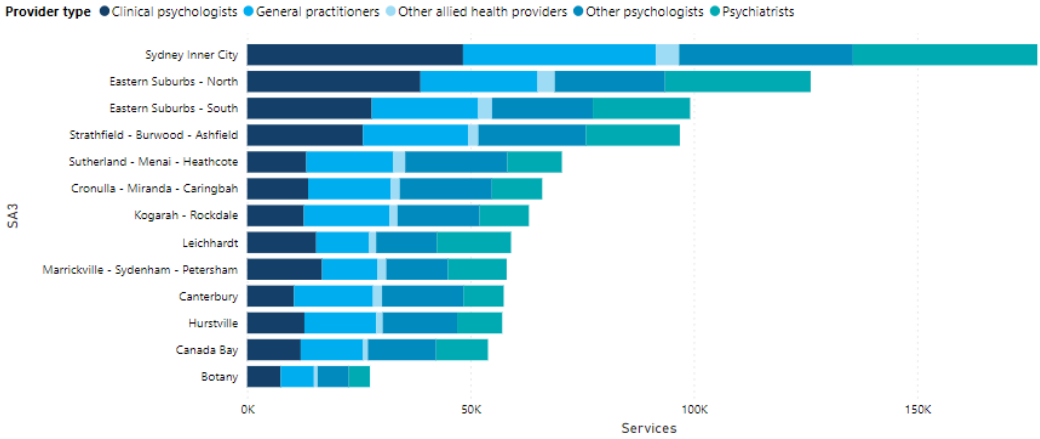
Figure 12: Number of people accessing Medicare-subsidised mental health services by service type, by SA3, 2020-21



Source: AIHW, 2022

Across the CESPHN region, 25% of services were provided by general practitioners, within the region there is variation in the proportion of services provided by general practitioners ranging from 20.1% in Leichhardt SA3 to 30.8% in Canterbury SA3. Leichhardt SA3 had the highest proportion of services provided by a psychiatrist (28.1%).(7)

Figure 13: Number of Medicare-subsidised mental health services by service type, by SA3, 2020-21



Source: AIHW, 2022

Mental health related prescriptions

In 2020-21, across the CESPHN region, there were 209,616 people who had a mental health related prescription under the PBS, giving a rate of 12.6 per 100 population. Almost six in ten patients (58.7%) were female and 41.2% were male. In this same year, just over 1.8 million mental health related prescriptions were filled, at a rate of 1,086.2 per 1,000 population.(7)

Across the five years to 2020-21, rates of patients per 100 population have remained stable. Rates of MH related prescriptions were relatively stable between 2015-16 to 2018-19, however there was a 5% increase in rates between 2018-19 and 2019-20.(7)

Table 3: Patients and prescriptions, CESPHN region, 2016-17 to 2020-21

Measure	2016–17	2017–18	2018–19	2019–20	2020-21
Number of patients	199,476	202,586	206,634	212,059	209,616
Patients per 100 population	12.7	12.6	12.7	12.8	12.6
Number of prescriptions	1,645,217	1,667,768	1,704,396	1,814,404	1,809,117
Prescriptions per 1,000 population	1,048.7	1,039.0	1,045.7	1,097.9	1,086.2

Source: AIHW, 2022

Within the CESPHN region in 2020-21, patients aged 45-54 years of age accounted for 16.7% of the patient profile, and 17.2% of prescriptions; this population group accounted for 12.6% of the CESPHN population. Those aged 55-64 years made up a further 14.9% of patients and 15.4% of prescriptions; this population group accounted for 10.7% of the CESPHN population.(2, 7)

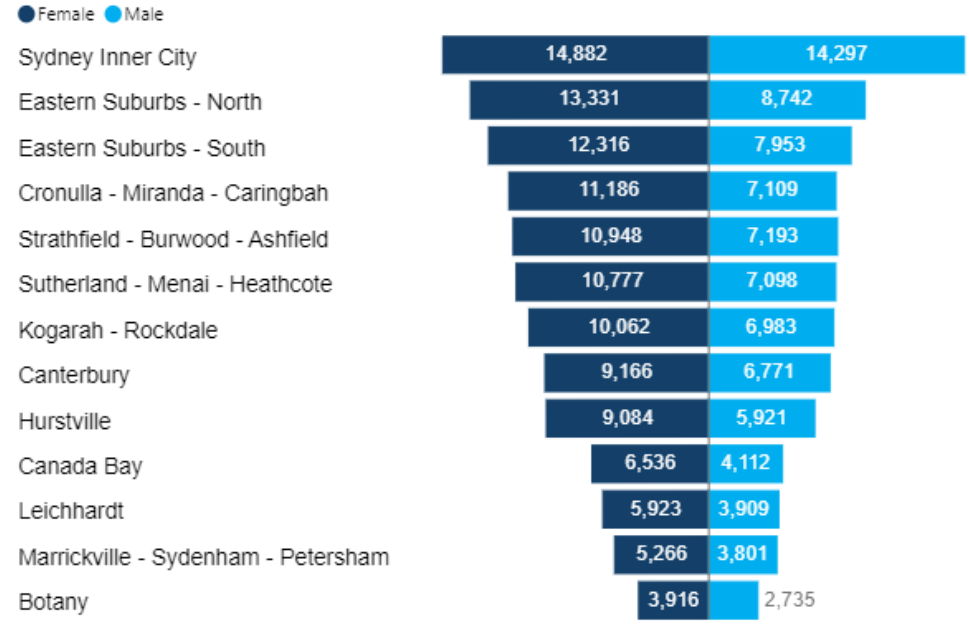
Table 4: Patients and prescriptions by age group, CESPHN region, 2020-21

Age Group	Patients (n)	Patients (%)	Prescriptions (n)	Prescriptions (%)
0–4 years	69	0.0%	172	0.0%
5–11 years	4,047	1.9%	29,775	1.6%
12–17 years	7,519	3.6%	63,139	3.5%
18–24 years	12,369	5.9%	98,661	5.5%
25–34 years	26,417	12.6%	204,951	11.3%
35–44 years	31,268	14.9%	260,113	14.4%
45–54 years	35,074	16.7%	310,578	17.2%
55–64 years	31,279	14.9%	277,784	15.4%
65–74 years	27,643	13.2%	239,452	13.2%
75–84 years	21,394	10.2%	191,073	10.6%
85 years +	12,536	6.0%	117,179	6.5%
Total	**209,616**	**100.0%**	**1,809,117**	**100.0%**

Source: AIHW, 2022

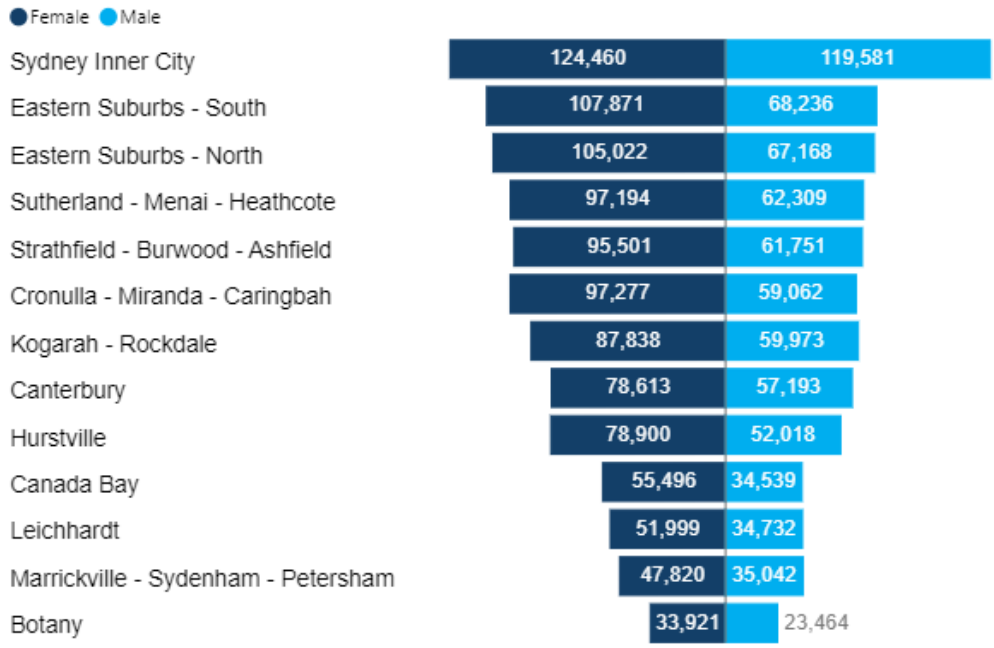
Note: Does not include prescriptions with missing patient characteristics. Therefore, totals may not match totals presented in other tables.

Figure 14: Patients sex by SA3, CESPHN region, 2019-20



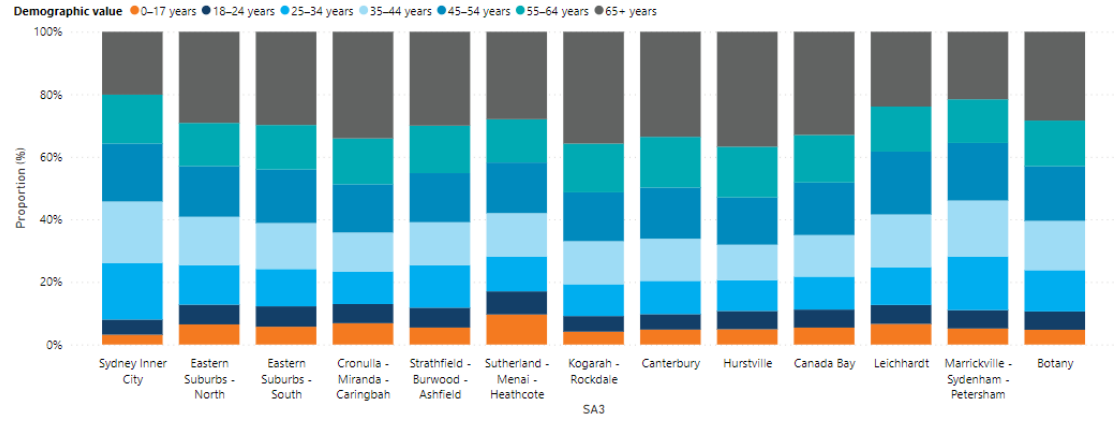
Source: AIHW, 2022

Figure 15: Prescriptions by sex by SA3, CESPHN region, 2020-21



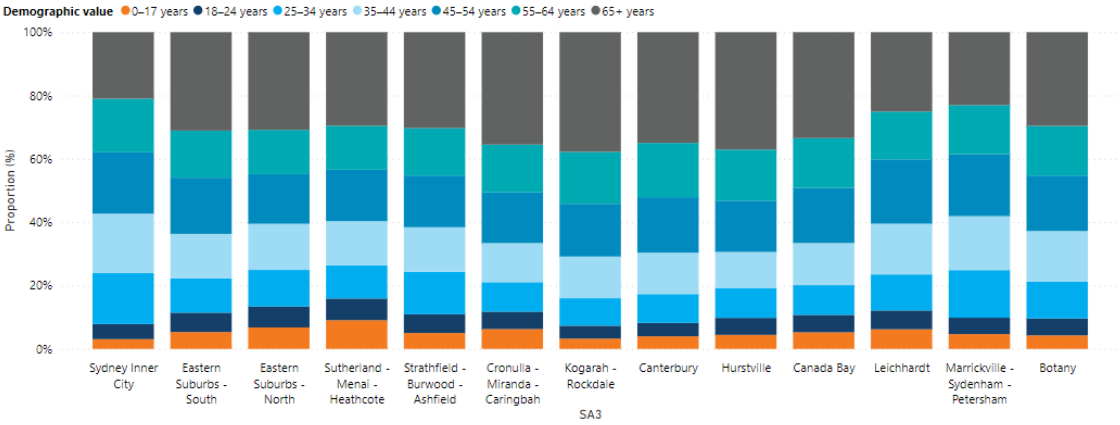
Source: AIHW, 2022

Figure 16: Patients by age group by SA3, CESPHN region, 2020-21



Source: AIHW, 2022

Figure 17: Prescriptions by age group by SA3, CESPHN region, 2020-21



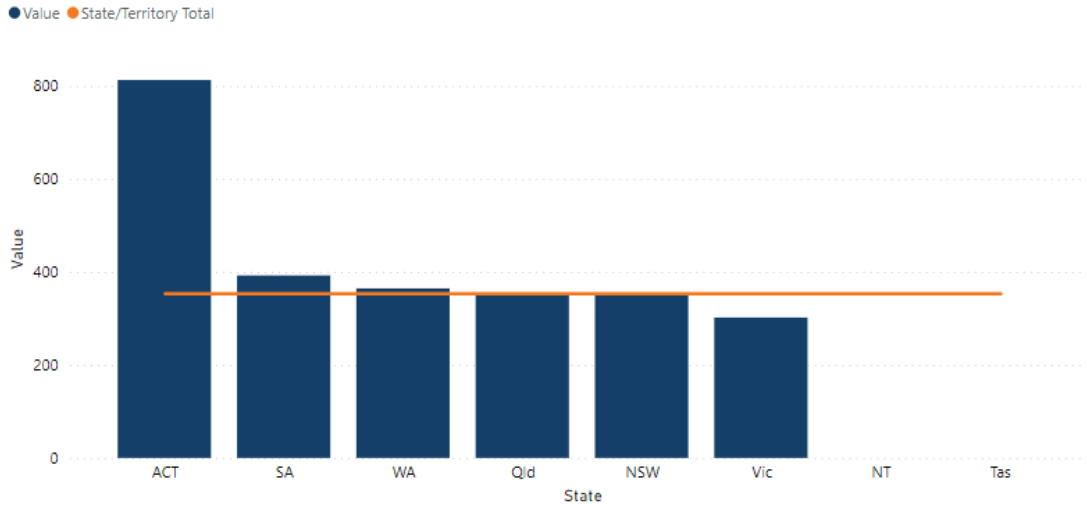
Source: AIHW, 2022

Community mental health care

Community mental health care refers to government-funded and operated specialised mental health care provided by community mental health care services and hospital-based outpatient and day clinics.

