Australian Government
Department of Health

phn
An Australian Government Initiative

Central and Eastern Sydney Primary Health Network

Mental Health and Suicide Prevention Needs Assessment Report

(Dec 2017)

This template must be used to submit the Primary Health Network's (PHN's) Needs Assessment report to the Department of Health (the Department) by **4 December 2017** as required under Item E.5 of the Standard Funding Agreement with the Commonwealth.

Name of Primary Health Network

Central and Eastern Sydney PHN

When submitting this Needs Assessment Report to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Report has been endorsed by the CEO.

Instructions for using this template

Overview

This template is provided to assist PHNs to fulfil their reporting requirements for a Needs Assessment as required under Item E.5 of the Standard Funding Agreement (Funding Agreement) with the Department.

Further information for PHNs on the development of needs assessments is provided in the *Needs Assessment Guide*, available on the Department's website (www.health.gov.au/PHN).

The key output of needs assessment will be to inform the Activity Work Plan. In addition, the information provided by PHNs in this report may be used by the Department to inform programme and policy development.

Reporting

The Needs Assessment report template consists of the following:

Section 1 – Narrative

Section 2 – Outcomes of the health needs analysis

Section 3 – Outcomes of the service needs analysis

Section 4 – Opportunities, priorities and options

Section 5 – Checklist

PHN reports must be in a Word document and provide the information as specified in Sections 1-5.

Limited supplementary information may be provided in separate attachments if necessary. Attachments should not be used as a substitute for completing the necessary information as required in Sections 1-5.

While the PHN may include a range of material on their website, for the purposes of public reporting the PHN is required to make the tables in Section 2 and Section 3 publicly available on their website.

Submission Process

The Needs Assessment report must be lodged to the Grant Officer via email on or before 15 November 2016.

Reporting Period

This Needs Assessment report will cover the period of 1 July 2016 to 30 June 2018 and will be reviewed and updated as needed by 15 November 2016.

Section 1 – Narrative

Needs Assessment process and issues (500-600 words)

The following needs assessment report provides an update to the CESPHN report submitted in November 2016. The ensuing document re-examines the health needs and service gaps across the region, reviewing and updating data sources, integrating feedback from key stakeholders, and outcomes resulting from activities undertaken to date.

The format of the report has been changed to align to the six Key Objectives and Priority areas for Mental Health and Suicide Prevention and provides relevance to Schedules and contractual obligations.

A range of data sources were used to refresh and refine the needs assessment, including: recently released data sets, needs assessments undertaken by stakeholder organisations such as the LHDs; emerging needs identified through consultations with the CESPHN Mental Health and Suicide Prevention Advisory Committee.

Data from program areas was also analysed to measure trends and changes to activities where commissioning services had commenced in the last 12 months. However, the availability of this data was limited and it is anticipated this data will be a more robust resource for future needs assessments.

Due to the resource intensive nature of service mapping, the full range of services across our region are in the process of being mapped and a part of the current year Activity Work Plans

The key findings from the below report show that there has not be any major changes in health or service needs for Mental Health and Suicide Prevention service delivery since the last needs assessment submitted in November 2016. The analysis highlights that there is a need for continued work in hard to reach populations.

There is also the opportunity to expand work outside of the Primary Mental Health Care Schedule and work with other teams within CESPHN such as the Digital Health team around the re-introduction of the My Health Record.

Additional Data Needs and Gaps (max 400 words)

Gaps in Data available on PHN website:

- Mental Health data sources remain sparse and where possible should align with the key areas for mental health focus
- Mental Health related MBS items have not been updates since the last needs assessment

General Data Gaps and Limitations:

- A number of data sets not available at PHN or SA3 level. These include:
    - Aboriginal and/or Torres Strait Islander data
    - Self harm fatalities
    - Dementia
    - Lord Howe Island

• Age specific data sets are not available, particularly for children and youth and older persons mental health
• Change in Local Government areas means the new Canterbury-Bankstown has a concordance of 43.1% within the CESPHN region. Where data that is only available at LGA level we are unable to be interpreted data for the Canterbury-Bankstown LGA, this is a particular issue as the former Canterbury LGA was an area of high need. When SA3 data is available it is a challenge to present as often stakeholders are unfamiliar with SA3 terminology and concordance.
• The Primary Mental Health Care Minimum Data Set (PMHC MDS) has been introduced, however the data collection and reporting system was compromised during the system transition and caution needed to be exercised when interpreting the data.

Primary Health Care data gaps and limitations:
• The CESPHN database of health professionals is continually being updated and reflects a snapshot in time.

Section 2 – Outcomes of the health needs analysis

This section summarises the findings of the health needs analysis in the table below. For more information refer to Table 1 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Outcomes of the health needs analysis		
Priority Area	Key Issue *(identified gap and needs with statistics or qualitative summary)*	Description of Evidence *(reference and limitations)*
Demographics and Health Status	The 2016 Census reported a total of 1,495,875 residents in the CESPHN population. The population is distributed across 15 statistical areas (SA3), including Norfolk Island and Lord Howe Island, both located off the eastern costs of NSW. The highest concentration of the population resides in the Sydney Inner City sub-regions (14.3%, n=214,249), followed by the Strathfield-Burwood-Ashfield sub-region (10.15%, n=151,873) and Eastern Suburbs – South (9.4%, n=140,654). Population estimates predict an increase of people aged 65 years or older as the concentration of residents (currently) aged between 20 and 44, will age over in the next 20 years or more.	Census 2016 [Internet]. ABS. 2017 [cited Oct 2017]. Available from: http://www.abs.gov.au/websitedbs/censushome.nsf/home/2016
Mental Health Prevalence	For the CESPHN population, the estimated prevalence rates of mental illness each year is approximately: ○ 345,547 people with symptoms not warranting diagnosis ○ 136,125 people with mild mental illness ○ 68,810 people with a moderate mental illness ○ 46,372 people with a severe mental illness	Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services (November 2015)

