Mental Health Regional Plan 2020-2025 incorporating Suicide Prevention

A PARTNERSHIP APPROACH TO REGIONAL MENTAL HEALTH AND SUICIDE PREVENTION

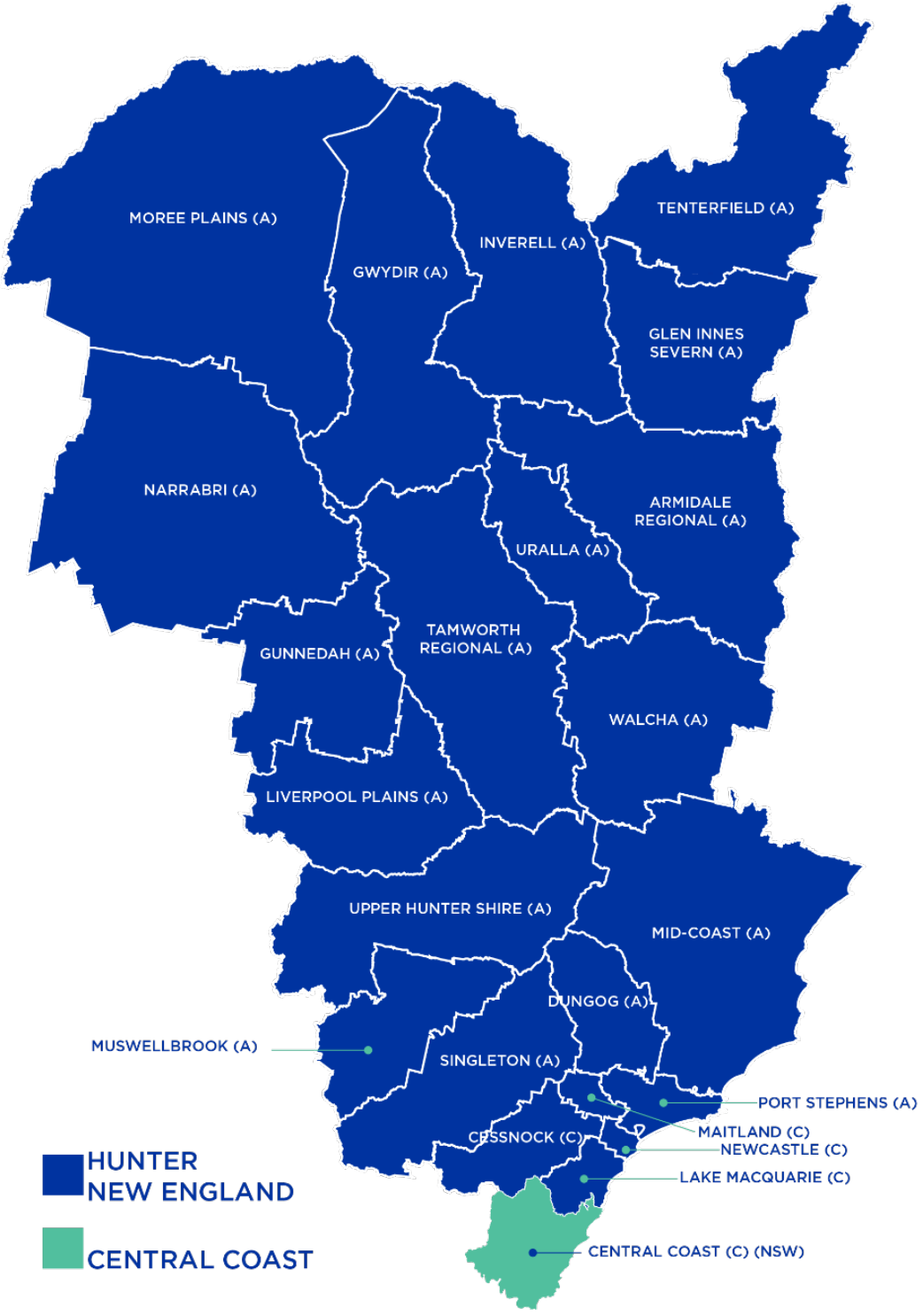
PRIMARY HEALTH NETWORK

phn HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

NSW GOVERNMENT Health
Central Coast
Local Health District

NSW GOVERNMENT Health
Hunter New England
Local Health District

Hunter New England and Central Coast Region



Note: The information contained in this document is a point-in-time snapshot and outlines the joint priorities of the Central Coast Local Health District, Hunter New England Local Health District and the Hunter New England and Central Coast Primary Health Network. We also acknowledge other initiatives between each partner that is occurring outside the joint priorities.

A partnership to address mental health and wellbeing and suicide prevention

This plan has been developed as a partnership between:

- Hunter New England and Central Coast Primary Health Network
- Central Coast Local Health District
- Hunter New England Local Health District.

Our commitment to improving the mental health and wellbeing, and preventing suicide in the communities in our region, is reflected in this regional plan.

Our commitment to Aboriginal and Torres Strait Islander people in our community

We acknowledge the traditional custodians of the land we walk upon today and respect their continuing culture and the contribution they make to the life of this vast region. Aboriginal Nations within the HNECC PHN region include: Anaiwan; Awabakal; Biripi; Darkinjung; Geawegal; Kamilaroi; Kuring-gai; Nganyaywana; Ngarabai; Wonnaru; and Worimi.

We commit to working in partnership with Aboriginal and Torres Strait Islander people to support their mental health and wellbeing in the context of their holistic approach to health.

Our commitment to those with lived experience of mental illness and suicide

We acknowledge people with a lived experience of mental illness, and with a direct experience of suicide, including those who have attempted suicide and those bereaved by suicide. Their voices are crucial in the development, implementation and evaluation of this plan.

We commit to continue to work with people with a lived experience of mental illness and with a direct experience of suicide, and their families and carers. We value their insight, experience and contribution in guiding us to make services and programs better meet their needs.

Foreword

We are committed to improving the health and wellbeing of the Hunter, New England and Central Coast communities as reflected in our existing and future partnerships across a range of health issues. We have a strong commitment to mental health and suicide prevention and recognise the importance of a system-wide approach to better outcomes for individuals and communities.

The 5th National Mental Health Plan, endorsed by the Australian Government and State and Territory Health Ministers in August 2017, requires the development of this plan. One of the eight priorities in this national plan is "achieving integrated regional planning and service delivery". This focus on regional planning supports NSW plans and frameworks such as the NSW Strategic Framework and Workforce Plan for Mental Health 2018 – 2022, requiring integrated regional planning and service delivery as part of the goal for connected care.

Our commitment to consulting with key stakeholders across our region, is demonstrated in the 2017 HNECC PHN Mental Health & Suicide Prevention Needs Assessment with nearly 600 people contributing to its development. This needs assessment provided a foundation for the development of critical services such as those for young people with complex needs and for this plan. Additionally, regional priority setting workshops, local health district activity data and the NMHSPT has informed the plan.

Our partnership goes beyond our three organisations. Since the establishment of PHNs in 2015, we have been working collaboratively with partners such as Aboriginal Health Services, general practice, other primary care and allied health services, and the social support sector, focusing on different health needs and system challenges in our region. Representatives from these services as well as consumers have contributed to the priorities in this plan.

We acknowledge that this plan was developed at a time of significant challenges for communities across the region. While the most recent burden of illness data has been used to guide this plan, it does not reflect these contemporary challenges. Long-term drought, and more recently severe bushfires and storms have placed communities under enormous strain. In early 2020, communities across our region were impacted by the challenges of the COVID-19 pandemic. As well as the significant impacts on those directly affected by this virus, and on our health services, there are challenges for our communities with the social isolation and economic shutdown strategies required to combat this pandemic. The cumulative impact of these external crises and the demand for mental health care requires us to work together to enhance mental health and wellbeing and prevent suicide.

It should also be acknowledged that another challenge facing our ability to address the mental health and wellbeing of the Hunter, New England and Central Coast communities, is the availability of workforce. The availability of General Practitioners, Allied Health Professionals and Specialist Mental Health clinicians remains challenging across the region. This highlights a risk to implementing the plan that can not be ignored.

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Common Terms

Term	Means
Aftercare	Aftercare is designed to increase access to and engagement with care to prevent repetition of suicidal behaviour or self-harm (Sax Institute)
Burden of disease or illness	Burden of disease measures the impact of living with illness and injury and dying prematurely (AIHW)
Carer	People who provide unpaid care and support to family members and friends who have a mental illness.
Chronic disease	Chronic diseases are a broad range of chronic and complex health conditions across the spectrum of illness, which are long-term and persistent (Department of Health).
Clinical Governance	Clinical governance is the systematic approach to ensure the integrity and accountability of health systems, by integrating clinical decision-making within an organisational framework to achieve clinical quality and improved performance (NSW Health).
Co-design	Co-design brings consumers, families, clinicians and staff together to improve health services (ACI)
Commissioning	Commissioning is a strategic, evidence-based approach to planning and purchasing services and is intended to be outcomes-focused, with health services centred on the needs of patients (Department of Health)
Consumer	A person who is currently experiencing or has experienced a mental illness, and has received treatment and support from a GP, public or private mental health service or staff of a community managed organisation (adapted from Mind Australia).)
COVID-19	Coronavirus Disease 2019, as source of 2020 global pandemic
Cross-sectoral approach	Refers to engaging and partnering with multiple sectors such as education, business and industry, employments, private health services and community services to achieve shared goals
Department of Health	Australian Government Department of Health
Integrated Care	Integrated care is about the organisation and delivery of health services to provide seamless, coordinated, efficient and effective care that responds to all of a person's health needs (RACP).
Mental health staff	Refers to clinicians including doctors, nurses and allied health staff, Aboriginal health workers, support workers and peer workers
Ministry of Health	NSW Government Ministry of Health
Models of care	A model of care broadly defines the way health services are delivered, describing best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event (ACI)
Postvention	Postvention is the provision of help and support services to people bereaved by suicide and is a significant form of suicide prevention (AISRPPA)
Primary Mental Health Care	Primary mental health care is a necessary part of comprehensive mental health care, provided at a primary care level and is an essential part of general primary care (WHO 2008).
Psychosocial support services	Psychosocial Support Services helps people with severe mental illness and reduced psychosocial function to build their capacity for daily living and to better manage their mental ill health
Recovery	Recovery of the person cared for is a process of developing a new sense of self, meaning and purpose in life, despite their diagnosis and possible continuation of symptoms and the need for some ongoing support (Mind Australia).

Referral pathways	Referrals pathways outline steps which are required to access all aspects of care across the service system to achieve the desired health outcomes
Stepped Care	Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to the individual's needs (Department of Health)
Stigma	Stigma is a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society (WHO)
Trauma-informed services	Trauma-informed services are aware of and sensitive to the dynamics of trauma as distinct from directly treating trauma (Mental Health Coordinating Council)

Acronyms

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACI	Agency for Clinical Innovation
AHO	Aboriginal Health Organisation
AIHW	Australian Institute of Health and Welfare
AISRPPA	Australian Institute for Suicide Research and Prevention and Postvention Australia
AMS	Aboriginal Medical Service
ANSMHWB	Australian National Survey of Mental Health and Well-being
ATAPS	Access to Allied Psychological Services
ATSI	Aboriginal and Torres Strait Islander Peoples
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Services
CC LHD	Central Coast Local Health District
CMO	Community Managed Organisation
DSM	Dynamic Simulation Modelling
ED	Emergency Department
GP	General Practitioner
HNE LHD	Hunter New England Local Health District
LGA	Local Government Area
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning or Queer
LHD	Local Health District
MBS	Medicare Benefits Scheme
NMHSPF	The National Mental Health Service Planning Framework - a tool designed to help plan, coordinate and resource mental health services to meet population needs.
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NMHC	National Mental Health Commission
NSWMHC	New South Wales Mental Health Commission
PBS	Pharmaceutical Benefits Scheme
PECC	Psychiatric Emergency Care Centre
PHN	Primary Health Network
RPBS	Repatriation Pharmaceutical Benefits Scheme
SEIFA	Socio-Economic Indexes for Areas
SES	Socio-Economic Status
SMHSOP	Specialist Mental Health Services for Older People
WHO	World Health Organization

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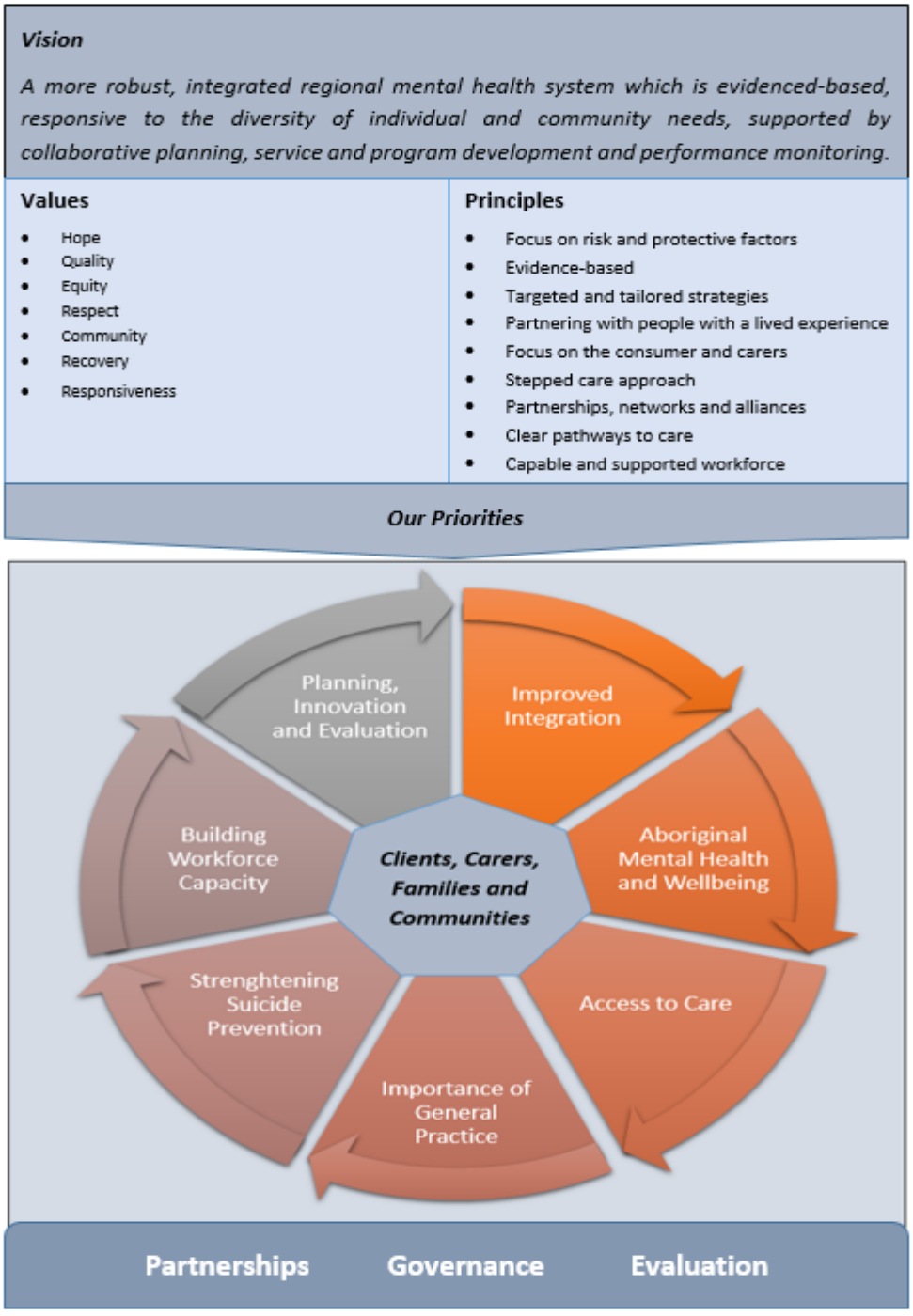
An overview of regional plan

This plan outlines a vision for a more robust, integrated mental health system focusing on seven priorities to improve mental health and wellbeing and reduce suicides across the Hunter, New England and Central Coast regions.

The plan is guided by values and principles which are aligned to national and state mental health and suicide prevention policies. Clients, carers, families and communities are at the centre of the plan, which focuses on seven priorities.



Introduction

The Regional Mental Health and Wellbeing Plan 2020-2025 (regional plan 2020-2025) provides a blueprint for more reliable and integrated mental health services in the Hunter, New England and Central Coast regions. In line with the directions of the Fifth National Mental Health and Suicide Prevention Plan (5th National Plan)[1], this plan acknowledges the need to provide more integrated care, and focus on the fragmentation across the service system to address unmet needs and improve outcomes and experiences of care for individual and communities in our area.

This plan sets out seven priority areas and describes actions required to result in improvements across the service system. It outlines the implementation process, governance, and monitoring and evaluation approach to ensure the realisation of a more robust and integrated mental health system.

Scope

The regional plan 2020-25 is a high-level strategic document that addresses critical priorities for mental health and suicide prevention. The plan encompasses primary mental health care services and the interface with specialist mental health services. It also covers support services outside the mental health sector and aligns with the strategic directions for the 5th National Plan[1] and HNECC PHN Mental Health Needs Assessment[2].

With common principles applicable across both Local Health Districts (LHDs) the plan accounts for differences, with strategies tailored to need across the region.

Plan Aims

The aims of the regional plan 2020-2025 are:

1. To embed integration of mental health and suicide prevention services and pathways for people with or at risk of mental illness or suicide through a whole of system approach
2. To drive and inform evidence-based service development to address identified gaps and deliver on regional priorities.

Achieving these aims will take commitment, innovation and redesign of service delivery models and resources across the service system.

Policy Context

While this plan focuses on the needs of the Hunter, New England and Central Coast regions, it sits within a broader and supportive policy context (Figure 1).

Informed by evidence, at national, state and local levels, the policy context supports regional planning focusing on an integrated mental health system and a coordinated response to suicide prevention.

Figure 1: Policy Overview

The 5th National Plan recognises that PHNs and LHDs provide the core architecture to support integration and planning at the regional level, key to addressing existing fragmentation [1].

To support the national policy requirement for joint regional planning and based on the best available epidemiological evidence, the National Mental Health Service Planning Framework has been developed to guide enhanced tools and resources to be available to PHNs and LHDs to plan and implement a stepped care approach.

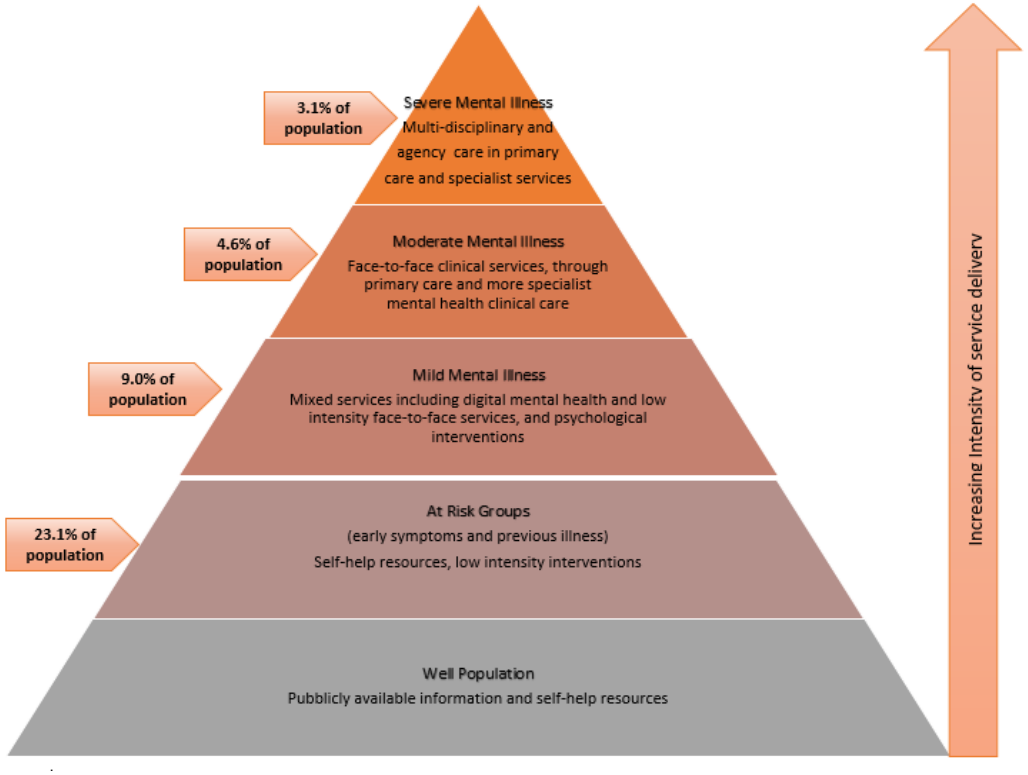
Stepped Care

Empirical evidence as well as key policy documents emphasise integration and coordination across the service system within a stepped care framework[3-5]. Stepped care involves providing person-centred care and is a central platform to guide regional planning, commissioning and coordinating primary mental health care services, and integration across the service system.

Defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, stepped care recognises there are a spectrum of needs, thus requiring a spectrum of clinical, psychosocial support and social support services (Figure 2)[1, 6]. Adapted from the 5th National Plan, Figure 2 describes the levels of care in increasing intensity and provides population estimates of those at each level of care.

A stepped care approach promotes person centred care which targets the needs of the individual. Rather than offering a one size fits all approach to care, individuals will be more likely to receive a service which more optimally matches their needs, does not under or over service them, and makes the best use of workforce and technology. A stepped care approach aims to provide the right service at the right time, with lower intensity steps available to support individuals both before and after the escalation of their symptoms[6]. The stepped care model assumes that a person can move between steps, up or down, dependent on their needs.

Figure 2: Schematic representation of stepped care model



The stepped care model was used to determine key gaps in services in the 2017 PHN Needs Assessment.

The principles of the stepped care model apply to suicide prevention in that evidence-based strategies are tailored to the needs of individuals with suicidal ideation, with increasing intensity of response and the ability to move between levels as key elements of suicide prevention. Australian data[7, 8] suggest a significant proportion of individuals who attempt suicide do not have contact with mental health services prior to the attempt, but may have contact with primary care services and other community supports. In the context of the stepped care model, safety planning for mental health clients and after care for those who have experienced suicide ideation and attempts are the most effective interventions[9]. For the well population and at risk groups, improving social connectedness, access to self-help and community-based supports such as peer workers are potentially the foundations of effective suicide prevention.

Suicide Prevention Frameworks

In 2018 there were 3,046 registered deaths of people due to intentional self-harm (suicide) in Australia[10]. There is a profound impact on family, friends and communities following death by suicide, as well as a high economic cost to our nation. Suicide prevention is everyone's business and requires commitment across sectors and the community[11].

With overarching guiding principles, the Strategic Framework for Suicide Prevention in NSW 2018–2023, sets out five action areas to guide strategies and ultimately achieve its goals[11]:

1. Building individual and community resilience and wellbeing

2. Strengthening the community response to suicide and suicidal behaviour
3. Supporting excellence in clinical services and care
4. Promoting a collaborative, coordinated and integrated approach
5. Innovating for a stronger evidence base.

Aligned to the 5th National Plan, this NSW framework[11] recognises the importance of a systems based approach to suicide prevention and supports community based initiatives to suicide prevention tailored to the local context.

Development of the Plan

Acknowledgement

In developing this plan, we have used the most recent burden of illness data[10, 12-15] to guide needs and responses. Since the publication of this data, our region has experienced significant community-wide challenges including prolonged drought, bushfires, storms and flooding. In 2019, all of our region was impacted by drought, with most areas affected by intense drought[16]. From September 2019 until January 2020, many of our communities were also affected by bushfires, with loss of life, property, and productive and recreational land.

In 2020, all of our communities faced the global challenge of the COVID-19 pandemic. This virus has caused deaths and illness across the region and has resulted in economic shutdown and social isolation to reduce transmission. It also created severe pressures on our health and support services and changed existing models of care.

In combination, these challenges have and continue to affect the mental health of our communities. While the most recent data suggests a significant need in our community, it does not capture the impacts of these challenges. In acknowledging this data limitation, our plan will strive to ensure our services, programs and strategies are responsive to the needs of our communities in these difficult times in the short, medium and long-term.

The development of the plan builds on the foundation of the 2017 Needs Assessment. With nearly 600 people contributing their views about needs, this needs assessment identified critical priorities for mental health and suicide prevention across the region.

There has been progress in service development since this needs assessment which guided the consultation and priority setting process.

Informed by national, state and local policies and the 2017 Needs Assessment the key steps in the development of the plan included (Figure 3):

- A review of burden of illness and service activity data at local government area (LGA) or Statistical Area 3 (SA3) level, where possible
- Consultation and priority setting process with 45 key stakeholders in four communities (Central Coast, Newcastle, Tamworth and Taree)across our region using Menti, a priority setting tool to determine

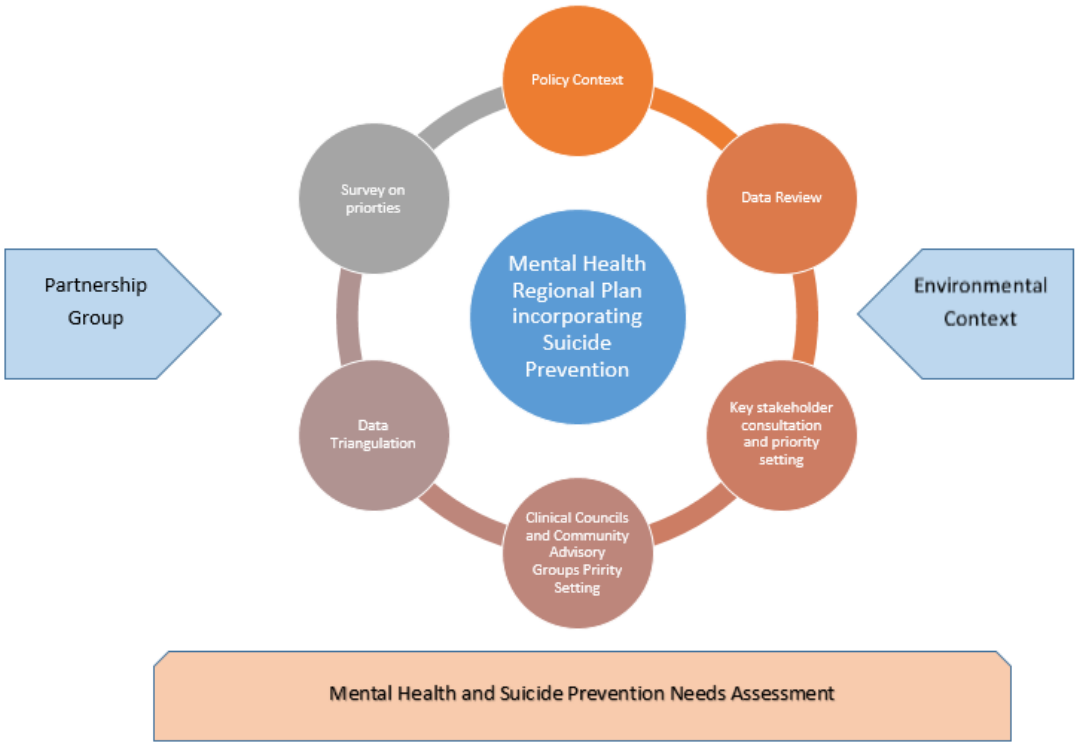
Progress since 2017 Needs Assessment

- Expansion of Headspace into most communities in the region
- Development of youth complex services in 11 communities through co-design processes tailored to each community
- Dynamic Simulation Modelling of Suicide Prevention in collaboration with primary care, specialist and support service providers, other sectors and consumers and carers
- Strengthening the way services in HNELHD engage with people who may be suicidal through redesign with all tiers of staff, consumers and carers
- Building on the Adult Community Mental Health Model of Care with an overarching framework for the delivery of these services in HNELHD
- Strategic approach to strengthening mental health services for children under 12 through cross sectoral partnerships on the Central Coast.

priorities. Key stakeholders were identified by representatives of each of the partner organisations from existing mental health and social support services, and also from consumer groups. The results of these workshops may reflect the interests of the participants.

- Priority setting process with members of the PHN Clinical Councils and Community Advisory Committee
- Triangulation of data to determine key priorities.

Figure 3: Overview of development of the plan



The priorities were critically reviewed by the partnership group and guided the key focus areas and actions for the plan. As a final step, an online survey of key stakeholders (n=84) including consumers, service providers and community members, gathered perceptions of the priorities and focus areas. The results of this survey indicated a high level of agreement with all focus areas under each priority. Comments provided by key stakeholders in the survey also informed actions for each focus area.

The draft plan was reviewed by the partnership group before being finalised and ratified by the Chief Executives of each of the participating organisations.

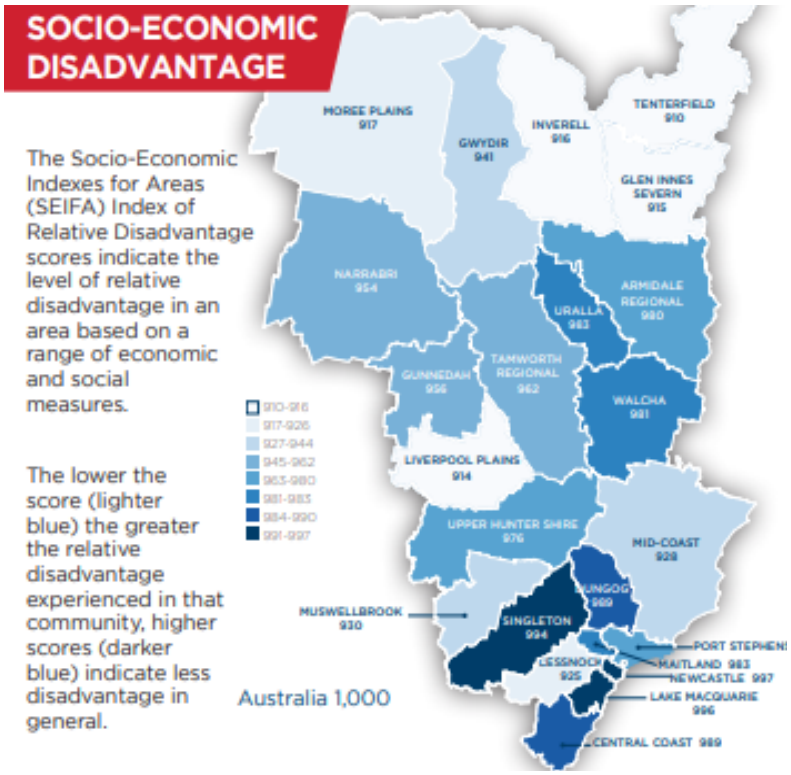
Our Area

The Hunter New England and Central Coast (HNECC) PHN is the second largest PHN in New South Wales by geography, covering 133,812 km2, reaching from just north of Sydney, across the north west of NSW, to the Queensland border. It includes 2 LHDs – Central Coast and Hunter New England, and spans across 23 LGAs and has a mix of metropolitan, regional and rural areas.

Our population

With close to 1.25 million people[17] our population is expected to increase by 19.5% to over 1.4 million by 2031[18]. There are some key population indicators relevant to the mental health and wellbeing of our communities:

- There are 65,515 (5.2% of the population) Aboriginal and Torres Strait Islander peoples, a higher proportion than in NSW and Australia[19]
    - The LGAs with the highest proportion of Aboriginal and Torres Strait Islander peoples include Moree Plains, Gunnedah, Liverpool Plains, Narrabri and Tamworth Regional[19]
    - Aboriginal and Torres Strait Islander peoples, particularly in our rural areas, experience significant disadvantage [19]
- Our population is ageing with 19% aged over 65 years, higher than state and national levels, and this proportion is predicted to increase[18].



- There are LGAs with significant disadvantage in our region based on the Socio-Economic Indexes for Areas (SEIFA), a measure of relative disadvantage[15]
- We have a lower proportion of people from non-English speaking backgrounds compared to state and national levels[15]
- Internet connections, increasingly important in accessing health care are less common in our region with 18.4% of our population not having access to the internet in their homes[15].
- There are limited public and community transport options across our region, including in the more populous LGAs of the Central Coast, Lake Macquarie and Newcastle, and in particular in rural and remote areas. These transport challenges, in combination with distances and geography of our region provide significant barriers in accessing to services.

Other indicators of need

There are other indicators of needs in our region that are associated with mental health and suicide risks:

Employment

Employment in a supportive organisational culture is considered a protective factor for mental illness. People who are currently employed are less likely to experience a mental illness than those who are unemployed[20].

- A higher proportion of the people in our region receive unemployment benefits compared to national levels[15].
- In March 2019, the unemployment rate across the PHN was 5.5%, higher than the state (4.5%) and national (5.2%) levels[15].
- The LGAs with the highest rates of unemployment were Glenn Innes Severn (9.6%), Tenterfield (8.7%) and Moree (8.1%)[15].

Alcohol

People who drink alcohol at risk levels are more likely to have high levels of psychological distress and have a mental illness[21].

- The proportion of the population who consumed alcohol at more than two drinks per day is higher for our PHN (19.5%), compared to state (15.5%) and national (16.15%) rates
    - Five LGAs have more than 25% of their populations drinking alcohol at more than two drinks per day (Gunnedah, Inverell, Liverpool Plains, Moree Plains and Walcha).

- The Central Coast (38.6%) and Hunter New England (36.7%) LHDs ranked second and third of all LHDs (31.5%) in NSW in the proportion of the population that drink alcohol at levels posing long-term risk to health[19].

Domestic Violence

Domestic violence has long term consequences for the physical and mental health of those experiencing this crime[22].

- In 2019, of seven of our LGAs were (Armidale, Gunnedah, Inverell, Muswellbrook, Narrabri, Tamworth Regional and Tenterfield) in the top 25 of all NSW LGAs for the number of recorded domestic violence related assault incidents attended by police[23].
- In 2018-19, the rate per 100,000 people of interpersonal violence-related hospitalisations in our PHN was 77.1/100,000 higher than the NSW rate (61.3/100,00)[19].
- There are LGAs where the rates of interpersonal violence-related hospitalisations are significantly higher than the state levels including Central Coast (74/100,000), Cessnock (89.4/100,000), Lake Macquarie (67.3/100,000), Moree Plains (145.3/100,000), Narrabri (101.8/100,000), Newcastle (92/100,000), Tamworth Regional (116.8/100,00)[19].

Disability

Adults with a disability experience higher rates of psychological distress than people without a disability. Nationally, in 2017-18, 32% of adults with a disability were likely to experience a high or very high level of distress compared to only 8% of people without disability[24].

- In our region, the proportion of people of all ages living with a profound or severe disability (6.6%) is higher compared to state (5.6%) and national (5.4%) levels[15].
- The LGAs with the highest rates of disability include Mid-Coast (8.7%), Cessnock (7.6%), Gwydir (7.5%)[15].

Vulnerable children

Factors such as family functioning, exposure to trauma and violence, and parental mental illness are associated with the mental health and wellbeing of children, and on their developmental outcomes[25]. Children who are exposed to trauma and abuse in childhood are also more likely to experience mental illness as adults[26]. Further, children who experience out-of-home care, and who are considered at risk of harm, are more likely to experience adverse mental health and developmental outcomes[27]. The 5th National Plan acknowledges the importance of a healthy start to life and includes an indicator for developmental vulnerability in the Healthy Start to Life domain[1].

- In our region 9.6% of children are developmentally vulnerable on two or more domains, a rate the same as the NSW rate[15]

- There are 3 LGAs in our region that have close to or more than double the proportion of children who are developmentally vulnerable on two or more domains – Gwydir (17.6%). Moree Plains (18.8%), and Walcha (18.2%)

In 2018, the rate/1,000 population of children and young people in statutory out-of-home care for Central Coast (14.1) and Hunter New England (13.8) were third and fourth highest of all NSW districts, with Aboriginal children relatively more like to experience out-of-home care[28].

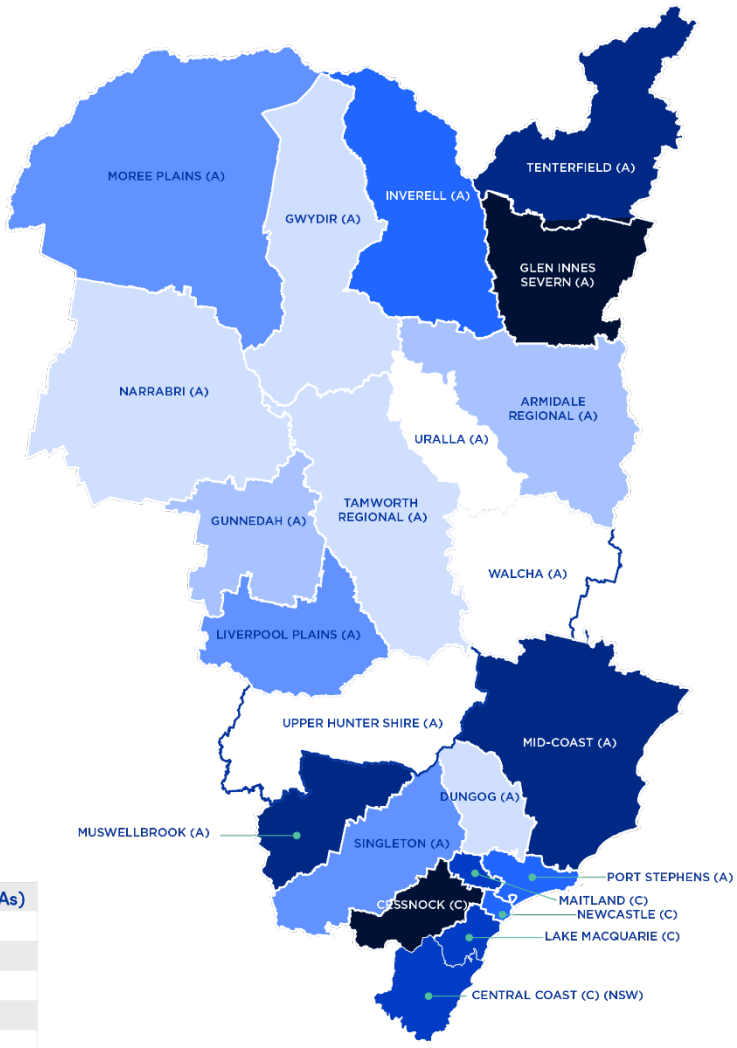
Mental health needs

Mental health data from our region, at LGA, SA3 or regional level indicate a significant need. These needs include:

- In 2017-18, the rate at which adults experienced high or very high psychological distress across our region was higher at 13.5 per 100 than the NSW (12.4) and Australian (12.9) levels[15].
- The majority of LGAs had rates of high or very high psychological distress, higher than the NSW rate. Rates of distress were greatest in Cessnock (16.0), Glen Innes Severn (14.8), Muswellbrook (14.4), Tenterfield (14.0), Mid-Coast (14.0), Maitland (13.8), Central Coast (13.7) and Lake Macquarie (13.5) LGAs[15]. It is noted that there may be differences in levels of psychological distress between Gosford and Wyong that current data do not reflect. Prior to the amalgamation of these two LGAs into the current Central Coast LGA (occurred in 2016), the rate of psychological distress was higher for Wyong (13.8) and was the second highest of all LGAs in our region[2].

Estimated number of people aged 18 years and over with high or very high psychological distress, based on the Kessler 10 Scale (K10) (modelled estimates) 2017-18

LGA	ASR/100
Armidale Regional (A)	12.5
Central Coast (C)	13.7
Cessnock (C)	16.0
Dungog (A)	11.8
Glen Innes Severn (A)	14.8
Gunnedah (A)	12.1
Gwydir (A)	11.7
Inverell (A)	13.3
Lake Macquarie (C)	13.5
Liverpool Plains (A)	13.0
Maitland (C)	13.8
Mid-Coast (A)	14.0
Moree Plains (A)	12.9
Muswellbrook (A)	14.4
Narrabri (A)	11.6
Newcastle (C)	13.2
Port Stephens (A)	13.4
Singleton (A)	12.7
Tamworth Regional (A)	11.8
Tenterfield (A) - part a	14.0
Upper Hunter Shire (A)	11.3
Uralla (A)	11.2
Walcha (A)	9.8



Quantile grouping (equal counts of LGAs)
9.8-11.3
11.4-11.8
11.9- 12.5
12.6-13.0
13.1-13.4
13.5-13.8
13.9-14.4
14.5-16

- In 2017-18, the rate at which people experienced chronic mental and behavioural disorders within the HNECC PHN region was 22.7 per 100 population, higher than the national (20.1) and state rates (18.8). All LGAs in the region experienced levels higher than the national and state rates. HNECC PHN LGAs with the highest rate of people experiencing mental and behavioural problems were Muswellbrook (27.6), Inverell (25.2), Moree Plains (25.2), Cessnock (25.2), Maitland (23.5), Mid-Coast (23.5), Newcastle (23.1), Lake Macquarie (22.8), and Central Coast (22.5)[15]. Differences in rates of chronic mental and behavioural disorders between Gosford and Wyong were also noted prior to LGA amalgamation. In 2014, Wyong LGA had the third highest rate of chronic mental and behavioural disorders of all LGAs in our region[2].
- Data at state or national level indicates there are a number of vulnerable groups (refugees, people from LGBTIQ community and those with a disability) who experience mental health problems at higher rates than the general population.

Perceptions of mental health priorities

Key stakeholders in priority setting workshops ranked their perceptions of mental health needs and mental health target groups. These health areas and target groups were identified from the literature, burden of illness data and the 2017 Needs Assessment[2]. The rank order for mental health areas and target groups from across the region is shown in Table 1.

Table 1: Regional Rank Orders for Mental Health Needs and Target Groups

Mental health area	Ranking	Target groups	Ranking
Moderate-severe mental illness	1	Children and young people	1
People impacted by trauma	2	Aboriginal People	2
People at risk of mental illness	3	People in rural and remote areas	3
People with chronic disease	4	Vulnerable population groups	4
People with eating disorders	5	Males 25-65	5
		Older people 80+	6

It is noted that there was little variation in ranking for mental health areas across all four communities.

Other mental health needs identified through the needs assessment and discussion at priority setting workshops include:

- The needs of children under 12 years of age, as separate from those of young people between 12 and 25 years
- Those who are isolated and experiencing relationship breakdowns
- People impacted by drought and fires, and COVID-19
- The impact of drug and alcohol use on mental health of individuals and communities
- Stigma associated with mental illness and preventing access to care
- Stoicism, especially in rural communities reducing help-seeking
- The impact of unemployment on mental health
- Lack of community connectedness.

Intentional self-harm and suicide in our region

Self-Harm Hospitalisations

- In 2018-19, rates of hospitalisations due to intentional self-harm were higher for the HNECC PHN region compared to the NSW rate for:
    - people of all ages (138.5 per 100,000) compared to NSW (90.7/100,000)
    - young people aged 15-24 years (339.8/100,000) compared to people aged 15-24 years across NSW (225.9/100,00)
    - males and females in both these age categories[19]
- In 2018-19, the rates of hospitalisations due to intentional self-harm in 13 of our LGAs were significantly higher than the state and include (all rates per 100,000 people): Armidale (196.4), Central Coast (121.5), Cessnock (157.6), Glen Innes Severn (161.5), Gwydir (161.5), Inverell (177.4), Lake Macquarie (149.6), Maitland (136.0), Mid-Coast (160.9), Moree Plains (162.8), Newcastle (168.9), Port Stephens (144.3), Tamworth Regional (168.9)[19]
- In NSW, in 2018-19, Aboriginal people had significantly higher rates of intentional self-harm hospitalisations than non-Aboriginal people[19]
- In this same time period in NSW, Aboriginal male youths and Aboriginal men of all ages had almost four times the rate of intentional self-harm hospitalisations than non-Aboriginal men[19]
- Nationally, a higher proportion of members of the LGBTIQ community report high or very high levels of suicidal ideation and suicide attempts compared to heterosexual people[29].

Suicide Rates

- The premature mortality rate from suicide and self-inflicted injuries in the HNECC PHN region is higher than for NSW[19].
- In 2017, there were 195 suicides recorded in the HNECC PHN region, a rate of 15.3 per 100,000 population, which is higher than the rate for NSW (10.8 per 100,000)[19].
    - Central Coast LHD recorded 41 suicides (11.9 per 100,000)
    - Hunter New England LHD recorded 154 suicides (16.5 per 100,000) in 2017[19]
- People living in regional and remote areas have higher rates of suicide. While PHN-level data are not available, 2017 suicide rates are higher in outer regional and remote areas of NSW (19.0 per 100,000) than inner regional areas (15.8 per 100,000) and major cities (9.3 per 100,000)[19].
- Aboriginal people have higher rates of suicide. While PHN-level data is not available, 2012-2016 suicide rates for Aboriginal people living in NSW are 17.1 per 100,000 and the rate for Aboriginal males is 27.7 per 100,000[19].
- Males have higher rates of suicide than females. Across all ages, the NSW 2017 suicide rate for men is 17.1 per 100,000 versus 4.7 per 100,000 for women. Males aged 55-64 years (24.0 per 100,000), 35-44 years (23.7) 25-34 years (22.7), and 45-54 years (22.0) and 75 years and over (21.2) are most at risk of suicide[19].
- The greatest number of suicides in the HNECC PHN occur between the ages of 25 and 55 years, with males accounting for most deaths[13].

Perceptions of suicide priorities

The results of priority-setting workshops determined the rank order for perceptions of suicide prevention target groups and challenges from across the region, as shown in Table 2.

Table 2: Regional Rank Orders for Suicide Prevention Target Groups and Challenges

Target groups	Ranking	Suicide Prevention Challenges	Ranking
Young people	1	Follow-up support for those with suicidal ideation	1
Aboriginal people	2	Follow-up support after presentation for suicide attempt	2
Males 25-65 years	3	Evidence based approaches to suicide prevention	3
People from vulnerable population groups	4	Intersectoral commitment to suicide prevention	4
People from rural and remote areas	5	Community capacity to address suicide	4
Older males 80+ years	6	Evidence-based approaches to post-vention	6

All workshops identified young people as the highest priority for suicide prevention target groups. There was variation in rankings across workshops for other target groups, and for rankings for service challenges.

Other suicide prevention needs identified through the needs assessment and discussion at priority setting workshops include:

- People living in regional and remote areas experience higher rates of suicide and higher risk factors
- People who are isolated and experiencing relationship breakdowns
- People impacted by disasters including drought, fires, flood and the pandemic
- People affected by drug and alcohol abuse
- Lack of evidence-based suicide prevention strategies
- Lack of a systematic evidence-based postvention strategy across our region, including a lack of services or awareness of available services for families, carers, friends and colleagues of people who have attempted suicide or died by suicide.

Comorbidities

Comorbidity is the presence of two or more physical or mental disorders (or diseases) in one person at the same time[30]. Almost all people (94.1%) with a mental and behavioural condition report another co-existing long-term health condition[14].

There is a significant gap in life expectancy between people with a mental illness and the general population, with 80% of this gap attributable to chronic diseases, many of which are preventable[30].

- People with mental illness are more likely also to have a range of chronic health problems and associated risk factors compared to those without a mental illness[30].
- While there have been improvements in morbidity and mortality indicators for chronic disease in the general population over the last few decades, this trend is not observed in people with a mental illness[30].
- There is evidence that people with chronic diseases and mental illness have worse health outcomes, poorer quality of life and incur higher costs associated with treatment[30].

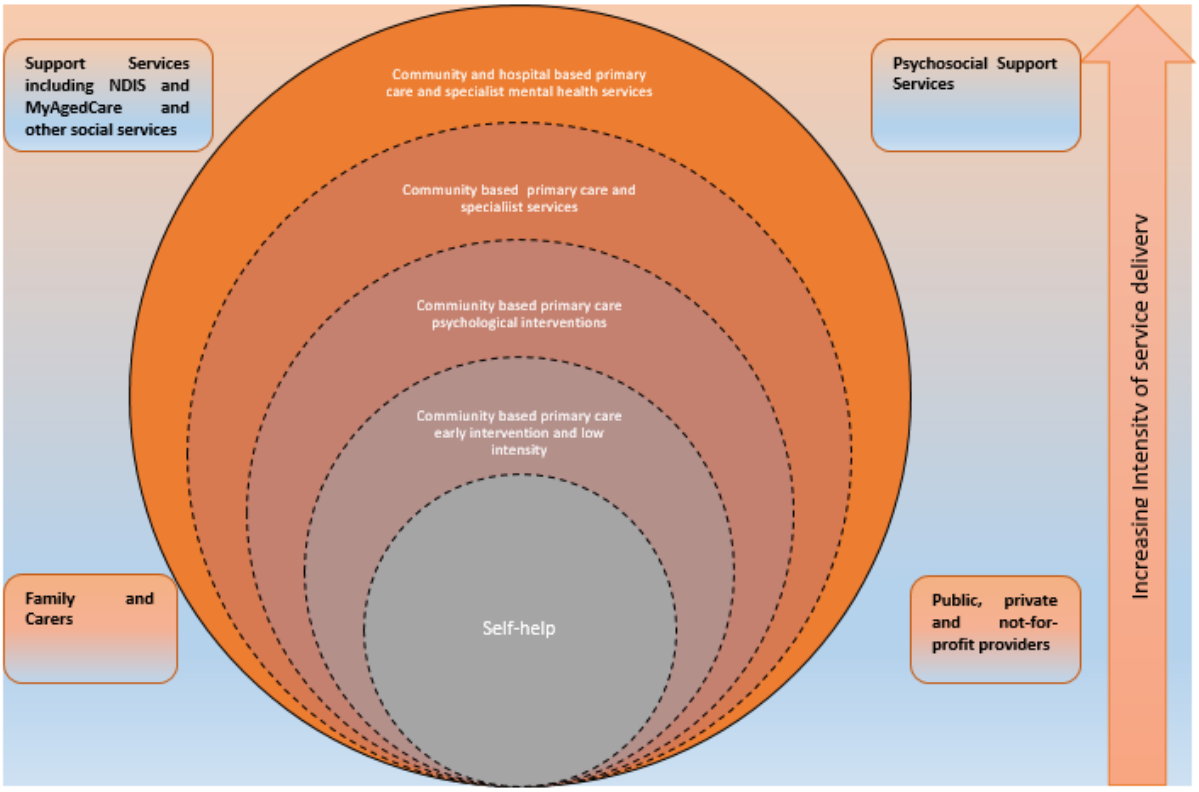
- Stigma also impacts on access to care for chronic conditions for those with mental illness[30].
- Substance abuse problems and mental illness account for 12% of the total burden of disease and is the leading cause of non-fatal burden[12].
- Data from general practices across our region indicated that patients with a record of a mental health diagnosis were: 2.5 times more likely to have an asthma diagnosis; 3.3 times more likely to have a COPD diagnosis; and 2.4 times more likely to have a diabetes diagnosis[2].
- It is estimated that 24.4% of GP patients in our region with a mental health diagnosis recorded also at least one other mental health diagnosis[29].

Mental health service system

The mental health systems comprises a complex mix of specialist and generalist clinical, psychosocial support and social support services. Mental health services and programs are funded through different levels of government. The Australian Government funds various mental health services through the Medicare Benefits Scheme (Medicare), as well as prescriptions through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS)[31]. They also fund other essential support programs and services, some of which are commissioned by Primary Health Networks such as Headspace[12]. These also include income support, social and community support, disability services (including National Disability Insurance Scheme), workforce participation programs and housing assistance[17].

Mental health clinical services are provided in the community and hospital settings. These clinical services are provided as parts of the general practice, public health system LHDs, the private health system and the not-for-profit sector. Key to an effective and comprehensive mental health system is the provision of psychosocial support services, social support services, including those provided by NDIS and MyAgedCare, and the support provided by family members and carers (Figure 4).

Figure 4: Overview of clinical service system



People in our region have access to a variety of services provided by a range of health professional groups in different settings[31]. Common across all levels of the service system for mental health care and suicide prevention, is the provision of care by GPs. GPs are often the first point of contact for people experiencing mental illness and potentially play an essential role in the mental and physical health care of patients and in coordination of their care[31].

State and territory governments fund and provide public sector specialised mental health care services, including admitted patient services in hospitals and those delivered in community settings. They also fund additional programs and support services, often delivered by the non-government sector[31].

Primary Care

Primary mental health care is a necessary part of comprehensive mental health care, provided at a primary (frontline) care level and is an essential part of general primary care. It involves diagnosing and treating people with mental disorders; putting in place strategies to prevent mental disorders; and ensuring that primary healthcare workers are able to apply key psychosocial and behavioural science skills to improve overall health outcomes for patients and their families[32]. The role of primary mental health care is complementary with tertiary and secondary level mental health services for people requiring more specialised mental health care[32].

In addition to GPs, there is a range of other primary mental health care services. These services are provided by private and not-for-profit individuals and organisations including allied health professionals, midwives, pharmacists, dentists, and Aboriginal health workers. HNECC PHN commissions primary care services for mental health and wellbeing across the region including:

- Primary Health Network Mental Health Service (PHNMHS) for people with mental illness or the provisional diagnosis of mental illness in a primary care setting where other pathways such as MBS (Better Access) initiatives are cost prohibitive or not available and allows access to short-term evidence-based psychological interventions
- Clinical Care Coordination is for people with a diagnosed complex and enduring mental illness along with associated factors that significantly impact their social, personal and work life, and who have been to hospital at least once for treatment of their mental illness, or are at risk of needing hospitalisation in the future if appropriate treatment and care is not provided.
- Psychological Interventions for people in Residential Aged Care Facilities delivers evidence based psychological intervention, delivered as low intensity, psychological therapy or clinical care coordination to people living in a Commonwealth Funded Residential Aged Care Facilities.
- Psychosocial Support Services (PSS) across the region, delivering non-clinical services to people with severe mental illness to help build functional capacity to enable personal recovery
- Access and referral services across the region to improve and increase the levels of support for patients eligible to receive funded primary mental health care services
- Headspace, with four main centres, and satellites or outreach services provided in most LGAs across the region is the National Youth Mental Health Foundation providing early intervention mental health services to 12-25 year olds, along with assistance in promoting young peoples' wellbeing
- Youth complex services are provided in 11 LGAs across the region for young people with moderate to severe and complex mental illness with two additional services expected to open in late 2020 or early 2021

LHD Mental Health Services

The LHDs in our region provide care for people with moderate to severe mental health issues.

Central Coast

Central Coast LHD provides a range of specialist services. There are two inpatient adult facilities, at Gosford (30 beds) and Wyong (35 beds), with a specialist inpatient service (Mir Miri – 15 beds) for those over 65 years at Wyong. There is a 4 bed PECC Psychiatric Unit that provides emergency care for up to 48 hours, also located at Wyong. At both Gosford and Wyong Hospitals Emergency Department Mental Health teams provide acute mental health assessment. The Mental Health Telephone Access Line (MHTAL) provides an access and intake point into Mental Health Services.

Central Coast LHD also delivers a range of services in the community, with their services structured for different age groups including:

Children and Young People

- Community based multidisciplinary service for children and young people aged 12 to 24 years with mild to moderate mental illness
- Limited services for children under 12 years including early intervention programs, family recovery and perinatal infant mental health
- Headspace sites at Lake Haven and Gosford, incorporating youth complex connecting care program

Adults

- Acute care teams are located in both the north and south parts of the Central Coast
- Care Coordination Team providing support through recovery
- Assertive Outreach Team providing intensive community-based rehabilitation
- Eating Disorders community-based service

Older People

- Community teams based at the north and south of the Central Coast providing case management
- Behaviour Assessment and Intervention Service (BASIS) provides assessment and behaviour management strategies for people living with severe and persistent behavioural and psychological symptoms

There are several services and programs provided in the community by Central Coast LHD including:

- Specialist Rehabilitation Clinicians with two clinicians
- Eating Disorders Service
- Aboriginal Mental Health Team
- Peer support workers
- Partnership program
- Mental Health Promotion

There are no psychiatric intensive care beds on the Central Coast with patients requiring this level of care admitted to services in Hornsby. There are no adult rehabilitation or long-stay beds for mental health, nor inpatient Mental Health beds for children and adolescents on the Central Coast. Significant gaps also exist in inpatient care with no provision for people with comorbid mental health and intellectual disability, head injury or dementia specific units.

Hunter New England

HNE Mental Health delivers a range of inpatient services and community mental health care, from prevention and early intervention to treatment, rehabilitation and continuing care across the Hunter New England Health District. Acute inpatient services are provided in Newcastle (Mater Campus-100 beds), Maitland (24 beds), Taree (24 beds), Tamworth (25 beds), and Armidale (8 beds). Included in the services at the Mater Campus are the Psychiatric Emergency Care Centre, Mental Health Intensive Care unit along with specialist units for older persons and those with substance abuse problems. There is also an inpatient unit for older people with dementia at Tamworth (16 beds).

Inpatient beds for children and young people are provided at the Nexus unit (12 beds) at John Hunter Hospital (JHH) in Newcastle, serving the whole of the northern region. Inpatient services for older people with dementia and other age-related mental illnesses are provided at the Mater Campus and Tamworth (16 beds).

Inpatient rehabilitation is provided at the Morisset Campus (130 beds plus 30 bed secure facility) and the Intermediate Stay Mental Health Unit (20 beds) at the James Fletcher Campus. Morisset also hosts a 12-bed Neuropsychiatry unit.

Community Services, both acute and rehabilitation, for adults are provided across the region using a number of modalities including outreach and telehealth. Community services for children and young people are also located across the District.

Community-based services are provided for children and young people, adults and older people across the region in larger rural centres and by outreach and telehealth to smaller towns. There are also a number of services and programs provided in the community by Hunter New England LHD including:

- Mental Health and Substance Use
- An early psychosis program
- Perinatal services
- Neuropsychiatry outpatient clinic
- Consultation liaison psychiatry
- Centre for Psychotherapy
- Forensic services
- Aboriginal mental health services for young people and adults
- Mental Health and Intellectual Disability.

Aboriginal Community Controlled Health Organisations

Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community[33].

While distinct from each other social and emotional wellbeing and mental illness are interlinked for Aboriginal people.

There are 9 Aboriginal health services located in the areas of our region identified in (Table 3)[34]

Table 3: Aboriginal Health Services in our region

Area	Aboriginal Health Service
Central Coast	Yerin Aboriginal Health Services, Wyong
Hunter	Ungooroo Aboriginal Corporation, Singleton
	Awabakal Newcastle Aboriginal Cooperative, Newcastle
Mid-North Coast	Biripi Aboriginal Corporation, Taree (2 locations) and Biripi Town Clinic
	Tobwabba Aboriginal Medical Service, Forster
New England	Pius X Aboriginal Corporation, Moree
	Armajun Aboriginal Health Service, Inverell
	Tamworth Aboriginal Medical Service, Tamworth
	Walhallow Aboriginal Corporation, Quirindi

Mental illness, including complex and enduring mental illness, grief and loss, and youth mental health have been identified in the HNECC PHN Aboriginal Needs Assessment[34] as priority needs. In line with the holistic approach to health, this report highlighted the need for better integration across physical and mental health, and improved access to services across the region by overcoming existing barriers to care[34].

HNECC PHN commissions services as part of the Indigenous Mental Health program that is funded by the Commonwealth. Services delivered as part of this program seek to improve access to integrated culturally appropriate and safe mental health services that holistically meet the needs of Aboriginal and Torres Strait Islander people. Through a co-design activity undertaken in collaboration with the Healing Foundation, these services recognize the connection Aboriginal and Torres Strait Islander people have to country, culture and community and address inter-generational trauma in order to heal.

Private Mental Health Inpatient Hospitals

In addition to inpatient services provided by LHDs, private hospitals across our region provide inpatient beds. Private hospitals providing inpatient care for people with a mental illness are described in Table 4.

Table 4: Private hospitals providing inpatient beds for people with a mental illness by towns

Area/Town	Town	Hospital
Central Coast	Woy Woy	Brisbane Waters Private Hospital (37 beds)

	Berkley Vale,	Berkley Vale Clinic (16 beds)
Lake Macquarie	Toronto	Toronto Private (35 beds)
	Warners Bay	Lakeside Clinic (51 beds)
Lower Hunter	Maitland	Maitland Private (25 beds)
Mid-North Coast	Taree	Mayo Private (20 beds)

In addition to inpatient services, these private hospitals also provide day programs and individual and group treatment sessions.

Key Mental Health Service Challenges

Key service challenges were identified from health service data, the 2017 Needs Assessment and priority setting workshops.

Integration

Integration is the pivotal theme underpinning the 5th National Plan, and is its number one priority area[1]. Integration of care focuses on the organisation and delivery of health services to provide seamless, coordinated, efficient and effective care that responds to all a person's health needs[35]. Perspectives of integrated care for mental health differ, but from the system as a whole include integration of care:

- between health services, social services and other care providers
- across primary, community, hospital and tertiary mental health care services supported by care pathways and care transitions
- between mental health and general health services
- between health care providers and consumers and other service users to engage and empower people through health education, shared decision-making, supported self-management, and community engagement
- to support both a population-based and person-centred approach to care, to focus on whole of community and individuals needs[36]

Shared care models between primary health services and specialist mental health service, which support integration of care, can lead to improved clinical outcomes and potentially reduced relapse rates[37]. Effective shared care models can be effective with a commitment to improvement across the system, and clinical models supported by care pathways[37].

As acknowledged by the 5th National Plan indicators that reflect the performance of services and the system for integrated mental health care are lacking` Commonly used indicators for integrated care in mental health are at best approximations. The admission rate for mental health related conditions is one example of a commonly used indicator. The use of this rate assumes that with better integration of care, admissions would be lower.

- In 2016-17, the rate for admissions for mental health related conditions to all hospitals in our PHN (2094.1/100,000) was higher compared to state (1979.9/100,000) and national rates (18884.1/100,000)[15]

- Higher rates for admissions for mental health related conditions to all hospitals in Lake Macquarie (2,483.1 per 100,000), Central Coast (2,356.1 per 100,000), Maitland (2,337.0 per 100,000), Newcastle (2,249.2 per 100,000) and Mid-Coast (2,244.5 per 100,000) [15]

- In 2017-18, there were slightly higher rates of overnight hospitalisations for mental illness in our PHN (110.9/10,000 population) compared to state (104.6/100,000)and national(104.4/10,000)[38]
  - Higher rates of overnight hospitalisations were observed in Newcastle (131.1), Wyong (117.2), Tamworth-Gunnedah (116.2), Great Lakes (116.2), Gosford (113.1), and Taree-Gloucester (112.1)[38]

We acknowledge that these are proxy indicators for integration, reflect a narrow view of the mental health system and are likely to be driven by supply rather than demand for inpatient services.

Access

Access to care needs are demonstrated through service data and through perceived needs across our region. The rate of access to mental health services based on MBS data for GP mental health plans, clinical psychologists, allied health and psychiatrists for each SA3 in our region are described in Table 5. These data are indicative of access challenges only, as other factors such as supply of clinicians and transport access contribute to the variation in rates.

In general, rates of access to services for rural areas are lower than for more urban areas, and lower than when compared with our region overall and to NSW and Australia[39]. However there are some notable exceptions. The rates of access to clinical psychologists and to psychiatrists in Wyong, despite it being a more urbanised area, are both lower than those for our area and state and national levels[39].

Ten of our 15 SA3s have lower access to clinical psychologists when compared to state and national levels and nine of our SA3s have lower than state and national levels access to allied health services for mental health care[39] (Table 5).

Table 5: Rates of access to MBS mental health services by discipline, for HNECC SA3s in 2017-18, with comparison to region, state and national rates

	GP Mental Health	Clinical Psychologists	Allied Health Mental Health	Psychiatry
SA3	**Rate of Services/100,000 population (all ages)**			
Gosford	18710	8526	25005	5737
Wyong	20328	4639	21085	4036
Lower Hunter	17150	6787	17064	4104
Maitland	19099	8621	20811	5570
Port Stephens	17059	6313	18452	4222
Upper Hunter	14568	2234	16756	2641
Great Lakes	16850	5558	21405	5228
Taree - Gloucester	15695	6780	21623	6408
Armidale	9829	6933	15571	2572
Inverell - Tenterfield	8402	2956	10296	2812
Moree - Narrabri	7737	1948	6174	1502
Tamworth - Gunnedah	9737	3738	11810	2547
Lake Macquarie - East	16685	9754	22702	6581

Lake Macquarie - West	16962	8447	23310	6029
Newcastle	18428	10198	25367	8008
HNECC PHN	**16702**	**7134**	**20552**	**5164**
NSW	**14344**	**8289**	**21236**	**7629**
National	**14411**	**9361**	**22871**	**7704**

Access to psychiatrists is also limited in most SA3s in our region. Only one SA3 (Newcastle) has a rate of access to psychiatrists above the state and national levels[39]. Even in the more populous SA3s of Gosford, Wyong, Maitland and east and west Lake Macquarie, the rate of access to psychiatrists is lower than the state and national levels[39].

Capacity of General Practice

There is significant variation in access to GP mental health treatment plans across our region. In 2017-18, at a local level, the rate at which services were delivered ranged considerably from 7,737 per 100,000 in Moree-Narrabri SA3 to 20,328 per 100,000 in Wyong SA3, with lower rates also recorded in Inverell-Tenterfield (8,402), Tamworth-Gunnedah (9,737) and Armidale (9,829) SA3s (Table 5). In 2017-18, the rate of GP mental health services provided through the MBS nationally was 14,411 per 100,000 population and 14,344 per 100,000 population in NSW. This compares to 16,702 per 100,000 population for the HNECC PHN region[39]

Variation in prescribing practices

There is significant variation in prescribing practices across our region for all mental health conditions. In 2018/19 the rate of prescribing mental health-related prescriptions for any condition at a national level is 1548/1000 population lower than our PHN rate of 2026/1000 population. The rate of prescribing of all mental health related prescriptions ranges from 1506/1000 population in Moree-Narrabri SA3 to 2419/1000 population in Great Lakes SA3. Only one SA3 has a rate lower than the national rate[40].

- The total number of PBS/RPBS prescriptions dispensed for antipsychotic medicines in 2016-17 in HNECC PHN region was 250,572, equivalent to 20,084 per 100,000 population (AIHW, 2018). This is higher on a per population basis than NSW and Australia, which were 16,601 and 16,414 per 100,000 population respectively[40].
- The SA3s in our region which had high rates of PBS/RPBS antipsychotic medication dispensing across all ages included Great Lakes (25,844 per 100,000 population), Newcastle (24,434) and Taree-Gloucester (23,279). HNECC SA3s with low rates across all ages included Upper Hunter (13,800), Moree-Narrabri (15,919) and Armidale (16,534/100,000)[40].
- Data from an earlier period (2013-14) indicate that variations in rates of prescribing for all medications exists across the PHN[41]. GPs prescribe the majority of mental health related prescriptions for all mental health conditions except for psychostimulants used for Attention Deficit Hyperactivity Disorder (ADHD) and nootropics for improved cognitive functioning[40, 41].
- In 2013-14, 11 out of the 15 SA3s in the PHN region ranked in the two highest deciles for antidepressant prescribing behaviour Australia-wide[41].

Perceptions of mental health service gaps and challenges

Key stakeholders in priority setting workshops ranked their perceptions of mental health service gaps and mental health service challenges. These service gaps and challenges were identified from the literature, burden of illness data and the 2017 Needs Assessment[2]. The rank orders for these from across the region are shown in Table 6.

Table 6: Regional Rank Orders for Mental Health Service Gaps and Challenges

Service Gaps	Ranking	Service Challenges	Ranking
Services for moderate to severe mental illness	1	Integration across service system	1
Services for children and young people	2	Navigating the mental health system	2
Early intervention services	2	Capacity of GPs to address mental health problems	3
Rehabilitation services	4	Workforce challenges especially in rural areas	4
Culturally safe mental health services	4	Service responsiveness	5
Services for people experiencing eating disorders	6	Evidence-based mental health promotion and prevention strategies	6
		Monitoring and assessing quality and outcomes	7
		Person and carer centred care	7

As with health needs, key stakeholders stressed the importance of separating out service gaps for children as different from those of young people.

Additional service challenges identified in priority setting workshops and aligning with the results of the 2017 Needs Assessment included:

- The needs of children (<12 years) with mental health problems identified as a high need
- Lack of a range of specialist services on the Central Coast including
    - Intensive care inpatient services
    - Longer stay and rehabilitation services
    - Children and young people's inpatient services
- There are challenges related to the effective implementation of the stepped care model in communities where the required services and programs at each level across the service system and pathways to support integration across the stages are limited or non-existent.
- Lack of models of care for perinatal mental health care is a high need
- Problems with integration of services with concerns including:
    - inadequate communication about care for people with a mental illness between specialist mental health and primary care services, and support services
    - timeliness and quality of care planning
    - lack of attention to mental health needs in the general health system
    - lack of adequate measures of integration which reflect the whole of the system

- Limited access to care at all levels is a high need across our region especially for
    - Psychiatrists
    - Psychologists
- The under-utilised potential of telehealth and other technologies is a high need in most communities, limited further by poor access to and quality of internet
- Significant cost barriers to accessing mental health services including travel costs
- Over-utilisation of prescription medication by GPs
- Ongoing instability in the service system because of the changes in organisations, commissioning and the advent of NDIS and MyAgedCare, impacting on referral pathways, access to care and on recruitment and retention of staff, particularly in rural areas
- The limited capacity of services, including support services, to develop and implement an approach to quality across the mental health service system
- Significant recent service challenges in drought, bushfires, floods and COVID-19 placing significant stress on communities leading to challenges for services to be more responsive
- Perception of lack of attention to physical health care for people with a mental illness
- Variation in compliance with physical health checks for admitted mental health patients
- Lack of investment in evidence-based mental health promotion across the region
- The 2017 Needs Assessment identified a range of access barriers including:
    - 81% of service providers and 71% of consumers, clients and community members reporting cost as a barrier to accessing services
- Transport barriers with limited public transport in many communities across the region[2].

Suicide Prevention Initiatives

Suicide prevention is everyone's business and the initiatives currently undertaken across our region largely reflect this approach. In line with the evidence, our services recognise the need for whole of community responses for suicide prevention.

On the Central Coast, the commitment to a partnership approach is reflected in the Suicide Prevention Central Coast (SPCC) Alliance strategic plan (2020-25) outlining priorities and action for the next five years. This alliance builds on the work of the Lifespan initiative and includes a broad range of agencies and stakeholders from all levels of government, local businesses, Community Managed Organisations, Aboriginal and Torres Strait Islander community organisations, lived experience advisors and spokespeople for the Gender and Sexually Diverse communities and Culturally and Linguistically Diverse (CALD) communities.

Everymind, a leading national not-for-profit institute of Hunter New England LHD, based in Newcastle undertakes local and national work in suicide prevention. As well as developing suicide prevention services and resources Everymind also undertakes research into most effective suicide prevention strategies. They have responsibility for the delivery of a number of programs in suicide prevention in the district which include:

- Mindframe, a national program that supports safe media reporting, portrayal and communication about suicide, mental illness and alcohol and other drugs.
- Life in Mind, a new national initiative connecting suicide prevention organisations, researchers, and programs and services to each other and the community, is delivered by a comprehensive digital platform for knowledge exchange around suicide prevention activities across Australia.

There are several suicide prevention initiatives across the region commissioned by the PHN including:

- Dynamic Simulation Modelling (DSM), a tool developed collaboratively with people from across our region, which will inform future procurement of suicide prevention initiatives, ensures the PHN commissioning strategy for suicide prevention is robust and evidence-based.
- The Way Back Support Service, funded by Beyond Blue, HNECC PHN and NSW Ministry of Health Suicide Prevention fund, and delivered by Hunter Primary Care, supports people within the first three months after a suicide attempt, and is currently being trialed in several sites in the Hunter region.

The NSW Governments' Towards Zero Suicides, designed to reduce the rate of suicides by 20% by 2023, has introduced a number of new initiatives for our region. These include the establishment of assertive outreach teams and the provision of alternatives to Emergency Departments. As part of this Towards Zero Suicides initiative, the Central Coast will establish the Way Back Support service, offering after care consisting of three months of follow-up and psychosocial, peer-based support in the community. Hunter New England has implemented a Suicide Care Pathway consisting of five stages of care.

Workforce Challenges

Workforce challenges, which impacted on service access and quality were identified across the PHN region. A description of key mental health workforce by discipline and LGA, with comparisons to regional, state and national figures is provided in Table 7. These data are provided by the number of full-time equivalent (FTEs) staff with FTE per 100,000 population.

Table 6: Workforce by disciplines across all LGAs for 2017

		GP		Psychologist		Psychiatrist		Mental Health Nurse	
LGAs	Population	FTE	FTE/100,000	FTE	FTE /100,000	FTE	FTE/100,000	FTE	FTE/100,000
Armidale Regional (A)	30688	29	95	35	114	3	10	26	83
Central Coast (C) (NSW)	339236	318	94	220	65	21	6	306	90
Cessnock (C)	57607	33	57	15	25	0	0	0	0
Dungog (A)	9188	3	33	3	33	0	0		0
Glen Innes Severn (A)	8919	9	101	5	53	0	0		0
Gunnedah (A)	12544	5	40	3	26	0	0		0
Gwydir (A)	5345	4	75	0	0	0	0		0
Inverell (A)	16694	14	84	10	61	0	0		0
Lake Macquarie (C)	203400	190	93	129	64	21	10	195	96
Liverpool Plains (A)	7865	3	38	3	38	0	0		0
Maitland (C)	81067	52	64	58	71	4	5	88	109
Mid-Coast (A)	92485	58	63	46	50	4	4	76	82
Moree Plains (A)	13491	10	74	0	0	0	0	0	0
Muswellbrook (A)	16431	13	79	5	33	0	0	3	18
Narrabri (A)	13313	7	53	4	32	0	0		0
Newcastle (C)	163171	220	135	299	183	46	28	333	204
Port Stephens (A)	70691	59	83	20	29	0	0	9	13
Singleton (A)	23550	24	102	8	36	0	0		0
Tamworth Regional (A)	61504	46	75	46	75	3	5	76	124
Tenterfield	6223	3	48	0	0	0	0	3	48
Upper Hunter Shire (A)	14277	9	63	4	26	0	0		0
Uralla (A)	6140	3	49	0	0	0	0		0

Based on these 2017 data there are key workforce challenges across our region which include:

- Sixteen of our 23 LGAs had GP FTE rates lower than state (88/100,000) and national (90/100,000) rates. Dungog (33/100,000), Liverpool Plains (38/100,000) and Gunnedah (40/100,000) had the lowest rates of GPs with Newcastle (135), Singleton (102) and Glen Innes (101) having the highest FTE rates[42].
- The majority of HNECC PHN LGAs (i.e. 16 out of 23) had no psychiatry presence, including Port Stephens and Cessnock LGAs, which had populations of 70,691 and 57,607 respectively[42].
- Access to psychiatrists is identified as a significant challenge on the Central Coast. With a population of close to 340,000 people there was only 6 psychiatrists per 100,000 population[42].
- Several our region's LGAs had no clinical psychology presence, including Gwydir (population of 5,345), Moree Plains (13,491), Tenterfield (6,223), Uralla (6,140) and Walcha (3,082). LGAs with low rates of FTE psychology per 100,000 population included Cessnock (25.3), Gunnedah (25.5), Upper Hunter Shire (25.9) and Port Stephens (28.6)[42].
- Even some of our more populous LGAs have lower FTE psychologists per 100,000 people when compared to state (85/100,000) and national (82/100,000) rates. The more populous areas with FTE rates of psychologists lower than state and national level include Central Coast (65/100,00), Lake Macquarie (64/100,000) and Maitland (71/100,000)[42].

- In 2017, there were 88.7 FTE mental health nurses per 100,000 population in the HNECC PHN region. Just over half of HNECC PHN LGAs (i.e. 13 out of 23) had no mental health nurses, including Cessnock and Singleton LGAs which had a population of 57,607 and 23,550 respectively[42]. Only six of our LGAs had rates of mental health nurses equal to or above state and national rates, with these areas all in areas in or near inpatient facilities[42].

Perceptions of Workforce Challenges

Key workforce challenges identified in the 2017 Needs Assessment and in priority setting workshops included:

- Poor or no access to child and adolescent psychiatrists in all communities across the region
- Poor access to developmental psychologists for children with mental and behavioural problems
- Poor access to public psychiatrists for adult care on the Central Coast, with this problem further exacerbated by the distribution of training positions for junior doctors in this area based on allocation from Northern Sydney LHD
- Reduced capacity of services, particularly in rural areas, to recruit and retain specialised mental health staff, especially psychiatrists and psychologists
- Significant turnover in mental health clinical and support staff affecting the quality and continuity of care
- Overreliance on provisional psychologists, especially in rural areas impacting retention
- Skills of staff in residential aged care facilities to manage behaviourally challenging residents
- Capacity of community based social support services to provide care for people with severe mental illness and other complexities, within their scope of practice
- Lack of focus in undergraduate nursing programs on providing care for people with a mental illness.

Foundations of our plan

The results of the process of development guided the foundations of our plan to create a vision and priorities for our plan.

Vision

Focusing on mental health prevention and promotion, early intervention, treatment and recovery, and suicide prevention, this plan will set the foundation for:

A more robust, integrated regional mental health system which is evidenced-based, responsive to the diversity of individual and community needs, supported by collaborative planning, service and program development and performance monitoring

The plan acknowledges the challenges inherent in working across different service and funding systems and remains committed to strengthening the collaboration across the primary care, and specialist mental health services and social support service system.

Values

Our values have been adapted from NSW Health Living Well[43] to reflect the context of our communities.

- Hope
- Quality
- Equity
- Respect
- Community
- Recovery
- Responsiveness

Now more than ever, for our communities, in the face of drought, bushfires and COVID-19 the responsiveness of our partners and services to mental health needs is a value which should guide all aspects of our work.

Principles

The development of responses to our community needs is guided by these principles and reflect evidence, our commitment to collaboration and effectiveness.

- Taking a population health approach, there is a focus on risk and protective factors to build capacity for promoting mental health and wellbeing, and preventing suicide
- Strategies are evidence-based or theoretically informed
- Strategies are targeted and tailored to specific vulnerable groups including specific cultural and age groups
- People with a lived experience are valued as vital in informing planning, service development and design, monitoring and evaluation of services

- There is a focus on the consumer and carers in the provision of accessible, safe and effective early intervention, treatment and recovery services, and suicide prevention initiatives
- A stepped care approach to service delivery enables matching services to intensity of need across the spectrum of age and illness
- Partnerships, networks and alliances between consumers, families, their carers, the community and the services system are acknowledged as key to effectiveness
- Clear pathways to appropriate and accessible services within the context of partnerships and networks across the region, and addressing known barriers to care
- Support and build the capacity of the workforce across the partnership to provide high quality care and support
- Adopt effective governance, monitoring and evaluation.

Our Commitments

Our commitments to implementing this plan are outlined in Table 8. Our five-year plan is ambitious and will require flexibility and agility in focusing on our priorities from across the services system through partnerships and innovation.

Table 7: Commitments to implementing the regional plan

Our Commitment	We will
Involve people with a lived experience	• Place people with a lived experience of mental illness and suicide risk at the centre of services and programs through co-design and engagement
Develop and sustain partnerships across services and sectors	• Undertake joint regional planning, monitoring and evaluation • Apply a partnership approach to service and program development through co-design • Work with non-health partners to support services across all ages
Explore innovative models of care and funding approaches	• Commit to innovation to meet community needs • Examine available resources in the context of need and priorities in this plan • Support new funding and resource models including joint commissioning and fund pooling
Build on our strengths	• Acknowledge the different stages of service development across the region • Work collaboratively and share expertise across the service system to achieve the aims of the plan
Support equitable access	• Improve service integration

	• Enhance access to care across our region • Invest in pathways to care when and where it is needed
Focus on outcomes and quality	• Invest in relevant data systems to support evaluating the effectiveness of the service system • Support a focus on transparency of data across the service system • Develop and implement practical clinical governance approaches

In setting out our commitments we also recognise the realities of the constraints in which we operate. In these uncertain times, these constraints may have an even great impact.

As collaborators, we acknowledge the differences in our funding streams and core business, which provide delineation of service roles but also constrain our ability to achieve the aims of this plan. For example, while we commit to integration across the service system, funding parameters based on specific program criteria or geographies place limitations on our ability to achieve integration.

Each of our partner organisations, is funded to provide specific services under governments' priorities and program guidelines. For LHDs, their commitment is to provide specialist mental health care in both hospital and community settings. These services are provided within designated program areas and funding streams based on the NSW Government priorities.

PHNs commission health services to meet the identified and prioritised needs of people in their regions and address identified gaps in primary health care. A key part of PHNs role is to work collaboratively within their regions to integrate health services at the local level to create a better experience for consumers, encourage better use of health resources, and eliminate service duplication. The commissioning role of the PHN is in response to specific Commonwealth government directives and funding streams. Program funding that at times relate to historical service delivery, each have specific guidance, limiting the flexibility to provide other services and complex challenges to redesign services to meet the changing local circumstances. This can act to prevent the PHN's ability to fully address local needs should the need differ to the program funding scope available.

Despite these constraints, we are committed to trialling innovative approaches, building on our strengths through leadership and a focus on our communities, to achieve the aims of the plan.

Our priorities

Our priorities, which reflect the vision, and results of our development process focus on improving the service system.

Figure 5: Our priorities

These seven priorities, all of equal importance, supported by focus areas and key actions, are needed to achieve a more robust mental health systems for the people of our region.

Priority area 1 – Integration

What difference will we see?

- