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HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

EXECUTIVE SUMMARY 2017

MENTAL HEALTH AND SUICIDE PREVENTION NEEDS ASSESSMENT

Hunter New England and Central Coast Primary Health Network

ACKNOWLEDGEMENTS

The participation by 782 stakeholders through interviews, focus groups, surveys and an online forum in this needs assessment reflects the strong commitment to improving mental health and to preventing suicide across the HNECC PHN region. Many people contributed willingly to this process with a common aim of trying to improve the mental health of the community. The views of service providers from many different disciplines and organisations who are committed to providing care to people in their communities were greatly appreciated and provided the needed insight into the mental health system. Most importantly we acknowledge the contribution of consumers, carers and community members. Your generosity in providing your mental health experiences has been invaluable and provided insight into the need to improve the mental health system to better meet your needs.

NEEDS ASSESSMENT TEAM

The preparation of this Mental Health and Suicide Prevention Needs Assessment has been undertaken as a collaborative project between the Hunter New England and Central Coast Primary Health Network and Consan Consulting. The team from the Hunter New England and Central Coast Primary Health Network included Jane Mendelson, Brooke Kelehear, Katrina Wallace and Karen Morris. Scott White and Kevin Rigby have supported communication and the consultation approaches used in the needs assessment. The Consan Consulting team included Robyn Considine, Dr Kate Davies, Dr Tonelle Handley and Dr Jane Rich.

This is an Executive Summary of the Needs Assessment Findings, the complete report can be found on the website **hneccphn.com.au**

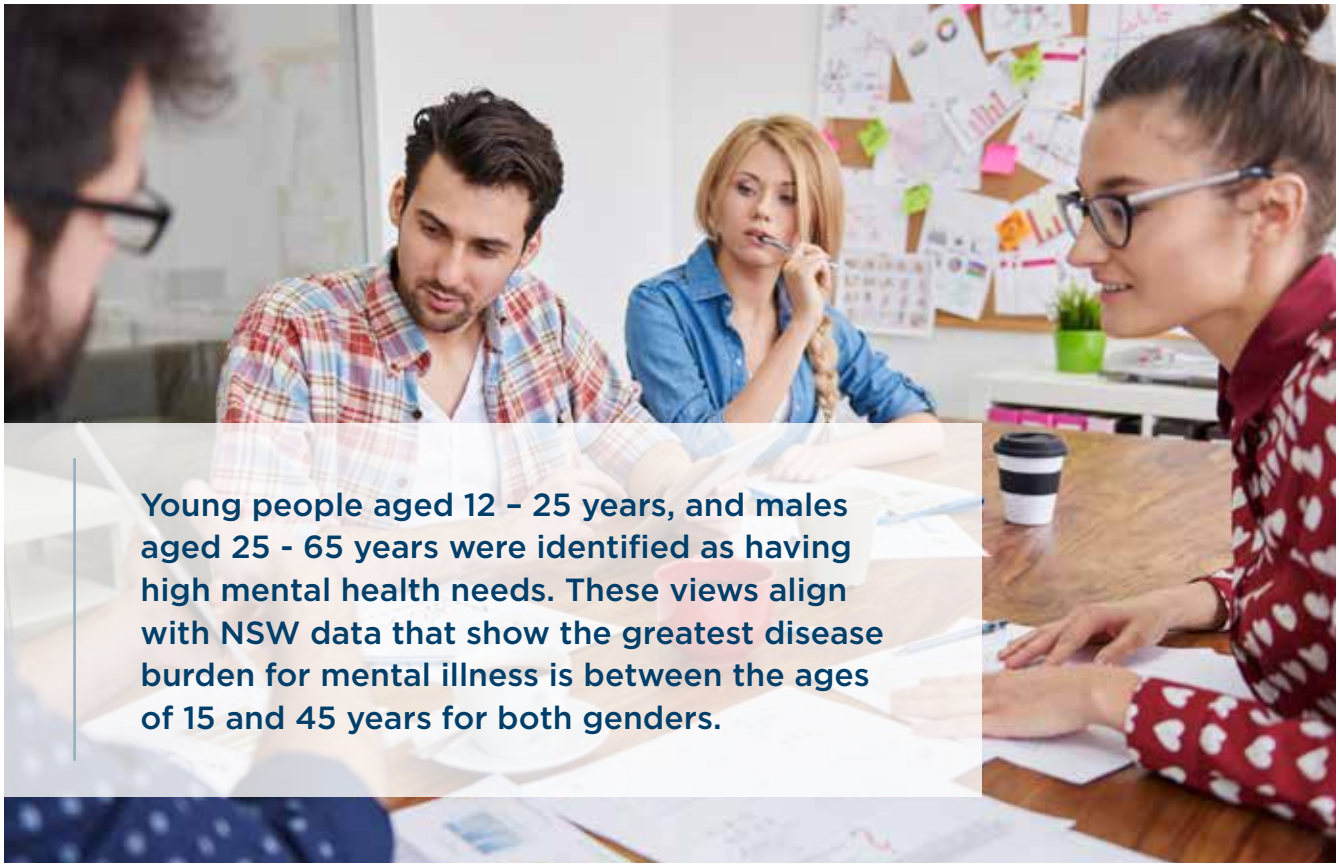
EXECUTIVE SUMMARY

Mental illness is a significant contributor to the disease burden in Australia. The systems for promoting mental health, preventing mental illness and suicide, and providing care for those experiencing mental illness need strengthening, with the primary health care sector playing a central role. Primary Health Networks are well placed to realise opportunities to facilitate a stronger mental health care system to better provide care to meet community needs.

This needs assessment is a key element in the role of Hunter New England and Central Coast Primary Health Network (HNECC) in leading mental health and suicide prevention planning and integration at a regional level. It aims to identify gaps and opportunities for the efficient commissioning and targeting of primary mental health services. Further, it will inform the development of regional mental health and suicide prevention plans to guide and support an improved and integrated mental health system.

Reviews of literature for mental health burden of illness, service models and barriers guided the needs assessment. Quantitative analysis of prevalence, morbidity and mortality data for the region and where possible by local government area was undertaken by HNECC. Qualitative methods were used with interviews and surveys of key stakeholders across all local government areas. Data from both these methods were triangulated to identify priority mental health, suicide prevention and service needs. The HNECC Clinical Councils and Community Advisory Committees were involved through consultations and in the validation of the priority needs.

The identified needs guided the development of 39 recommendations, which provide an opportunity to inform the development of integrated services to meet the needs of communities across the HNECC PHN region. The strength of this needs assessment is in the consistency of findings between the quantitative and qualitative methods, and the commitment of stakeholders to willingly share their views on mental health and suicide prevention needs. This needs assessment has built high expectations that mental health and suicide prevention services can be improved to meet the identified priorities with effective planning as the key first step.



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Mental Health Needs

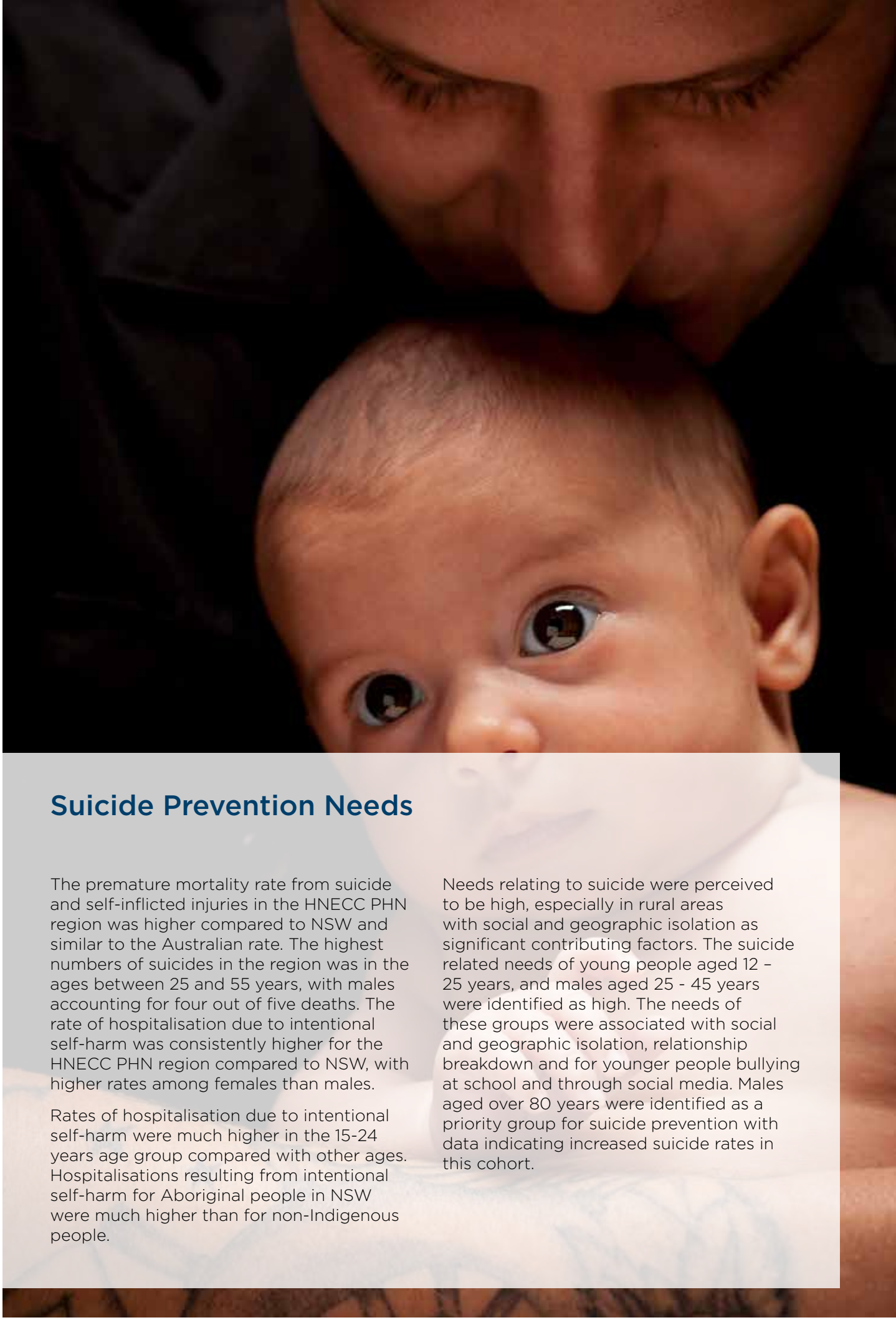
As reflected in national data, the most common mental illnesses experienced by people in the HNECC PHN region were depression, anxiety and drug and alcohol misuse. The rate of people experiencing psychological distress and chronic mental and behavioural disorders was higher across the HNECC PHN region compared to NSW and Australia. The levels of high psychological distress were higher for males, whilst levels of very high psychological distress were higher for females.

Data showed that those people experiencing mental illness were more likely to also have a range of chronic health problems. People experiencing moderate to severe mental illness, including episodic and chronic mental illness, and those experiencing other health and social complexities, were identified by stakeholders as having high needs across all local government areas.

The mental health needs of Aboriginal and Torres Strait Islander peoples were consistently high across the HNECC PHN region. In NSW, the prevalence of psychological distress was nearly three times higher in Aboriginal people than in non-Indigenous people. The impact of intergenerational trauma for Aboriginal and Torres Strait Islander peoples, including the impact on family functioning, drug and alcohol use and domestic violence was identified as contributing to these high needs.

Young people aged 12 – 25 years, and males aged 25 - 65 years were identified as having high mental health needs. These views align with NSW data that show the greatest disease burden for mental illness is between the ages of 15 and 45 years for both genders. Common across these age groups were factors associated with family dysfunction, social and geographical isolation, drug and alcohol use, and for young people the impact of bullying. Factors such as grief and loss, adjustment to life in aged care facilities, and social and geographic isolation were factors contributing to the high needs of males aged over 80 years and of people residing in aged care facilities.

The needs of lesbian, gay, bisexual, transgender, intersex and questioning people were identified as high with associated factors including stigma, discrimination, and community and service awareness and respect.



Suicide Prevention Needs

The premature mortality rate from suicide and self-inflicted injuries in the HNECC PHN region was higher compared to NSW and similar to the Australian rate. The highest numbers of suicides in the region was in the ages between 25 and 55 years, with males accounting for four out of five deaths. The rate of hospitalisation due to intentional self-harm was consistently higher for the HNECC PHN region compared to NSW, with higher rates among females than males.

Rates of hospitalisation due to intentional self-harm were much higher in the 15-24 years age group compared with other ages. Hospitalisations resulting from intentional self-harm for Aboriginal people in NSW were much higher than for non-Indigenous people.

Needs relating to suicide were perceived to be high, especially in rural areas with social and geographic isolation as significant contributing factors. The suicide related needs of young people aged 12 – 25 years, and males aged 25 - 45 years were identified as high. The needs of these groups were associated with social and geographic isolation, relationship breakdown and for younger people bullying at school and through social media. Males aged over 80 years were identified as a priority group for suicide prevention with data indicating increased suicide rates in this cohort.

Service Needs

The findings of this needs assessment have identified service gaps and barriers to access for people experiencing mental illness and suicidal ideation across all communities.

Overnight hospitalisations for mental illness in the HNECC PHN region vary across the region but occur at a rate higher than the Australian average. This occurred for anxiety and stress disorders, bipolar and mood disorders, depressive disorders and for drug and alcohol use. The hospitalisation rate for schizophrenia and delusional disorders was lower than the Australian rate.

Prescribing rates for medication to treat mood disorders, anxiety and for psychotic symptoms vary across the HNECC PHN region, however rates in many communities are in the highest deciles for prescribing in Australia. Reasons for this vary but may be related to a range of community and social factors, service access and prescribing practices of GPs and psychiatrists.

Distribution of primary mental health care service providers (GPs, allied health providers) and the patient provider ratio varied across the HNECC PHN region irrespective of rurality. Similarly, there was significant variation in the patient to provider ratio for psychiatry and psychology services, with lower rates more likely in rural areas.

Services for people experiencing moderate to severe chronic mental illness, including those with other complex problems, were identified by key stakeholders as the priority service need across all communities. In line with the service data, access to psychiatrists

and psychologists across the region, especially in rural areas, was a high need with costs due to gap payments for these clinicians, a significant barrier to care. Access to psychiatrists was identified as a high need for adults, especially in rural areas, and for children and young people across the HNECC PHN region. Transport in urban and rural areas was a significant barrier to care, with public transport limited or unavailable in many communities.

The lack of early intervention approaches and services was identified as a high service need, especially for young people. Specific early intervention services such as those for early psychosis was identified as a particular need. More broadly the need for early intervention approaches across all services with the aim of preventing hospital admissions was recognised. However, services currently apply the opposite approach with people experiencing deteriorating mental illness having limited access to services that could intervene to prevent admission to acute services.

Consistent with findings at a national level, the current mental health service system is perceived as not supporting integrated and collaborative care. This severely impacts on the quality of, and access to, care. With significant changes in services over the last decade there is a perception of instability in the service system, further contributing to the perceptions of access problems. This also limits the capacity of community members and service providers to navigate the mental health system. Integrated planning across the mental health system was identified as a priority to address these service needs.

With general practice playing a central role in mental health care, the capacity of this key service to provide care for people with mental illness was a high priority service need. Specific areas of capacity which needed strengthening included training for GPs in mental health with a focus on skills, knowledge and attitudes towards mental illness across the age group; and improving the capacity of general practice to provide care through practice nurses and allied health staff. Associated with these priorities was the need to strengthen the capacity of services to recruit and retain allied health staff to provide care in general practice and in community services.

The need to strengthen the capacity of community based social support services to provide care for people with severe mental illness and other complexities, was recognised as a priority. This need required strengthening of the approaches to quality and governance across all health and social services; and ensuring staff in these services have the knowledge and skills to provide support to people experiencing mental illness. It also requires staff to understand their scope of practice and for services to have clear protocols and pathways in place for escalating those with deteriorating mental illness to clinical care.

The availability of mental health promotion and prevention services was a key service gap. In particular, the need to ensure evidence-based and systematic approaches to mental health promotion and prevention was a priority.

Support for families and carers of people living with mental illness was a high need. This was about providing direct support, but more importantly recognising and respecting the key role that families and carers play in caring for people experiencing mental illness, and involving them in decision making about care.

The service needs identified for suicide prevention were related to ensuring those people at risk were identified across the service system, with support services in place when and where they were needed. The fact that many people who attempt or complete suicide have little or no contact with services prior to the event, warrants greater attention on risk factors across the service system and across the community. Supporting community and service based approaches to suicide prevention is a high priority. Whilst some communities have developed post suicide intervention strategies and services, there is a high need to strengthen these post-vention strategies.

RECOMMENDATIONS

Priority Groups

1. In developing regional plans recognition should be given to:
    a. Priority population groups identified in this needs assessment:
        i. Aboriginal and Torres Strait Islander people
        ii. Young people aged 12 – 25 years
        iii. Males aged 25 - 65 years
        iv. Males aged over 80 years
        v. Older people residing in aged care facilities
        vi. Members of the LGBTIQ community
    b. Priority groups in relation to mental illness identified in this needs assessment:
        i. People experiencing chronic and episodic moderate to severe mental illness
        ii. People experiencing chronic and episodic moderate to severe mental illness and other health and social problems
        iii. People experiencing early psychosis
    c. Priority groups in relation to suicide prevention identified in this needs assessment:
        i. Aboriginal and Torres Strait Islander people
        ii. Young people aged 12 – 25 years
        iii. Males aged 25 - 65 years
        iv. Males aged over 80 years
        v. People with previous suicide attempts
2. HNECC should ensure that services commissioned by HNECC demonstrate the appropriate targeting of these priority groups and report on activity and outcomes in relation to these priorities.

Addressing Factors Associated with Mental Illness and Suicide

3. In order to provide holistic care and to support early intervention, the factors associated with mental health and suicide reported in this needs assessment need to be identified in regional plans, service plans and in client health care plans with strategies to address factors including:
    a. Stigma associated with help seeking
    b. Social and geographic isolation
    c. Trauma (including intergenerational trauma)
    d. Cultural safety
4. All services commissioned by HNECC should demonstrate that they are culturally safe and have implemented cultural safety strategies to support access and care for Aboriginal and Torres Strait Islander peoples
5. In line with the RACGP standards for general practices, HNECC should build the capacity of general practices to provide respectful and culturally appropriate care
6. Supported by capacity building strategies, services commissioned by HNECC should ensure compliance with the National Mental Health Standards "Diversity Responsiveness" by accounting for the cultural and social diversity of consumers and meeting their needs and those of their carers and community throughout all phases of care including for:
    a. Aboriginal and Torres Strait Islander people
    b. Culturally and Linguistically Diverse (CALD) people;
    c. Those with different religious and spiritual beliefs
    d. People with differences in gender and sexual orientation
    e. People with physical and intellectual disability
    f. People across ages and socio-economic status
7. HNECC and services providers should monitor and manage the significant barrier to accessing services presented by the cost of services, and ensure services for mental health and suicide prevention are provided in communities where gap payment is not a condition of service
8. Options for addressing the significant barrier of transport to specialised services should be explored in the regional plans
9. Strategies to support national campaigns addressing stigma at a local level should be explored by HNECC and other services across the service system
10. Strategies to overcome stigma barriers encountered by people experiencing mental illness when accessing community transport need to be implemented

Frameworks and Models of Care

11. The HNECC stepped care framework, which reflects evidence and national and state mental health policies should form the basis of service models and should inform regional plans
12. Decisions on commissioning of services should reflect the principles outlined in this report for addressing mental health and suicide prevention
13. Early intervention is a priority for improving mental health outcomes and is applicable across:
    a. All stages of life
    b. All mental illness categories
14. The hub and spoke model, which supports integrated care between main referral sites (hubs) and those in outlying communities (spokes) should form the basis of service delivery for mental health care
15. From the perspective of HNECC, consideration should be given to applying the hub and spoke model in service planning and commissioning with alignment against LHD clusters, where this fits with program objectives
16. The population health needs of communities should guide the planning and delivery of services across the mental health system
17. Mental health prevention and promotion, and suicide prevention should reflect evidence based frameworks with an emphasis on strategies which are broader than education and training
18. Mental health promotion and prevention, and suicide prevention strategies should be implemented across sectors including:
    a. Youth specific services
    b. Education and training sectors
    c. Community and sporting groups
    d. Workplaces
    e. Aged care facilities
    f. General health system
19. The capacity of communities to implement evidence-based post-vention strategies needs strengthening

General Practice

20. The capacity of general practice to play a central role in mental health care needs to be supported through:
    a. Supporting multi-disciplinary teams including mental health nurses to work in general practice improve patient access and outcomes
    b. Education and training of GPs particularly in relation to evidence based guidelines and stigma
    c. Access to specialist advice for GPs when needed
    d. Support for GPs in developing and monitoring mental health care plans
    e. Access to allied health staff in local communities to support clinical care and case management
21. HNECC should advocate for simplifying the credentialing processes for mental health nurses to work in general practice
22. The stability of the mental health support service system and the associated pathways to care should be a priority to support the central role of GPs in mental health care
23. Direct twenty-four-hour access to psychiatrists for GPs in rural towns and other communities where there are no acute facilities should be provided.

Service Gaps

24. Strategies to address the gap in services for people experiencing chronic and episodic moderate to severe mental illness including those with other health and social problems is a priority
25. To address the priority gap for people experiencing chronic and episodic moderate to severe mental illness there is a need to:
    a. Reduce waiting times and cost barriers for psychiatry across communities
    b. Improve patient and service provider experience of the mental health line
    c. Provide greater access to experienced psychologists across communities
    d. Apply assertive and proactive case management and follow-up
    e. Reorient services to keep people out of acute settings rather than the current system which channels people to the acute setting due to a lack of services
    f. Ensure patient and service provider experience is routinely measured and monitored
26. Services for early psychosis should be accessible across communities
27. Services to support families and carers should be accessible and promoted across communities
28. Organisations that provide support services to people with mental illness should demonstrate their capacity to access clinical care for clients when symptoms are escalating. This could occur through partnerships, consortia or in-house access to clinicians and requires mechanisms for escalating clients experiencing a worsening of symptoms

Quality and Effectiveness

29. All services should be required to demonstrate an approach to quality through the development, implementation, monitoring and evaluation of:
    a. Service improvement plans
    b. Clinical governance frameworks
    c. Case review policies and procedures
    d. Clinical supervision
30. Commissioning of services by HNECC should reflect the need for an approach to quality, requiring services to demonstrate this commitment as an element of key performance indicators
31. In ensuring an approach to quality, commissioning of services should consider the service model, and discipline and experience of staff
32. The capacity of services to develop and implement an approach to quality should be strengthened with the aim of developing a consistent approach with tailoring to service types
33. Services should ensure a commitment to measurement and reporting of activity and outcomes in line with the quadruple aims of health care (patient experience, clinician experience, population health outcomes and efficiency)
34. The development of outcomes which are consistent across like services and evidence-based, tailored to services, measured efficiently and able to be used for service improvement and client care should be resourced and implemented

Workforce

35. A focus on building the capacity of mental health service staff to increase the impact of mental health services should be a key feature of regional plans
36. Services should be required to demonstrate that professional development and supervision is accessible to staff, particularly for psychologists
37. Recruitment and retention strategies for allied health staff in services should be implemented in line with a hub and spoke model

Planning and Commissioning

38. In partnership with HNECC, the development of regional plans for mental health and for suicide prevention should involve and be supported by:
    a. Chief Executives of Central Coast and Hunter New England Local Health Districts, their Directors of Mental Health and their cluster managers
    b. Service Managers of other clinical and support services
    c. Private providers including medical specialists, GPs and allied health
39. As part of the regional planning process all participating providers and organisations should demonstrate willingness to reform service models to meet community needs.

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HNECC PHN acknowledges the traditional owners and custodians of the lands that we live and work on as the First People of this Country.

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