Outcomes of the health needs analysis		
	It is estimated 9.7 % of the population aged 18 years and over reported high or very high levels of psychological distress. This is lower than the National and New South Wales rates (11.7% and 11.0% respectively). The highest rates in the region are in the SA3s of Canterbury (12.6%) and Marrickville – Sydenham – Petersham (11.2%). Nationally rates in psychological distress have increased since 2011-13, however the CESPHN rate has decreased.	Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks
Low Intensity Mental health	For the CESPHN population, the estimated prevalence rates of people who would benefit from access to low intensity mental health services each year is approximately: ○ 241,256 people under early intervention ○ 143,135 people under Mild severity	*Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services (November 2015)*
Children and Young People	**Children and Adolescents** The Young Minds Matter data provides synthetic estimates on mental disorders among 4-17 year-olds. The estimates are based on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing and provides rough data on the prevalence of Mental disorder of 4-17 year-olds in the region. The data shows that the rates for both 4-11 year-olds and 12-17 year-olds across all mental disorders are lower than the national rate. Within CESPHN the SA3s with the highest rates for 4-11 year-olds are; Sydney Inner City, Cronulla – Miranda – Caringbah and Sutherland – Menai – Heathcote. The SA3s with the highest rates for 12-17 year-olds are; Sydney Inner City, Botany and Marrickville - Sydenham – Petersham. Prevalence is also estimated at mild, moderate and severe levels, with rates across CESPHN lower than the national rate in all categories. Headspace From 1 July 2016 to 30 June 2017 3,621 young people accessed one of the five headspace centres in the CESPHN region. 2,460 of these young people accessed a centre for the first time during this period. Across the region, females are more likely to access Headspace compared to males. The rate of young people	Young Minds matter: The mental health of children and adolescents, Synthetic Estimates based on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Accessed via https://www.health.gov.au/internet/phn/publishing.nsf/content/phn-secure Accessed 18 August 2017 Headspace National Youth Mental Health Foundation. Headspace centres Central and Eastern Sydney PHN Financial Year 2016/17 (1 July 2016 – 30 June 2017)

Outcomes of the health needs analysis		
	identifying as 'other' is higher than the national rate, particularly at the Camperdown and Ashfield sites. Age distribution trends are in line with national trends except for Headspace Camperdown where 21-23 year-olds and 18-20 year-olds are higher, which is likely due to the close proximity in location to tertiary educational institutions. CESPHN Headspace centres have lower rates of Aboriginal and/or Torres Strait Islander young people particularly in Camperdown and Hurstville. Rates of young people from culturally and linguistically diverse (CALD) backgrounds who attend Headspace centres are much higher in the CESPHN region (21.4%) than the national rate (9.4%). Rates are highest in Hurstville, Ashfield and Bondi Junction. This matches the CALD distribution across the region. There are a higher proportion of younger people who identify themselves as lesbian, gay, bisexual, trans, intersex and questioning (LGBTIQ) (25.9%) compared to the national rate (20.5%) particularly in the Camperdown site (36.1%). The main reasons young people attend Headspace centres within the region are for mental health, followed by engagement and assessment. The rate of young people receiving alcohol and/or drug specific interventions is double the national rate. The Miranda site has a rate 5 times the national rate and the Hurstville rate is 3 times the national rate. Young people attending Headspace centres in the region were estimated by service providers to have mild to moderate general symptoms and sub-threshold diagnosis higher than the national rate. However, threshold diagnosis rates are lower meaning young people attending Headspace sites are have lower severity mental health diagnosis than Headspace sites nationally.	**Limitation:** Limited Data available for Child and youth Mental Health outside of the headspace datasets
Under-Serviced and/or hard to reach populations	In the last 12 months the former ATAPS program has undergone a redesign process to have resources better placed to meet community needs, particularly for hard to reach populations. The new target groups for the program are; Children, Young people, Women Experiencing perinatal depression, Culturally and Linguistically Diverse (CALD) Communities, People who have attempted or are at risk of suicide or self-harm, those who Identify as Aboriginal and/or Torres Strait Islander and adults living in the LGAs of Bayside, Georges River, the Canterbury portion of Canterbury-Bankstown and Strathfield.	

Outcomes of the health needs analysis

	The analysis of mental health needs of Children, Young Health, People who have attempted or are at risk of suicide or self-harm and people who identify as and Aboriginal and/or Torres Strait Islander are addressed under the relevant sections of the health needs section. Women experiencing prenatal or postnatal depression In 2012, the Australian Institute of Health and Welfare released a report identifying several indicators associated with prevalence of perinatal depression including; being aged under 25, being a smoker, born in Australia, living in a household where English is the main language, living in an area of disadvantage and being overweight or obese. Within the CESPHN region, Botany SA3 has high rates in four of the six indicators, and Sutherland – Menai – Heathcote, and Cronulla-Miranda-Caringbah SA3s have high rates within the CESPHN region for three of the six indicators putting women in these areas at higher risk. Culturally and Linguistically Diverse (CALD) Communities There is significant cultural diversity across the CESPHN region, including diversity in language spoken and country of birth. Within cultural groups, variation exists amplifying diversity across the cultural groups. It is acknowledged that variation between individual cultural groups exists, creating an additional level of heterogeneity. Language, recognition of overseas qualifications, limited support networks, and confidence in authorities' impact level of engagement, understanding and confidence in the health care sector. The highest rates of CALD populations were comparable to the total population with Sydney Inner City (n=162,619) and Kogarah-Rockdale (n= 162,619) having the highest number and proportion of CALD residents at rate of 10.88%, followed by Canterbury (n=98,178) at 6.57% of the total CESPHN population.	Australian Institute of Health and Welfare 2012. Experience of perinatal depression: data from the 2010 Australian National Infant Feeding Survey. Information Paper. Cat. no. PHE 161. Canberra: AIHW. Australian Bureau of Statistics 2017, SA3 General Community Profiles Census 2016 [Internet]. ABS. 2017 [cited Oct 2017]. Available from: http://www.abs.gov.au/websitedbs/censushome.nsf/home/2016 Limitation: Updated SEIFA data has not been released for the 2016 census, therefore potential changes to pockets of disadvantage across the region cannot be assessed in line with the areas of need of underserviced populations and areas of high psychological distress.

Outcomes of the health needs analysis		
	The 2016 Census indicated variability in the distribution of people who speak a language other than English and/or born overseas. In terms of language diversity, the proportion of Asian-origin languages had the highest incidence, followed by Greek and Arabic English literacy is considered pertinent to health outcomes related to the ability of a person to self-manage their health condition, readily access to healthcare services, reduce variation in clinical outcomes. For the purposes of this report, limited English literacy has been considered as follows; • Consumers who speak a language other than English • Consumers who do not speak English at all • Consumers with limited English language capability Most recent data (2016) indicates that an estimated 6.8% (102,739) consumers have limited English literacy and language skills. Across the CESPHN region, three (SA3) regions rank highest in terms of population with limited English literacy are; Canterbury (19.7%), Strathfield-Burwood-Ashfield[1] (15.8%) and Hurstville (14.9%).	
Severe and Complex	The life expectancy for people experiencing severe mental illness is reduced by 15 to 20 years – largely due to cardiovascular disease and cancer rather than suicide – and the gap is widening. An estimated 3.5% of the Australian population will have a severe mental illness or substance use disorder; 2.2% of individuals aged 0-14 years, 3.4% of individuals aged 15-24 years, 4.1% of individuals aged 25-64 years and 2.9% of individuals aged 65 years + Eating disorders have been flagged as an issue across the CESPHN region with individuals more likely to attend primary health care for reasons other than their eating disorder. In 2012, more than 913,000 people nationally had an eating disorder	Mental Health Commission of NSW (2016). *Physical health and mental wellbeing: evidence guide,* Sydney, Mental Health Commission of NSW. State of New South Wales *Eating Disorder: Community Data and Primary Health Care Needs Assessment joint report from SLHD and SESLHD*

Outcomes of the health needs analysis		
	Sydney and South Eastern Sydney LHDs and Sydney Children's Hospital Network ambulatory service data from 2014 shows that 238 people were seen with eating disorder as their primary diagnosis; 44 people were seen with eating disorders as a secondary diagnosis Individuals with an eating disorder are more likely to access primary health care for other conditions rather than the eating disorder; Sydney LHD data shows the following as the top five secondary diagnosis where an eating disorder was the primary diagnosis: anxious (avoidant) personality disorder, borderline personality disorder, mixed anxiety depression disorder, mental and behavioural disorders due to use of alcohol (harmful use), dependent personality disorder	
Suicide Prevention	There is limited data available at the local level regarding suicide and self-harm however it has been identified as an issue within pockets of our population. In 2016 nationally, Intentional self-harm accounted for over one-third of deaths (35.4%) among people 15-24 years of age, and over a quarter of deaths (28.6%) among those 25-34 years of age. For those people 35-44 years of age, 16.0% of deaths were due to intentional self-harm In 2016 nationally, suicide was the leading cause of death among all people 15-44 years of age, and the second leading cause of death among those 45-54 years of age. The median age at death for suicide was 43.3 years. This compares to a median age of 81.9 years for all deaths. In NSW, suicide rates per 100,000 remained relatively stable between 2007 and 2013 (8.9 – 9.5), peaking in 2014 (10.5) and continuing to remain stable over 2015-2016 (10.6-10.3). In 2015 across NSW, males had a higher suicide (16.3 per 100,000) than females (5.1 per 100,000) across all ages. Rates of suicide were highest amongst males aged 45-54 (28.6 per 100,000), followed by males aged 35-44 (22.8 per 100,000). The highest rates in females were females aged 35-45 (7.9 per 100,000).	Australian Bureau of Statistics, 2017, Causes of Death, Australia 2016 viewed, 26 October 2017. http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2016~Main%20Features~Intentional%20self-harm:%20key%20characteristics~7 Suicide in NSW (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health Accessed 10 November 2017 Suicide by PHN (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health Accessed 10 November 2017

Outcomes of the health needs analysis		
	Between 2010 to 2015, suicide rates within CESPHN fluctuated, ranging from a low of 7.5 per 100,000 in 2012, to a high of 10.1 in 2014. Increases have been seen across both SESLHD and SLHD since 2012. In 2011 SESLHD had a lower rate (7.8) than SLHD, however since SLHD has continued to have a lower rate than SESLHD. Research shows that for every suicide, 10-135 people are affected. This equates to approximately 1,310 to 17,685 individuals affected by suicide in 2013; these individuals are then more likely to need mental health support themselves.	Suicide by LHD (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health Accessed 10 November 2017 Maple, M., Kwan, M., Borrowdale, K., Riley, J., Murray, S. & Sanford, R. (2016) 'The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia'. Sydney: Suicide Prevention Australia **Limitation** Intentional Self-Harm Fatalities data not publicly available at PHN/SA3 level. Hospitalisation rates don't provide details on mechanisms, gender or age ranges
Aboriginal and Torres Strait Islander Health Mental Health	The number of residents that identified as Aboriginal and/or Torres Strait Islander was 12,765 (1% CESPHN population). The distribution of this population group followed a similar trend as the total population with the highest number and proportion of Aboriginal and/or Torres Strait Islander residents living in Inner Sydney City (0.17%, n=2,489). In NSW, rates of high or very high psychological distress among Aboriginal people (2015) was reported at 21.7% compared with 11.6% of the non-Aboriginal population. Between 2011-15 the cause of death attributed to Mental and Behavioural disorders was 34.9 per 100,000 population. This is higher than the Non-Aboriginal Rate of 29.3 per 100,000 population	Census 2016 [Internet]. ABS. 2017 [cited Oct 2017]. Available from: http://www.abs.gov.au/websitedbs/censushome.nsf/home/2016 NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health Accessed 9 November 2016 Deaths by cause and Aboriginality SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health Accessed 10 November 2017 **Limitations:** Datasets not available at the PHN/SA3 level

Outcomes of the health needs analysis		
Older Persons Mental Health	Demographics In 2016, the CESPHN region had 225,592 residents aged 65 years or older, or 13.5% of the total CESPHN population. In terms of absolute population, the following CESPHN sub-regions (SA3) had the highest number of people aged 65 years or older; Lord Howe Island (18.2%), Cronulla-Miranda-Caringbah (17.9%) and Hurstville (15.9%). The CESPHN region has a diverse, multicultural population with more than one-third born overseas. These populations are distributed across all sub-regions with concentrated pockets in Burwood, Strathfield and Canterbury LGAs. Dementia Dementia presents a significant challenge to health and aged care in Australia, and affects almost 1 in 10 (8.8%) people aged 65 and over. While dementia is not caused by age, it does primarily affect older people. Based on evidence including Australian population projections, there are an estimated 354,000 people with dementia in Australia in 2016. Between 2006 to 2016, there was a 40% (n= 252,000) rise in people with dementia in Australia, with an estimated 43% of those diagnosed (n=108,360) aged 85 years or older. There is a high proportion of people aged 65 years or older residing in the CESPHN region. The SA3s with estimated high proportion of incidence of dementia are; Kogarah- Rockdale (n=826), Strathfield-Burwood–Ashfield (n=724) and Cronulla-Miranda–Caringbah (n=2,138). Several sub-regions have higher rates of this cohort than others with co-existing levels of vulnerability, such as high proportions of people for whom English is a second language, have low levels of health literacy and socioeconomic disadvantage.	Census 2016 [Internet]. ABS. 2017 [cited Oct 2017]. Available from: http://www.abs.gov.au/websitedbs/censushome.nsf/home/2016 Dementia in Australia [Internet]. Australian Government. 2012. Available from: https://www.aihw.gov.au/reports/dementia/dementia-in-australia/data Australian Institute of Health and Welfare. Australia's health 2016. Canberra: AIHW; 2016. Information and data on aged care in Australia [Internet]. Australian Government. 2017. Available from: www.GEN-agedcaredata.gov.au Data Limitations: Dementia rates only at national level

Outcomes of the health needs analysis		
Rural Health (Norfolk Island and Lord Howe Island)	Norfolk Island Norfolk Island is an external Australian territory location 1600km off the eastern coastline of NSW. The population is 1,748 (0.12% of the CESPHN population) with a slightly higher proportion of female residents (53.2%) than males (46.8%). The Norfolk Island population reported higher levels of "High to Very High" psychological distress compared to the NSW population (13 per cent compared with 9.8 per cent) Consultation indicated that the most common mental health presentations to hospital have included depressive disorders and general anxiety / panic disorders. It was also indicated that some people in the community avoid accessing mental health services due to privacy and confidentiality concerns. There is no available data in relation to suicide. Anecdotally, there have been no suicide attempts in recent years, however this was difficult to corroborate. Lord Howe Island (LHI) Data from LHI is not available as the population size is too small to calculate without identifying residents.	Census 2016 [Internet]. ABS. 2017 [cited Oct 2017]. Available from: http://www.abs.gov.au/websitedbs/censushome.nsf/home/2016 Sources: NIHE-Health Services Survey Report 2015 (R&S Muller Enterprise Pty Ltd) Consultation Limitations There is limited health and service information available for LHI.

Section 3 – Outcomes of the service needs analysis

This section summarises the findings of the service needs analysis in the table below. For more information refer to Table 2 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Outcomes of the service needs analysis		
Priority Area	Key Issue	Description of Evidence
Low Intensity Mental Health	A review of the eMHPrac listing shows 88 types of low intensity e-mental health supports available to the CESPHN community, 70 of which have no charge to access the service (79.5%) Listings through eMHPrac are categorised by tags which fits into 35 categories. The most common tag is 'Online program' with 27 listings (31%), followed by App (n=23), Anxiety (n=22), Depression (21), Information (20) and Youth (19) all having tags which cover over 20% of listed services. Additional mapping of the CESPHN area identified 129 low intensity services available in the region. Access to these services has been categorised as: ○ In person (n=100) ○ Online (n=44) ○ Phone (n=73) ○ 24-hour phone (n=5) • 91 of these services are free to the consumer In addition to the above services, the below services are currently being commissioned by CESPHN and are free of charge to the end user: • NewAccess Coaching: Goal-focussed support to help manage day-to-day pressures • Mindfulness Program for Arabic and Bengali Speakers - Promotion of emotional balance, resilience, wellbeing and stress reduction	e-mental health in practice (eMHprac), available at: http://www.emhprac.org.au/services/ JM Consultancy (2017). Low Intensity Mental Health Services Mapping for Central and Eastern Sydney Primary Health Network Region.

Outcomes of the service needs analysis		
	• Mental Health First Aid Training - Mental health first aid is the help provided to a person who is developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis. The Mental Health Atlas for the Central and Eastern Sydney region identified 9 services which provide information and guidance for the community; 5 offer information and are interactive, 1 offers information and is non-interactive and 3 offer professional assessment and guidance related to health care. 4 of these services are offered through Health and 5 are offered through NGOs	Salvador-Carulla. L., Maas. C., Fernandez. A., Prigent A, Gandré C., Xu T, Alvarez-Galvez J. & SalinasPerez J. (2016). The Integrated Mental Health Atlas of the Central and Eastern Sydney PHN. Mental Health Policy Unit. Brain and Mind Centre. Faculty of Health Sciences. University of Sydney
Child and Youth	Across Headspace sites, the Hurstville site has the highest visit frequency followed by Camperdown and Ashfield. Over 2016-17, both Bondi Junction and Ashfield sites saw increases in the total services delivered from the previous year. Camperdown remained stable however Miranda and Hurstville saw a decline in services. Young people reported the most common wait time for their first appointment was 1-2 weeks which is in accordance with national wait times. However, 14.2% of young people (within the CESPHN region) felt that the wait time was too long. Young people within the CESPHN region have higher rates of self-referral into Headspace sites than nationally, particularly in Camperdown.	Headspace National Youth Mental Health Foundation. Headspace centres Central and Eastern Sydney PHN Financial Year 2016/17 (1 July 2016 – 30 June 2017)
Psychological services for Under Serviced and/or Hard to Reach Populations	In the last 12 months the former ATAPS program has undergone a redesign process to have resources better placed to meet community needs, particularly for hard to reach populations. The new target groups for the program are; Children, Young people, Women Experiencing perinatal depression, Culturally and Linguistically Diverse (CALD) Communities, People who have attempted or are at risk of suicide or self-harm, Identifies and Aboriginal and/or Torres Strait Islander and adults living in the LGAs of Bayside, Georges River, Canterbury-Bankstown and Strathfield. Referral data for the last 12 months of psychological support services is split into two categories – 1 July 2016 to 8 January 2017 consisting of the ATAPS model. 9 January 2017 to 30 June 2017 consisting of the newly designed Psychological Support Services (PSS) model. ATAPS received 1264 referrals, with	CESPHN PMHC MDS, 2017

Outcomes of the service needs analysis		
	PSS receiving 1256 referrals. Across both models 'general' referrals had the highest proportion of referrals (48.5% and 43.6% respectively). All other referral types as recoded by the Primary Mental Health Care Minimum Data Set (PMHC MDS) remained similar between the two models. The most noticeable difference is in Aboriginal and/or Torres Strait Islander referrals which more than doubled from the transition from ATAPS to PSS (2.5% vs 5.5%). Data on CALD referrals was not available under the ATAPS model, Under PSS 132 (10.6% of referrals) CALD referrals were received. The transition from ATAPS to PSS saw additional provisional referrers being able to refer into the program. This saw an increase in Mental Health Professionals referring from 6.6% under ATAPS to 15.7% Under PSS. Issues with extracting data from the PMHC MDS has restricted the ability to analyse data to patterns of geographic referral and measure access in identified geographically underserviced areas. Further work will be completed with the PMHC MDS to enable monitoring against areas of need. Once referrals are accepted, the number of clients accessing psychological support services over 2016/17 (includes both ATAPS and PSS) was 2539clients 2.10.6% of these clients identified as speaking a language other than English. Overall under ATAPS and PSS in 16/17; 12,215sessions were provided by 158 providers. *See Aboriginal and/or Torres Strait Islander section for PPS information* Consultation with the child and maternal health team identified the following service gaps around access to Perinatal Mental health services; the only Mother /baby Unit in the region is a private hospital (St John of God Burwood), there are long waiting lists for ECSW and Tresillian. There is limited promotion /awareness of PND resources for women and limited/no bulk billing psychiatrists Consultation with the CESPHN Mental Health and Suicide Prevention Advisory Committee found the following service gaps for the LGBTI community; Lack of welcoming environments, lack of services for	*Mental Health and Suicide Prevention Advisory Committee Needs Assessment Workshop August 2017*

Outcomes of the service needs analysis		
	social and emotional wellbeing of this client group, lack of inclusive mainstream services and a lack of intersection between; Homelessness, Ageing populations, CALD, Aboriginal and/or Torres Strait Islander and Alcohol and other Drugs	**Limitations:** During the transition to the PMHC MDS- the data collection and reporting system was compromised. The figures here may not be 100% accurate and have been interpreted with caution. CESPHN is in process of rectifying the error and will re-run the analysis once the system has been restored.
Severe and Complex Mental Illness	Care Coordination A review of the service provision and a co-design process found that the funding model, access and equity across the region were constraints of the Mental Health Nurse Incentive Program (MHNIP). At 30 June 2017, 14 Mental Health Nurses (MHN) were working across 14 provider organisations with 7.0 FTE across all provider organisations. Referrals of clients into the program could only be made by health professionals attached to the provider organisation and provider organisations were not necessarily servicing clients in the geographic areas of most need. MHNs were found to have been taken away from their clinical and care coordination roles to support their clients in other ways, particularly around psycho-social needs. Under the new service model the provider organisation has targets to increase the MHN workforce to 13.0FTE MHNs and develop a Peer support workforce with a target of 7.0 FTE Peer Support workers. This will allow MHNs to have a more clinical role and with the introduction of the peer worker to provide more psycho-social support. Referrals into the program are now open to every GP in the region, psychiatrists, state mental health services, non-government organisations, MHNs and peer workers, allowing equitable access across the region. Physical health of Mental Health clients – Shared Care models The life expectancy for people experiencing severe mental illness is reduced by 15 to 20 years – largely due to cardiovascular disease and cancer rather than suicide – and the gap is widening. Despite improvements in physical health and longevity in the general population through better lifestyle and	

Outcomes of the service needs analysis		
	medical advances, people with severe mental illness have not shared in these benefits. They often experience economic and social marginalisation, including from health care professionals and systems, in addition to severe metabolic consequences from antipsychotic medication. As a result, people experiencing serious mental illness attend the GP more often but are screened less frequently for common conditions than the general population. Mental Health Shared Care programs support the path of recovery and physical health of a consumer whose care is shared by the GP and the Local Health Districts/Networks. The Shared Care model clearly specifies which service will be responsible for identified aspects of their physical health care. Across the region, CESPHN commissions shared care models across Sydney LHD, South Eastern Sydney LHD and St Vincent's Health Network. The Sydney LHD model includes features to support GPs to undertake physical screening and treatment interventions with this vulnerable population. South Eastern Sydney LHD model uses a Mental Health Nurse who provides a recovery orientated shared care service for consumers with complex mental and physical health care needs. Direct support is provided to General Practitioner (GPs) or other health services in coordinating care and bridging the gap to mental health care. St Vincent Health Network model uses a Shared Care Clinical Nurse Consultant to support a stepped care service model for the district. The nurse will work with GPs to coordinate the provision of services for the client. These models will be monitored to measure their effectiveness and ensure clients' needs are being met. <u>Overnight Hospitalisations and bed days for mental health conditions (overnight) and intentional self-harm (same day and overnight)</u> In 2015/16, CESPHN ranked 9th out of 15 Metropolitan PHNs for all mental health hospitalisations (95 per 10,000 people). While our rate per 10,000 people has not significantly changed since 2014-15 (96 per 10,000), our ranking has changed from third highest to ninth highest. 56.8% of hospitalisations were in specialised care, this is the second lowest proportion for all Metropolitan PHNs. 19.2% of hospitalisations were in private hospitals; this is the fifth lowest in Metropolitan PHNs. Indicating that approximately half of all mental health hospitalisations are in specialised care, with the majority occurring in public hospitals.	Mental Health Commission of NSW (2016). *Physical health and mental wellbeing: evidence guide,* Sydney, Mental Health Commission of NSW. State of New South Wales AIHW (2017). Hospitalisations for mental health conditions and intentional self-harm 2015/16. Accessed 30 November 2017.

Outcomes of the service needs analysis		
	Within the CESPHN region five SA3 regions have higher rates of overnight hospitalisation per 10,000 for all mental health disorders; Marrickville-Sydenham-Petersham (136 per 10,000), Sydney Inner City (136 per 10,000), Leichhardt (124 per 10,000), Eastern Suburbs - South (113 per 10,000) and Botany (100 per 10,000). Across all mental health conditions within the CESPHN region, the highest proportion of total overnight hospitalisations was for drug and alcohol use (27%), followed by Schizophrenia and delusional disorders (19%) Anxiety and stress disorder (14%), Intentional Self-harm (13%), and Bipolar and Mood Disorders, Depressive episode and Dementia (9% each). In 2015/16, CESPHN ranked 6th out of 15 Metropolitan PHNs for all mental health bed days (1,459 per 10,000 people). 74.9% of bed days were in specialised care, this is the second lowest proportion for all Metropolitan PHNs. 24.3% of bed days were in private hospitals, this is the fifth lowest in Metropolitan PHNs. Indicating that the majority of mental health bed days in the CESPHN region take place in specialised care within public hospitals. Within the CESPHN region six SA3 regions have higher rates of bed days per 10,000 for mental health disorders than the CESPHN rate; Eastern Suburbs-South (2,565 per 10,000), Marrickville-Sydenham-Petersham (1,986 per 10,000), Leichhardt (1,932 per 10,000), Botany (1,768 per 10,000) and Sydney Inner City (1,659 per 10,000) Across all mental health conditions within the CESPHN region, the highest proportion of total bed days was for Schizophrenia and delusional disorders (35%), followed by Drug and alcohol use (17%), Bipolar and Mood disorders (14%), Depressive episodes (14%,), Anxiety and depression (8%), Dementia (7%) and intentional Self-harm (6%) Mental Health conditions where the CESPHN rate of overnight hospitalisations is higher than the national and metropolitan rate are; schizophrenia and delusional disorders, dementia and drug and alcohol use.	

Outcomes of the service needs analysis		
	Overnight hospitalisations at an SA3 level within the CESPHN region rank highly at a national level for particular mental health conditions. In particular for schizophrenia and delusional disorders Marrickville – Sydenham – Petersham SA3 has the 19th highest rate nationally (out of 333 SA3s), for Stress and anxiety, Leichhardt SA3 has the 46th highest rate nationally, for Dementia Eastern Suburbs – South has the 23rd highest rank nationally and for Drug and Alcohol Use Sydney Inner City and Marrickville – Sydenham – Petersham have the 4th and 20th highest rates respectively. Mental Health conditions where the CESPHN rate for bed days is higher than the national and metropolitan rates are; schizophrenia and delusional disorders, depressive episodes, drug and alcohol use and intentional self-harm. Beds days at an SA3 level within the CESPHN region rank highly at a national level for particular mental health conditions. In particular for schizophrenia and delusional disorders Eastern Suburbs – South is ranked 12th nationally, for depressive episodes Leichhardt SA3 is ranked 31st highest, for Dementia Strathfield – Burwood – Ashfield is ranked 52nd, for intentional self-harm Botany SA3 has the 3rd highest rate and for Drug and Alcohol use, Leichhardt SA3 has the highest rate of bed days nationally, with Sydney Inner City having the second highest and Marrickville - Sydenham – Petersham having the 12th highest. Whilst Alcohol and other drug hospitalisations and bed days are not typically included as a severe and complex mental health picture. Within the CESPHN region, the high rates of hospitalisations and bed days relating to AOD are reflected within the overall Mental Health hospitalisation and bed days data and must be accounted for in the analysis.	
Suicide Prevention	There is limited data available at the local level regarding suicide and intentional self-harm rates, however our region has a higher proportion of non- specialised care compared to specialised care for intentional self-harm (7 per 10,000 vs 4 per 10,000).	

Outcomes of the service needs analysis		
	Across CESPHN in 2015-16, intentional self-harm overnight hospitalisations were at a rate of 12 per 10,000, lower than the national rate of 17 per 10,000. Residents living in Botany SA3 had the highest rate of hospitalisation (20 per 10,000), followed by Marrickville – Sydenham-Petersham (15 per 10,000), Sydney Inner Sydney (17 per 10,000), Eastern Suburb South (15 per 10,000) and Leichhardt (15 per 10,000) SA3s. The SA3 with the lowest hospitalisation rate is Canada Bay (7 per 10,000). With the exception of Sydney Inner City SA3, all of the above SA3s rates have increased from 2014-15. Bed days for Intentional Self Harm across CESPHN were 87 per 10,000. This is higher than the national rate of 81 per 10,000 and an increase on the 2014-15 rate (66 per 10,000). This increase is reflected across the different SA3s in the region. Botany SA3 has significantly increased from 2014/15 (48 per 10,000) to 2015/16 (215 per 10,000) where it now has the highest rate of bed days within the CESPHN region. Eastern Suburbs – South (180 per 10,000) has the second highest rate, which has doubled from 2014-15 and Leichhardt (158 per 10,000) has tripled.	AIHW (2017). Hospitalisations for mental health conditions and intentional self-harm 2015/16. Accessed 30 November 2017.
	Research regarding service utilisation by those who have suicided, shows that 45% of people had accessed healthcare support in the 6 months prior to their suicide. 31% of people who have suicided had accessed a GP or Psychiatrist and 19% had accessed a Psychologist or Counsellor; highlighting the need to support our primary care professionals in identifying these at-risk individuals.	Maple, M., Kwan, M., Borrowdale, K., Riley, J., Murray, S. & Sanford, R. (2016) 'The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia'. Sydney: Suicide Prevention Australia
	Consultation with the CESPHN Mental Health and Suicide Prevention Advisory Committee found the following service gaps around youth suicide prevention; Lack of youth friendly service providers and services, the need for peer support networks, the need for more resilience and health promotion strategies and supporting police to respond to a mental health crisis.	*Mental Health and Suicide Prevention Advisory Committee Needs Assessment Workshop August 2017*
Aboriginal and Torres Strait	We have limited Aboriginal specific mental health service options across the region and limited access to local level Aboriginal data regarding mental health.	

Outcomes of the service needs analysis		
Islander Health Mental Health	On a state level, the rate for hospitalisations for Mental disorders amongst Aboriginal people in NSW has been increasing since 2011-12 (2,577.5 per 100,000), peaking in 2015-16 (3,179 per 100,000). In 2015/16, across the CESPHN region, hospitalisations rates for Mental Disorders (5051.5 per 100,000 population; n=684) was higher than NSW (3179.9 per 100,000), and was the highest rate across NSW PHNs. Within the CESPHN region in 2015/16, both the Sydney LHD (6,038.8 per 100,000) and South Eastern Sydney LHD (4,215.6 per 100,000) had higher rates of hospitalisations for mental health disorders than NSW. Injury and poisoning is third highest for hospitalisations among Aboriginal people (3613.6) compared to non-Aboriginal people (2114.7) across the PHN but still lower than NSW (3870.8) per 100,000 population (2014/15).	Hospitalisations by cause and Aboriginality, Mental disorders, NSW 2015-16 (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health
	During 2015/16, 220 clients accessing Psychological Support Services funded by CESPHN identified as being Aboriginal and/or Torres Strait Islander. 40.5% of Aboriginal and/or Torres Strait Islander clients are aged 12-24 years, 29.5% are aged 25-34 years, 12.5% are aged 35-44 and 12.5% are aged 45-54.	CESPHN PMHC MDS, 2017
	Hospitalisations for people where Dementia as a principal diagnosis or as a comorbidity in persons aged 65 and over is at higher rate with Aboriginal people than non-aboriginal people, with the exception of Aboriginal Males from 2011-12 to 2013-14 where the rate of non-aboriginal males (2398 per 100,000 to 2356 per 100,000) is higher than the rate of Aboriginal males (2299 per 100,000 to 2259 per 100,000). 2014-15 is the first year Aboriginal male Hopsitalisation rates (2953 per 100,000) have been higher than Aboriginal females rates (2794 per 100,000) since 2006-07.	Dementia as a principal diagnosis or as a comorbidity, hospitalisations by Aboriginality, persons aged 65 and over (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed 16 November 2017.
	Consultation with the CESPHN Mental Health and Suicide Prevention Advisory Committee found the following service gaps around access to service for Aboriginal and Torres Strait Islander people; a lack of Aboriginal and/or Torres Strait Islander staff and cultural competency, poor service alignment to where the community needs services resulting in lack of access to (competent) services, poor data collection and the need for further consideration of social and emotional well-being being greater than Mental Health.	Mental Health and Suicide Prevention Advisory Committee Needs Assessment Workshop August 2017

Outcomes of the service needs analysis		
MBS Utilisation	We've seen an increasing rate of mental health treatment plan (MHTP) claims by GPs with mental health skills training, mental health plan reviews and GP mental health consultations across the region. There is also local anecdotal evidence of inappropriate use of GPMP and/or TCAs for people with mental health conditions or concerns. Highlighting the need for further education and support for primary care clinicians regarding MBS claims There has been an increase in the number of psychiatrists including a person other than the patient during initial diagnosis of a patient and continuing management of a patient within our region, however uptake is still low. There is also low uptake of home visits by psychiatrists and low availability of psychiatrists willing to bulk bill patients. Low uptake of use of psychiatrists to conduct an assessment and management plan and/or review on behalf of GPs. There are few out of consult room visits conducted by Allied Mental Health Professionals across the region which can impact on service accessibility for some client groups.	MBS Statistics by Medicare Local Reports (http://medicarestatistics.humanservices.gov.au/statistics/med_locals.jsp) accessed 15 September 2016
Digital Health	The CESPHN database of health professionals identifies that there are thirteen practices where there is one or more psychologist who are registered for my health record. This suggests that mental health professionals may need training in the lead up to the opt out system from July 2018.	CESPHN Internal database, accessed 15 November July 2017 Limitation: Information on CESPHN database is gathered by CESPHN census and updates through practice visits. Therefore, availability of data depends on voluntary response from census and collection from visits
Workforce	Health Workforce Australia data shows that in 2015 there were 330 Psychiatrists working in a clinical role in the CESPHN region, however the availability of access to bulk billing Psychiatrists across the region is still being identified.	Health Workforce Data, http://data.hwa.gov.au Accessed 24th October 2016

Outcomes of the service needs analysis		
	The CESPHN database of health professionals identifies that 11% of psychologists in the region speak a language other than English. The top languages include Cantonese, Greek, Spanish and Mandarin. However, this workforce is not located in areas of highest need with the LGAs of Bayside, Woollahra and Georges River having the lowest access. Modelling between need and demand of mental health services and the required workforce including, workforce capacity and resource estimates is an area that has not currently been explored in the CESPHN region. The National Mental Health Service Planning Framework (NMHSPF) tool has been identified as a resource to enable this process and will be used to further understand this workforce needs in the region.	CESPHN Internal database, accessed 15 November 2017 Limitation: Information on CESPHN database was gathered from CESPHN census and therefore availability of data depends on voluntary response from census.
Older Persons Mental Health	Hospitalisations and bed days In 2015/16 CESPHN age standardised overnight hospitalisations per 10,000 population for Dementia is higher than the rate for National and Metropolitan PHNs (7 per 10,000 vs 6 and 6 per 10,000 respectively). The CESPHN rate has increased since 2014/15, as have the national and metropolitan rates. Two SA3 regions have rates higher than the CESPHN rate; Eastern Suburbs - South (9 per 10,000) and Strathfield - Burwood - Ashfield (9 per 10,000) with Eastern Suburbs -South ranking as the 23rd highest rate of SA3s nationally (out of 333 SA3s). CESPHN age standardised bed days per 10,000 population for Dementia is lower than the rate for National and Metropolitan PHNs (80 per 10,000 vs 93 and 95 per 10,000 respectively). The bed day rate has increased within the CESPHN region, as well as Nationally and in Metropolitan PHNs. Eight SA3 regions have higher rates of Bed days per 10,000 for Dementia compared to the CESPHN rate; Strathfield - Burwood - Ashfield (127 per 10,000), Botany (104 per 10,000), Marrickville - Sydenham - Petersham (102 per 10,000), Eastern Suburbs - South (98 per 10,000), Cronulla - Miranda - Caringbah (91 per 10,000), Leichhardt (87 per 10,000), Canterbury (84 per 10,000) and Sutherland - Menai – Heathcote (83 per 10,000). Strathfield, Burwood-Ashfield, SA3 is ranked 52nd highest amongst SA3s nationally	AIHW (2017). Hospitalisations for mental health conditions and intentional self-harm 2015/16. Accessed 30 November 2017.

Outcomes of the service needs analysis		
	Across the region the rate of specialised care hospitalisations is 0 per 10,000. Both the national and metropolitan rate is 1 per 10,000. This means that people who have overnight hospitalisation with a diagnosis of dementia are not being cared for in wards where staff are specialised in treating people with dementia. Consultation with the CESPHN Mental Health and Suicide Prevention Advisory Committee found the following service gaps for around access to service for older people; A lack of access to psychologists, particularly for people in Residential Aged Care Facilities (RACFs), the increased suicide risk for older people and issues associated with social isolation as people age and lose support networks	Mental Health and Suicide Prevention Advisory Committee Needs Assessment Workshop August 2017
Rural Health (Lord Howe and Norfolk Islands)	Norfolk Island Adult Counselling services There is currently a mental health counselling service from a standalone building on the hospital site. The Mental Health Counsellor is an experienced and skilled practitioner (Registered Psychologist) who is well versed in providing a broad range of counselling services including relationship counselling, mediation and family dispute resolution. In addition to the above counselling sessions, there are additional home visits, case management of complex mental health clients, training and education of hospital nursing staff, preparation of reports for the court, professional development for Police and the NI School Teachers and coordination of a Community "Drum Beat" Program. There is no cover when the counsellor goes on leave. Furthermore, the lack of other service options and the location of the counsellor (standalone building) exacerbates privacy and confidentiality issues. Child and Youth Counselling services A child and youth counsellor currently visits the school 16 weeks each year. The counsellor has been very successful and has been accepted by children at the school and the community in general. However, even after an increase to 16 weeks each year from 12 weeks, it is reported to be inadequate considering the needs of young people. Family therapy services were also identified as a need.	CESPHN Norfolk Island Needs Assessment Submitted August 2016 Community and school feedback via interagency meeting, October 2017.

Outcomes of the service needs analysis		
	General practice Upskilling General practitioners on the Island noted that they require further training and development to ensure they can provide appropriate mental health services to their patients. There is also a lack of formal referral linkages to psychiatric services on the mainland. Health Promotion Previously there has been minimal health promotion available on the island, as part of CESPHN activities a staged approached is being implemented, starting with lifestyle and risk factors promotion before more services are added to the island. The need for a Health and wellbeing coordinator and a child, youth and family mental health clinician have been identified by the community. This will include having AOD experience to avoid stigma around seeing a drug and alcohol clinician. Lord Howe Island (LHI) High need for community education on topics such as drugs and alcohol, diabetes, mental health, and women's health.	
Service navigation and pathways	Health Pathways Sydney Over the past 12 months (October 2016 - September 2017) Non-urgent Mental Health Assessment and advice had the third highest unique page views of all referral pathways (n=251). During the same time period the Psychological Support Services (PSS) pathway had the 11th highest unique page views (n=194). South Eastern Sydney Health Pathways South Eastern Sydney Health Pathways has not gone live, therefor utilisation data is not available.	Health Pathways Sydney, data analytics report (November 2017)

Section 4 – Opportunities, priorities and options

This section summarises the priorities arising from the Needs Assessment and options for how they will be addressed. This could include options and priorities that:

- *may be considered in the development of the Activity Work Plan, and supported by PHN flexible funding;*
- *may be undertaken using programme-specific funding; and*
- *may be led or undertaken by another agency.*

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Low Intensity Mental Health	• Promote e-mental health resources • Access to low intensity digital mental health services • Coaching services (non-digital low intensity mental health services) • Implementing a stepped care approach into General Practice (Lead Site Activity) • Mindfulness interventions in CALD communities (Lead Site Activity) • Coaching services in Aboriginal and Torres Strait Islander communities (Lead Site Activity) • Mental Health First Aid for underserviced groups (Lead Site Activity)	Increased awareness and uptake of low intensity services across the region Increased identification and support for mental health issues in general practice Greater variety of mental health services to service the varying needs of populations Increased awareness and ability to respond to mental health issues by GPs and AMHPs	Proportion of regional population receiving PHN-commissioned mental health low intensity services Average cost per PHN commissioned mental health low intensity service Clinical outcomes for people receiving PHN-commissioned low intensity mental health services	CESPHN
Children and Young People	• Commission headspace centres to provide youth mental health services in	Young people accessing headspace Centres are receiving care and support	Proportion of regional youth population receiving youth-specific	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	line with the headspace model framework and within a stepped care approach. • Monitor early intervention activities for young people with or at risk of severe mental illness in the primary care setting • Commission pathways for assessment and treatment of children and young people within a stepped care model, including psychological support services. • Explore ways to increase workforce capacity in particular increase the number of child mental health professionals in the region	within a stepped care approach to support their needs	PHN commissioned mental health services	
Psychological Therapies for under serviced and/or hard to reach populations	• Provide access to a range of applied psychological therapies for people from under-serviced and/or hard to reach populations • Monitor effectiveness of commissioned services including access to psychological therapies for people from under-serviced and/or hard to reach populations aligned to the needs of the CESPHN region • Promote the expansion of provisional referral pathways across the region to	Mental health needs of hard to reach groups addressed through better targeting of services and introduction of stepped care models Effective stepped care processes demonstrate the incidences of stepping up or stepping down based on the needs of consumers.	Proportion of regional population receiving PHN commissioned mental health services – Psychological therapies delivered by mental health professionals Average cost per PHN commissioned mental health service – Psychological therapies delivered by mental health professionals	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead

	improve utilisation of psychological therapeutic services for underserviced and hard to reach people in the CESPHN region.
	• Workforce development
	  ○ Increase capacity of primary care workforce to refer and provide services within a stepped care approach
	  ○ Promote and increase the number of bi-lingual mental health professionals delivering services across the region
		Referrers and service providers will understand how to navigate, refer to and provide services using a stepped care approach
		
		Provisional referral pathways implemented and utilised across the region
		
		Region has a workforce to provide services to meet the needs of communities.
			Clinical outcomes for people receiving PHN commissioned Psychological therapies delivered by mental health professionals.	

Severe and Complex Mental Illness	• Monitor the new service model Primary Integrated Care Supports (PICS) against the program aims and objectives
	  ○ Multidisciplinary teams, including a peer workforce to provide coordinated care across the CESPHN region
	  ○ Promote inclusion of peer workforce in PICS model to mental health nurses in the CESPHN region though educational activities
		Improved care coordination for individuals experiencing severe mental illness
		
		Increased number of people who have a nominated GP
		
		Increased number of clients who attend physical health checks
		
		Improved access to services for CALD communities in the region
			Proportion of regional population receiving PHN-commissioned mental health services – Clinical care coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses).
			
			Average cost per PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness.	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	○ Improve Access to Free psychiatric services for people experiencing Severe mental illness but are unable to pay • Shared Care arrangements between LHDs and GPs improve physical health outcomes of mental health consumers along with mental health needs being met	Increased choice and control of services consumers have access to. Access to psychiatric services under the PICS model		
Suicide Prevention	• Workforce development ○ Increase the capacity of the primary care workforce to assess and respond to those at risk of suicide ○ Including General Practice workforce in suicide prevention initiatives ○ Focus on young people through headspace Centres • Monitor Service Delivery Model – Coordinated After Care against program aims and objectives • Deliver psychological therapies targeting suicide prevention	Improved access to suicide prevention support through primary health care Services delivered to meet needs of the population	Number of people who are followed up by PHN-commissioned services following a recent suicide attempt.	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Aboriginal and Torres Strait Islander Health Mental health	• Target services to meet the needs of Aboriginal youth • Assess the effectiveness of Youth Health and Wellbeing Coordinators in the La Perouse area to engage and support young people to access culturally appropriate mainstream services • Build community capacity to support health and wellbeing • Assess effectiveness of Aboriginal outreach worker to engage and support young Aboriginal people to access services at headspace Ashfield • Ensure Psychological Therapies are delivered with cultural appropriateness to Aboriginal and/or Torres Strait Islander people	Services address the health and wellbeing needs of the Aboriginal communities	Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate.	PHN, LHDs, ACCHO
Stepped Care	• Explore the development and implementation of a stepped care approach to mental health across the region • Workforce Development: ○ Increase the capacity of the primary care workforce to assess, navigate, refer and	Clear and accessible pathways to care for mental health concerns at all levels of intensity/acuity Referrers and service providers will understand how to navigate, refer to	Proportion of PHN flexible mental health funding allocated to low intensity services, psychological therapies and for clinical care coordination for those with severe and complex mental illness	CESPHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	provide services within a stepped care approach ○ Ensure the primary care workforce has access to training to ensure competence in cultural appropriateness, trauma informed practice and other areas of practice as identified	and provide services using a stepped care approach		
Older Persons Mental Health	• Expansion of Beyond Blue New Access coaching program to include older people within aged care facilities (RACFs)	Increased awareness and uptake of low intensity services for this population group	Proportion of older people receiving PHN commissioned Psychological therapies delivered by mental health professionals.	
Rural health (LHI and NI)	**Norfolk Island** · Monitor implementation of 3 stage Norfolk Island Health Promotion Plan - Enhancing Health and Wellbeing Knowledge and Awareness • Enhance health and wellbeing knowledge and awareness • Commission roles of Health and Wellbeing Coordinator and Child, Youth and Family Clinician	**Norfolk Island** Increased awareness of health and wellbeing and active help seeking by the community to access supports.	Number and type of health promotion activities Number of people accessing services provided by Child, Youth and Family Clinician	CESPHN SESLHD

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Building positive attitudes: Creating awareness and influencing behaviour			
Digital Health	• Work with digital health team to ensure all commissioned providers are aware of the My Health Record changes and can explain these changes confidently to consumers.	Region is ready for the My Health Record implementation		
Workforce	▪ Workforce development and capacity is an important consideration to providing appropriate services to communities, in particular to those who are vulnerable and may have barriers to accessing support. Therefore, workforce needs have been identified across priority areas	The region has a workforce who understand how to navigate, refer to and provide services using a stepped care approach in a culturally appropriate way.		

Section 5 - Checklist

This checklist confirms that the key elements of the needs assessment process have been undertaken. PHNs must be prepared, if required by the Department, to provide further details regarding any of the requirements listed below.

Requirement	✓
Governance structures have been put in place to oversee and lead the needs assessment process.	✓
Opportunities for collaboration and partnership in the development of the needs assessment have been identified.	✓
The availability of key information has been verified.	✓
Stakeholders have been defined and identified (including other PHNs, service providers and stakeholders that may fall outside the PHN region); Community Advisory Committees and Clinical Councils have been involved; and Consultation processes are effective.	✓
The PHN has the human and physical resources and skills required to undertake the needs assessment. Where there are deficits, steps have been taken to address these.	✓
Formal processes and timeframes (such as a Project Plan) are in place for undertaking the needs assessment.	✓
All parties are clear about the purpose of the needs assessment, its use in informing the development of the PHN Annual Plan and for the department to use for programme planning and policy development.	✓
The PHN is able to provide further evidence to the department if requested to demonstrate how it has addressed each of the steps in the needs assessment.	✓
Geographical regions within the PHN used in the needs assessment are clearly defined and consistent with established and commonly accepted boundaries.	✓
Quality assurance of data to be used and statistical methods has been undertaken.	✓
Identification of service types is consistent with broader use – for example, definition of allied health professions.	✓
Techniques for service mapping, triangulation and prioritisation are fit for purpose.	✓
The results of the needs assessment have been communicated to participants and key stakeholders throughout the process, and there is a process for seeking confirmation or registering and acknowledging dissenting views.	✓
There are mechanisms for evaluation (for example, methodology, governance, replicability, experience of participants, and approach to prioritisation).	✓