In 2019-20 there were 2,153,154 service contacts provided in major cities in NSW by community mental health care. This equates to a rate of 352.2 service contacts per 1,000 population, slightly lower than state and territory totals of 393.2 per 1,000 population.(7)

Figure 18: Community mental health service contacts per 1,000 population, by state, 2019-20



Source: AIHW, 2022

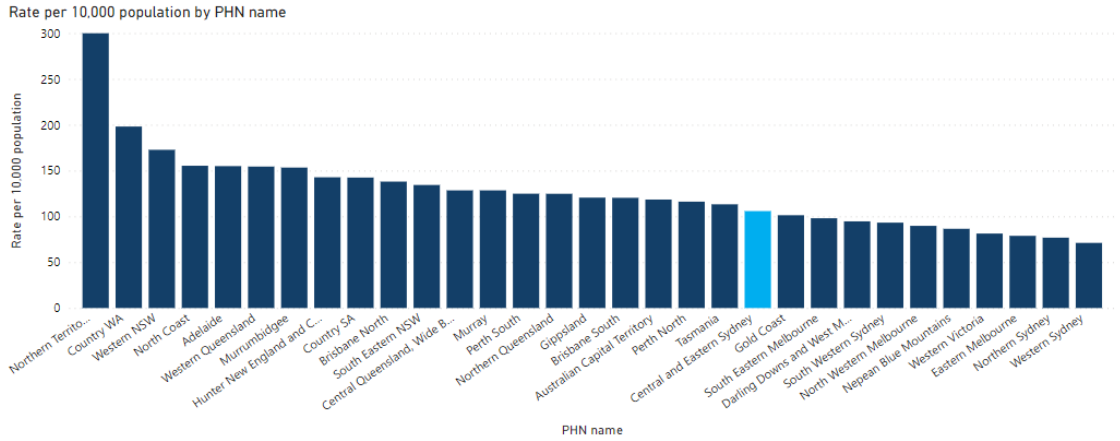
Hospitalisations for mental health conditions

Hospital emergency services

Between 2015-16 to 2020-21, there was a 3.9% average annual increase in the number of mental health related emergency department presentations, and a 1.7% average annual increase in the number of total emergency department presentations in the CESPHN region.

In 2020-21, there was 17,616 mental health related emergency department presentations across the CESPHN region, equating to 105.8 mental health related emergency department presentations per 10,000 population. This is an increase from 2019-20, where there were 100.3 mental health related emergency department presentations per 10,000 population.(7)

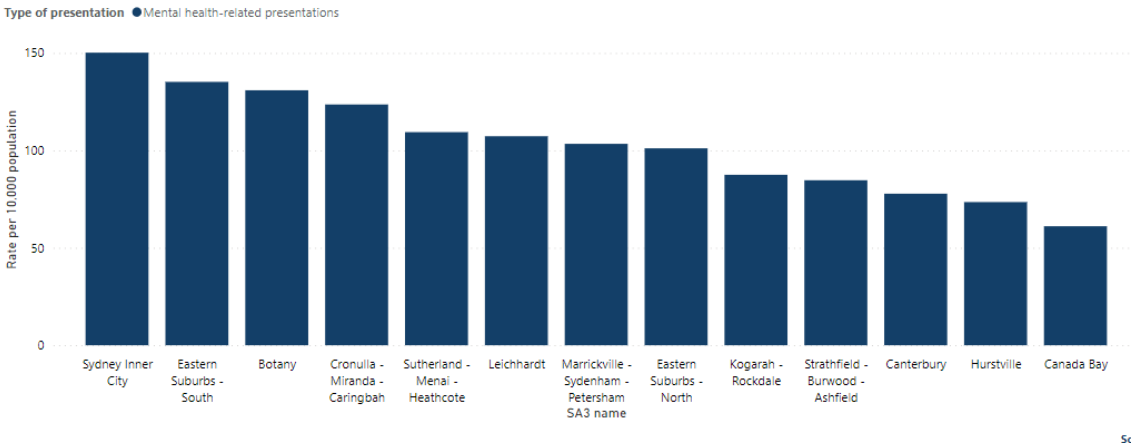
Figure 19: Mental health related emergency department presentations, PHN, 2020-21



Source: AIHW, 2021

Across the CESPHN region, Sydney Inner City SA3 had the highest proportion of mental health related emergency department presentations per 10,000 population (150.2), followed by Eastern Suburbs – South (135.2) and Botany SA3 (130.9). (7)

Figure 20: Emergency department presentations by SA3, 2020-21



Source: AIHW, 2022

Overnight admitted mental health-related care

In 2019-20, there were 102.3 overnight admitted mental health-related hospitalisations per 10,000 population in the CESPHN region, slightly lower than the national average (108.1 per 10,000 population). There was a total of 1,621.2 patient days per 10,000 population, slightly higher than the national average (1,443.6 per 10,000 population). The majority (75%) of these patient days were for psychiatric care.(7)

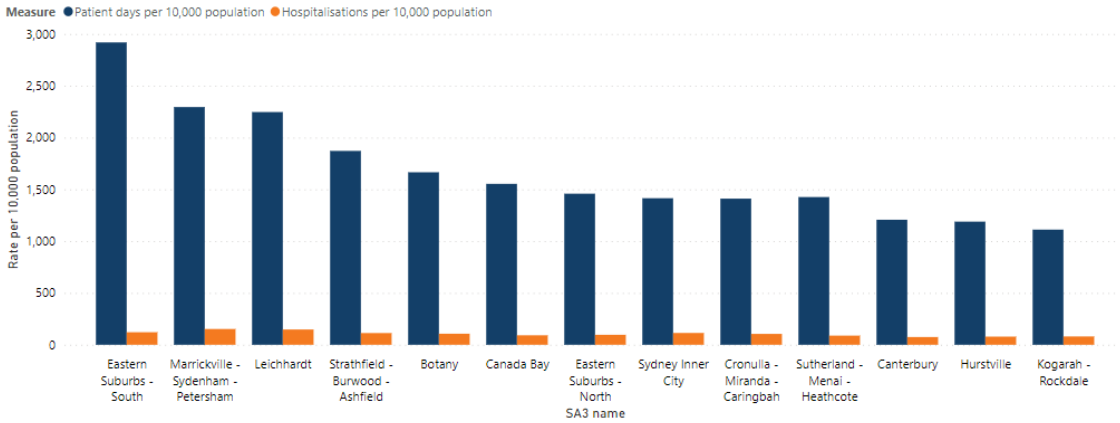
Table 5: Overnight admitted mental health related rates in the CESPHN region, 2019-20

PHN	Patient days per 10,000 population	Procedures per 10,000 population	Psychiatric care days per 10,000 population	Hospitalisations per 10,000 population
Central and Eastern Sydney	1,621.2	278.3	1,223.1	102.3

Source: AIHW, 2022

The highest rate of overnight admitted mental health-related hospitalisations were recorded in Marrickville-Sydenham-Petersham SA3 (152.3 per 10,000 population), Leichhardt SA3 (147.5 per 10,000 population) and Eastern Suburbs South SA3 (121.1 per 10,000 population).(7)

Figure 21: Overnight admitted mental health related rates by SA3, 2019-20



Source: AIHW, 2022

Residential mental health care

Residential mental health care services provide specialised mental health care on an overnight basis in a domestic-like environment and may include rehabilitation, treatment or extended care.
There was no data for our region on residential mental health care services in 2019-20.

Psychosocial disability (NDIS)

The CESPHN region is covered by two NDIS service districts, South Eastern Sydney and Sydney. As of 31 December 2021, 12% of participants from South Eastern Sydney and 18% of participants from Sydney had a primary disability of psychosocial disability. Both service districts have rates higher than the benchmark rate of 11% of participants.(8)

Data shows that both service districts had lower average number of participants per provider where the primary disability was psychosocial disability compared to the benchmark – South Eastern Sydney (2.85), Sydney (2.82) and benchmark (3.27).(8)

Nationally, where psychosocial disability was the primary disability, there was a 72% plan utilisation. Within the CESPHN region, this varied between service districts (73% in South Eastern Sydney and 66% in Sydney).(8)

There were slightly lower proportions of participants who reported that they chose who supported them within the service districts in CESPHN region; South Eastern Sydney had 52% of participants with primary disability of psychosocial disability who chose who supported them compared to 50% in Sydney and 54% nationally. NDIS participants within the service districts in the CESPHN region reported higher proportions of participants who felt NDIS helped them have more choice and control over their life (South Eastern Sydney 75%, Sydney 79%) compared to national benchmark (75%).(8)

Specialist homelessness services

In 2019-20, there were 26,547 clients with a mental health issue receiving specialist homelessness services in NSW. Nationally, the top reasons clients with a mental health issue sought support were housing crises/inadequacy, family/domestic violence, and financial difficulties.(7)

Psychiatry workforce

In 2020, there were 364 psychiatrists working in a clinician role in the CESPHN region (344.6 FTE) giving a rate of 21.9 per 100,000 population (20.7 FTE per 100,000 population), higher than the state and national rates for number of practitioners (12.8 and 13.7) and FTE (12.2 and 13.0) per 100,000 population respectively.(9)

Table 6: Psychiatrists by location, 2020

Measure	CESPHN	NSW	Australia
Number of Practitioners	364.0	1,042	3,519.0
Number of Practitioners (rate per 100,000 population)	21.9	12.8	13.7
FTE Total	344.6	992.4	3,329.4
FTE Total (rate per 100,000 population)	20.7	12.2	13.0
FTE Clinical	293.6	860.5	2,914.5
FTE Clinical (rate per 100,000 population)	17.6	10.5	11.3

Source: HWA, 2021

Demographics

Fifty-six per cent (56.0%) of psychiatrists working across the CESPHN region in 2020 were male.(9)

In 2020, seven out of ten (70.1%) of FTE psychiatrists across the CESPHN region were aged 45 years and older, this is slightly lower than both the state and national rates of 73.9% and 72.2% respectively.(9)

Table 7: Proportion of psychiatric workforce by age groups and location, 2020

Age group	CESPHN (%)	NSW (%)	Australia (%)
20-34	2.0	2.6	3.4
35-44	27.9	23.5	24.6
45-54	28.6	34.5	33.2
55-64	22.4	22.5	23.8
65-74	14.3	13.1	12.5
75-99	4.8	3.8	2.7
Total	100.0	100.0	100.0

Source: HWA, 2021

Years intend to work

In 2020, 39% of psychiatrists in the CESPHN region intended to only work up to another 10 years. 100% of psychiatrists in Hurstville SA3 indicate that they intend to only work up to five more years. Almost 60% of psychiatrists in Leichhardt SA3 indicate that they do not intend to work more than ten years.(9)

Table 8: Psychiatrist years intended to work by SA3, 2020

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Canada Bay	18.9	18.9	13.5	16.2	21.6	10.8	0.0
Canterbury	0.0	0.0	0.0	0.0	100.0	0.0	0.0
Cronulla-Miranda-Caringbah	0.0	40.0	30.0	30.0	0.0	0.0	0.0
Eastern Suburbs – North	27.5	22.5	12.5	17.5	20.0	0.0	0.0
Eastern Suburbs – South	15.7	5.9	9.8	21.6	39.2	7.8	0.0
Hurstville	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Kogarah-Rockdale	11.1	11.1	18.5	22.2	37.0	0.0	0.0
Leichhardt	41.2	17.6	23.5	17.6	0.0	0.0	0.0
Marrickville-Sydenham-Petersham	0.0	0.0	100.0	0.0	0.0	0.0	0.0
Strathfield-Burwood-Ashfield	22.9	25.7	0.0	17.1	34.3	0.0	0.0
Sutherland-Menai-Heathcote	25.8	16.1	7.3	15.3	28.2	4.8	2.4
Sydney Inner City	22.6	16.4	10.9	17.0	27.9	4.5	0.8
CESPHN	18.9	18.9	13.5	16.2	21.6	10.8	0.0

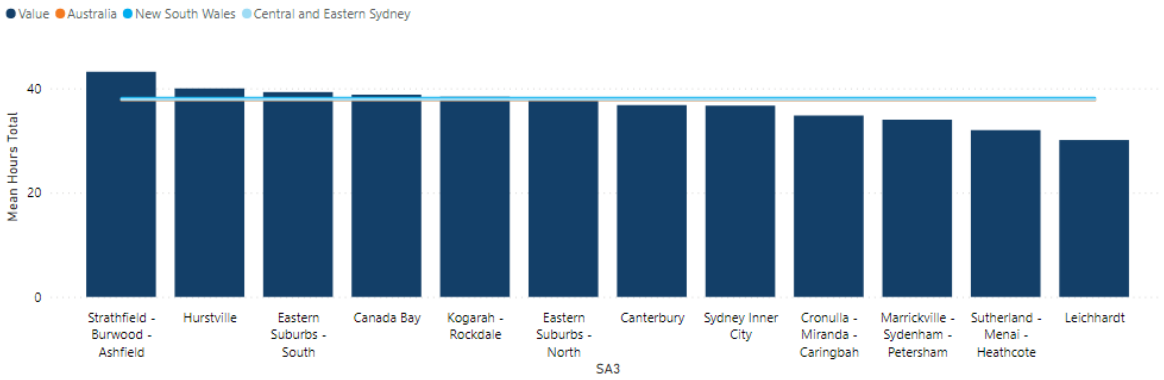
Source: HWA, 2021

Hours worked per week

Total hours

In 2020, on average psychiatrists in Australia worked 37.8 total hours per week, slightly lower than NSW where psychiatrists worked on average 38.1 total hours per week. In the CESPHN region, psychiatrists worked on average 37.9 total hours per week.(9) Average weekly working hours ranged from 43.2 hours per week in Strathfield-Burwood-Ashfield SA3 to 30.1 hours per week in Leichhardt SA3.(9)

Figure 22: Psychiatrist mean hours total by SA3, 2020

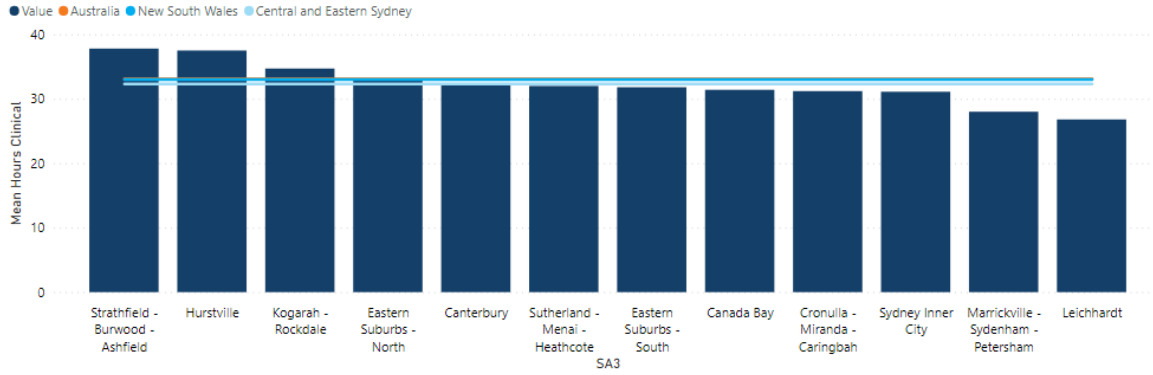


Source: HWA, 2021

Clinical hours

In 2020, on average psychiatrists in Australia worked 33.1 clinical hours per week, slightly higher than NSW where psychiatrists worked on average 33.0 clinical hours per week. Psychiatrists in the CESPHN region worked, on average, 32.3 clinical hours per week.(9) Average weekly clinical hours ranged from 37.8 hours in Strathfield-Burwood-Ashfield SA3 to 26.8 hours in Leichhardt SA3.(9)

Figure 23: Psychiatrist mean hours clinical by SA3, 2020



Source: HWA, 2021

Psychologist workforce

In 2020 there were 2,705 psychologists working in a clinical role in the CESPHN region (2,284.4 FTE) giving a rate of 162.4 per 100,000 population (137.2 FTE per 100,000 population), higher than the state and national rates for number of practitioners (114.0 and 110.0) and FTE (96.3 and 93.4) per 100,000 population respectively.(9)

Table 9. Psychologists by region, 2020

Measure	CESPHN	NSW	Australia
Number of Practitioners	2,705	9,315.0	28,264
Number of Practitioners (rate per 100,000 population)	162.4	114.0	110.0
FTE Total	2,284.4	7,863.7	23,992.8
FTE Total (rate per 100,000 population)	137.2	96.3	93.4
FTE Clinical	1,851.4	6,435.9	19.536.4
FTE Clinical (rate per 100,000 population)	111.2	78.8	76.0

Source: HWA, 2021

Demographics

Eight in ten (81.1%) of psychologists working in the CESPHN region in 2020 were female.(9)

In 2020, approximately one-fifth (21.2%) of FTE psychologists across the CESPHN region were aged 20-34 years old, this is in line with both the state and national rates of 21.3% and 21.9% respectively; there is a higher proportion of psychologists aged 35-44 years in our region than state and national rates.(9)

Table 10: Proportion of psychologist workforce by age groups and location, 2020

Age group	CESPHN (%)	NSW (%)	Australia (%)
20-34	21.2	21.3	21.9
35-44	28.8	26.9	27.1
45-54	24.5	23.7	24.5
55-64	15.5	17.5	17.0
65-74	8.7	9.3	8.4
75-99	1.2	1.3	1.3
Total	100.0	100.0	100.0

Source: HWA, 2021

Years intended to work

Approximately one-third (32.2%) of psychologists working in the CESPHN region intend to work up to another 10 years. Of note, all psychologists currently working on Norfolk Island intend to work up to 5 years only. Approximately four out of every ten psychologists in Botany SA3 intend to work up to 10 years only.(9)

Table 11: Psychologist years intended to work by SA3, 2020

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	17.4	21.7	17.4	26.1	0.0	17.4	0.0
Canada Bay	17.4	18.3	11.0	19.3	24.8	5.5	3.7
Canterbury	13.7	12.3	6.8	28.8	20.5	13.7	4.1
Cronulla – Miranda – Caringbah	9.2	20.9	11.1	27.5	20.3	8.5	2.6
Eastern Suburbs – North	14.5	17.3	10.5	25.0	21.6	9.0	2.2
Eastern Suburbs – South	15.7	13.9	12.5	18.2	23.9	12.5	3.2
Hurstville	14.6	14.6	9.7	21.4	26.2	10.7	2.9
Kogarah – Rockdale	14.4	20.3	12.7	19.5	24.6	5.9	2.5
Leichhardt	18.4	16.3	17.0	22.7	13.5	12.1	0.0
Marrickville – Sydenham – Petersham	17.3	20.0	13.3	14.7	21.3	9.3	4.0
Norfolk Island	100.0	0.0	0.0	0.0	0.0	0.0	0.0
Strathfield – Burwood – Ashfield	21.8	16.8	13.4	20.7	19.6	7.8	0.0
Sutherland – Menai – Heathcote	18.4	19.3	12.3	17.5	17.5	12.3	2.6
Sydney Inner City	14.4	16.1	9.5	21.1	25.1	11.3	2.5
CESPHN	**15.5**	**16.8**	**11.2**	**21.5**	**22.5**	**10.4**	**2.2**

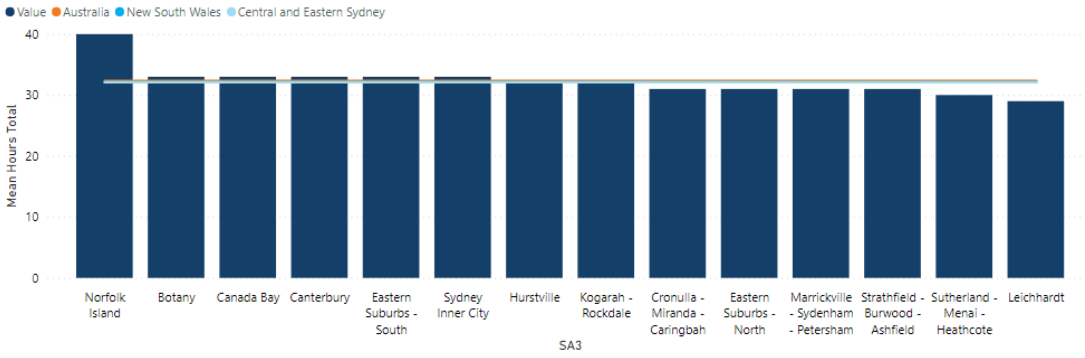
Source: HWA, 2021

Hours worked per week

Total hours

In 2020, on average psychologists in Australia worked 32.3 total hours per week, slightly higher than NSW where psychologists worked on average 32.1 total hours per week. Across the CESPHN region, psychologists worked 32.1 total hours per week.(9) Average weekly working hours ranged from 40 hours per week on Norfolk Island to 29 hours per week in Leichhardt SA3.

Figure 24: Psychologist mean hours total by SA3, 2020

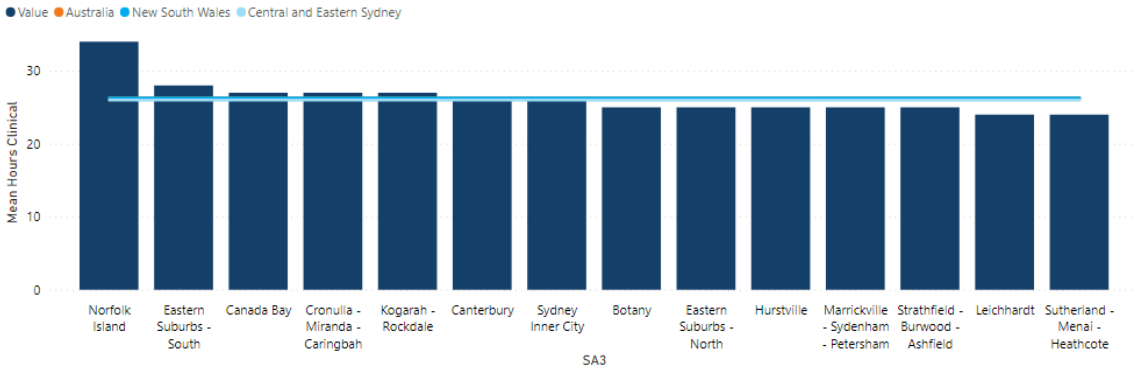


Source: HWA, 2021

Clinical hours

In 2020, on average psychologists across both Australia and NSW worked 26.3 clinical hours per week. Psychologists in the CESPHN region worked, on average, 26.0 clinical hours per week.(9) Average weekly clinical hours ranged from 34.0 hours on Norfolk Island to 24.0 hours in Sutherland-Menai-Heathcote SA3.

Figure 25: Psychologists mean hours clinical by SA3, 2020



Source: HWA, 2021

Mental health nurse workforce

In 2020 there were 1,428 mental health nurses working in a clinician role in the CESPHN region (1,400.1 FTE) giving a rate of 85.7 per 100,000 population (84.1 FTE per 100,000 population), higher than the state rates for number of practitioners (82.1) and FTE (79.0) per 100,000 population respectively.(9)

Table 12: Mental health nurses by region, 2020

Measure	CESPHN	NSW	Australia
Number of Practitioners	1,428	6,709.0	23,347.0
Number of Practitioners (rate per 100,000 population)	85.7	82.1	90.9
FTE Total	1,400.1	6,451.2	22,008.7
FTE Total (rate per 100,000 population)	84.1	79.0	85.7
FTE Clinical	1,367.8	6,282.1	21,468.3
FTE Clinical (rate per 100,000 population)	82.1	76.9	83.6

Source: HWA, 2021

Demographics

Two-thirds (66.6%) of mental health nurses working in the CESPHN region in 2020 were female.(9)

In 2020, over one-third (39.0%) of FTE mental health nurses across the CESPHN region were aged 20-34 years old, this is higher than both the state and national rates of 27.8% and 25.9% respectively.(9)

Table 13: Proportion of mental health nurse workforce by age groups and location, 2020

Age group	CESPHN (%)	NSW (%)	Australia (%)
20-34	39.0	27.8	25.9
35-44	24.2	22.7	22.4
45-54	17.3	22.0	23.4
55-64	14.8	21.4	22.8
65-74	4.4	6.0	5.3
75-99	0.3	0.2	0.2
Total	100.0	100.0	100.0

Source: HWA, 2021

Years intended to work

In 2020, 42.0% of mental health nurses in the CESPHN region intended to only work up to another 10 years. Of note, 100% of mental health nurses working in the Sutherland-Menai-Heathcote SA3 indicate that they do not intend to work more than 10 years. More than half of mental health nurses in Strathfield-Burwood-Ashfield (57.8%) and Eastern Suburbs North (56.5%) SA3's do not intend to work more than 10 years and 50% in Hurstville SA3 intend to work up to 5 years.(9)

Table 14: Mental health nurse years intended to work by SA3, 2020

SA3	0-5 years (%)	6-10 years (%)	11-15 years (%)	16-20 years (%)	21-30 years (%)	31-40 years (%)	41+ years (%)
Botany	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Canada Bay	21.2	21.2	10.6	14.7	21.2	6.9	4.1
Canterbury	15.0	30.0	25.0	15.0	15.0	0.0	0.0
Cronulla – Miranda – Caringbah	16.9	16.9	9.1	26.0	13.0	14.3	3.9
Eastern Suburbs – North	13.0	43.5	0.0	17.4	13.0	0.0	13.0
Eastern Suburbs – South	21.5	19.2	10.1	20.6	17.8	8.2	2.6
Hurstville	50.0	0.0	50.0	0.0	0.0	0.0	0.0
Kogarah – Rockdale	17.4	22.6	12.2	10.4	23.5	10.4	3.5
Leichhardt	0.0	0.0	100.0	0.0	0.0	0.0	0.0
Marrickville – Sydenham – Petersham	0.0	0.0	100.0	0.0	0.0	0.0	0.0
Strathfield – Burwood – Ashfield	35.3	22.5	9.8	15.7	7.8	3.9	4.9
Sutherland – Menai – Heathcote	0.0	100.0	0.0	0.0	0.0	0.0	0.0
Sydney Inner City	21.5	18.2	9.1	18.9	17.8	11.4	3.0
CESPHN	**21.7**	**20.3**	**10.7**	**17.9**	**17.5**	**8.6**	**3.4**

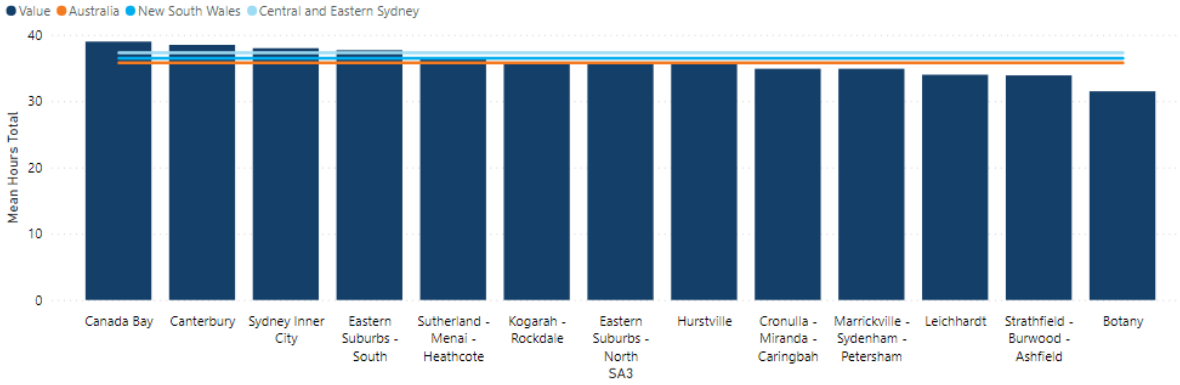
Source: HWA, 2021

Hours worked per week

Total hours

In 2020, on average mental health nurses in Australia worked 35.8 total hours per week, slightly lower than NSW where mental health nurses worked on average 36.5 total hours per week. Across the CESPHN region, practice nurses worked 37.3 total hours per week.(9) Average weekly working hours ranged from 39 hours per week in Canada Bay SA3 to 31.5 hours per week in Botany SA3.(9)

Figure 26: Mental health nurses mean hours total by SA3, 2020

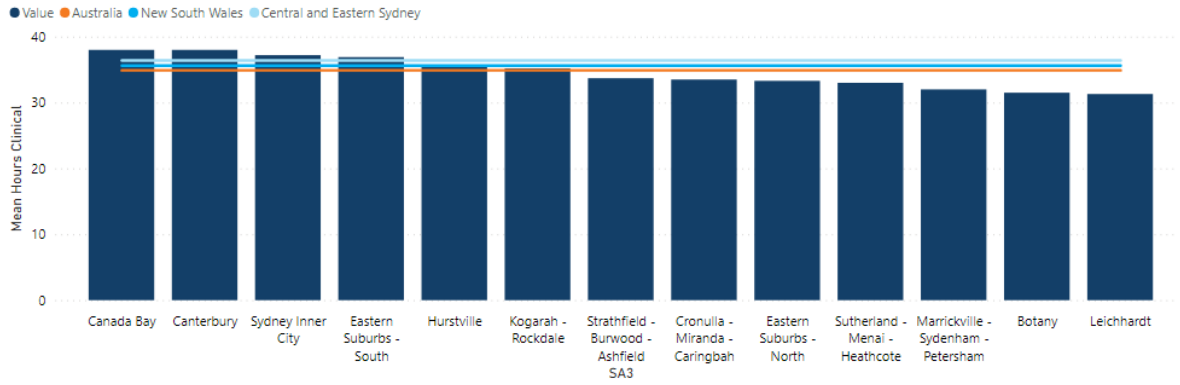


Source: HWA, 2021

Clinical hours

In 2020, on average mental health nurses in Australia worked 34.9 clinical hours per week, slightly lower than NSW where mental health nurses worked on average 35.6 clinical hours per week. Mental health nurses in the CESPHN region worked, on average, 36.4 clinical hours per week.(9) Average weekly clinical hours ranged from 38 hours in Canada Bay SA3 to 31.3 hours in Leichhardt SA3.(9)

Figure 27: Mental health nurses mean hours clinical by SA3, 2020



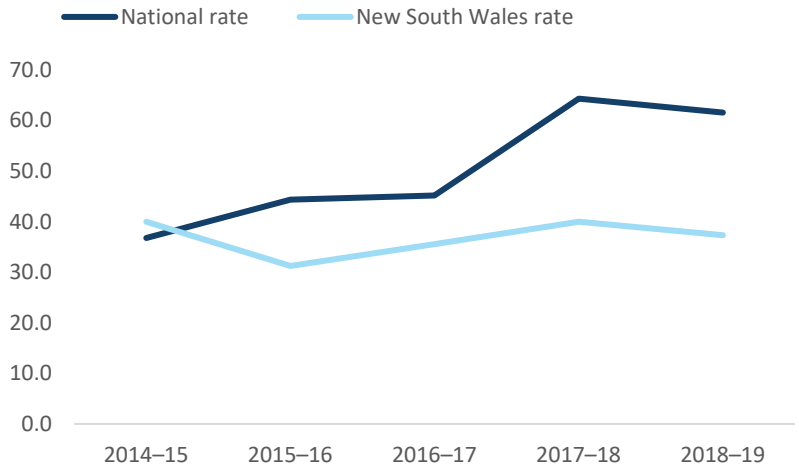
Source: HWA, 2021

It has been reported that a large proportion of the mental health nurse workforce was redeployed throughout various stages of the COVID-19 pandemic. It is still unknown what ongoing affects this will have and when this workforce will return to business as usual.

Peer workforce

In 2018-19 there were 37.3 (FTE) consumer peer workers per 10,000 mental health care providers in NSW who worked within the public health system. This is lower than the national rate of 61.6 (FTE) consumer peer workers per 10,000 mental health care providers. The rate of consumer peer workers in NSW has remained relatively stable over the last five years, however the rate has increased nationally. It is important to note that there is a limitation to this data as The National Mental Health Establishments Database does not capture peer workers outside the public mental health system. Figures (numbers) reported are an underestimate of (lower than) total peer workers in NSW.(10)

Figure 28: Rate of consumer peer workers (FTE) per 10,000 Mental Health Care Providers



Source: AIHW, 2021

Community managed workforce

In 2021, the community managed organisation (CMO) mental health workforce in NSW was:

- Estimated to be 5,838 paid workers, including direct care, managers and administrators, and 2,429 volunteers. In terms of the paid workforce, this translates to 3,911.3 FTE or 28% of the total mental health workforce in NSW
- Female dominated (72% of workers are female) and young (64% of workers are aged under 45 years)
- Primarily made up of mental health support workers (49%), followed by consumer peer workers (14%), support coordinators (8%), allied health (6%) and psychiatrist/ other medical practitioner (4%).(10)

Just over half (52%) of the CMO workforce was employed on a permanent basis, with the remainder of the workforce being employed on a temporary basis. The majority (54%) of the workforce was employed on a part time basis. Most CMOs surveyed in 2021 believe a further increase in workforce numbers, with higher skill levels, will be demanded in the future.(10)

Service gaps

Service gaps identified through consultation and program feedback include:

Workforce:

- Recruitment issues due to current workforce shortages in the mental health sector and changes to MBS Better Access sessions in 2020.
- Lack of identified and bi-lingual positions to engage with Aboriginal peoples and CALD individuals.
- Lack of access to mental health clinician, particularly for people in RACFs as there is a lack of financial incentive for mental health clinicians to provide visits to RACFs.
- Lack of specialist psychologists for young children.
- Lack of clinicians trained in geriatric psychological intervention /psychiatry.
- Low access to bulk billing psychiatric care in the region and few psychiatrists working in outpatient services for GPs to refer their patients to.
- Low access to affordable child and adolescent psychiatrists and mental health clinicians across the region.
- Hesitancy of service providers to use translation services such as TIS.
- More consistent staffing to avoid having to repeat information to service providers involved in care
- Support and training needed for GPs to confidently identify people who would benefit from the MBS items for eating disorders.
- Support and training needed for GPs to confidently provide care to people with mental health needs requiring a higher level of support.
- Supporting GPs involved in shared care.
- Better peer-to-peer models.

Coordination and integration:

- Greater co-location and integration of services to create a “single” entry point into mental health support. The support should cater for all levels of care to increase the timeliness of accessing the right care at point of help seeking, and support individuals at the stage that they are at.
- Care coordination and Service Navigation support should be built into clinical services for all levels of care with a focus on bi-cultural and Aboriginal and Torres Strait Islander roles to ensure engagement of hardly reached communities.
- Referrer confusion about appropriate referral pathways to services and general service navigation.
- Service planning and continuity of care is challenging with time limited funding.
- Poor cross collaboration between services within the sector.
- Peer mentor and service navigation support Excessive information and regular changes to service availability and service modalities leading to confusion, particularly for the CALD communities.
- Lack of communication processes for patient discharge information between LHD services and PHN commissioned services, to ensure the individual is linked to the most appropriate service and is well supported during the transition of care.
- Need for improved pathways for transition of care for severe mental health consumers being discharged from hospital to community programs.
- Co-design of approaches to address mental health and substance use in Aboriginal communities.
- Building capacity with local network of schools to establish better referral pathways

- Lack of information sharing on availability of mental health services.
- Greater integration of programs and initiatives to address the physical health needs of people living with mental illness. (11)
- Increased funding is required to support programs that address the physical health needs of people living with mental illness that can begin to address the life expectancy gap. (11)
- Greater integration between services for people living with neurodiversity and co-occurring mental illness
- Service models need to be trauma informed and responsive

Digital technologies

- Lack of infrastructure to offer digital options for RACF residents.
- Improved technological solutions are needed for referral forms such as smart forms.
- Poor uptake of telehealth due to technology fatigue, difficulties accessing/ using technology, lack of privacy when using the technology, with individuals deferring care until COVID-19 safe face to face services become available.
- There has been a drop in health professionals offering telehealth support in the recent COVID-19 outbreak (from June 2021) and people are finding supports (GP, psychologist, psychiatrist) difficult to engage with or unavailable to them.
- Insufficient use of secure messaging or MyHealth Record across different professions.

Low intensity services:

- Increased complexity of mental health needs of clients presenting at low intensity services, causing increased pressure on services.

Moderate intensity services:

- Increasing demand to access PSS services, coinciding with a decline in PSS providers due to workforce capacity and shortages.
- Challenges with identifying mental health needs in older people from CALD backgrounds due to a lack of culturally appropriate services and a lack of health promotion initiatives to engage CALD communities.
- Affordable access to psychometric assessment and neuropsychological assessment.
- Affordable access to dieticians as part of the eating disorder treatment plans.
- Lack of sufficient and affordable services specifically for the treatment of personality disorders, ADHD and eating disorders in primary care.
- Lack of support, medical and/or allied health, when transitioning from child to adult services.
- Increased complexity of mental health needs of clients presenting at moderate intensity services, causing increased pressure on services.
- Reduced access to evidence-based treatment, in particular group therapy, due to COVID-19 restrictions as telehealth options are not suitable for some therapeutic approaches or for some cohorts.
- Lack of mental health services in Canterbury LGA particularly for youth.
- Lack of funding and services to diagnose and treat people with neurodiversity.
- Lack of funding for diagnostic testing for clients.
- Evidence to that suggests non-neurotypical clients may still be experience brain maturation past 25 years of age, so it is essential to provide ongoing support for clients who are young adult where there might be a gap.
- The intersectionality of neurodiversity and sexuality and gender diversity is a new area of research. It is newly being recognized a common intersection and these clients are doubly vulnerable.

- Lack of primary care child mental health services across the region.

High intensity services:

- Some Aboriginal people and CALD individuals have difficulty accessing psychosocial services. Canterbury was also identified as an area with inequitable access to psychosocial services.
- Service providers have observed increased psychosocial needs in Sydney Inner City and Inner West particularly for people from Chinese speaking backgrounds for which there is a lack of culturally appropriate services.
- There are higher levels of referrals than can be supported by the Youth Enhanced Services and lower availability of appropriate LHD child and youth services. Long wait times for Aboriginal youth access to mental health services at LHD's have also been reported. This is increasing pressure on headspace services.
- There is a lack of mental health services that address physical health needs at the same time as mental health needs. Increasing demand for metabolic clinic and physical health care for those with a mental health diagnosis. There is a backlog of health screening and assessment plans for health screening due to appointments during lockdown being postponed meaning there will be a need for surge staff to meet demands after lockdown.
- A need for a model of shared care which includes upskilling of GPs to manage individuals prescribed clozapine. Higher engagement with GPs is required to decrease pressure on LHD run clinics and provide consumers with a choice in the setting in which they are more comfortable to receive care.
- Lack of longer-term referral options are available for people with severe mental illness with complex needs who require care coordination to assist their recovery but are not eligible for the NDIS. Increased referral out options are needed including outreach programs and step-down options from psychosocial programs.
- Lack of services specifically for the treatment of personality disorders in primary care, and few options at the community and sub-acute level.
- Lack of clinicians in the region trained in providing DBT and a lack of confidence to deliver this intervention. The lack of clinicians, and high demand for DBT services has caused long waitlists for the limited services currently available. Group DBT including those targeted at young people specifically is needed. LHD DBT services have paused during the COVID-19 pandemic due to staff being deployed elsewhere, or the need to deliver this service face to face rather than by telehealth.
- Both Connect & Thrive and Primary Integrated Care Supports (PICS) programs have a large waiting list with long wait times (approximately 8 weeks); particularly in the areas of Newtown, Marrickville and Burwood.
- Community consultations indicated the following unmet psychosocial needs: housing, lack of community engagement, isolation and loneliness, education, daily living skills, and employment.
- Limited opportunities for families, friends, and carers to be involved in support.
- Challenges reaching out to and engaging with complex severe mental illness (SMI) clients who are homeless or rough sleepers where it is difficult to access and gain trust.
- Upskilling opportunities for commissioned services staff in providing support like housing, welfare, advocacy, Centrelink, education– the cohort of people referred into psychosocial services experiencing SMI often present with highly complex additional support needs including crisis support.
- Upskilling and training for commissioned services staff on housing, welfare, Centrelink processes and procedures would be highly beneficial not only to the workforce but in ensuring people referred into mental health programs receive the wraparound support they need.

Suicide prevention services:

- A need for better integration and coordination between services, sharing of data/ clinical documentation between service providers as people often present at different hospitals in our region, and more awareness of services available to reduce hospital emergency admissions from intentional self-harm.
- Lack of primary care professionals identifying individuals at risk of attempting suicide.
- Primary care professionals identifying a lack of appropriate services, including barriers to accessing acute services, to support/refer individuals at risk of attempting suicide.
- Appropriate aged care supports and potential gate keeper training of GPs, Primary Care nurses and community pharmacists for older people who have attempted suicide or experience suicidal ideation (whether in residential care or living independently in community).
- Supporting police to respond to a mental health crisis.
- Bilingual or culturally appropriate services.
- Youth suicide prevention.
- Need for peer support networks and more resilience and health promotion strategies.

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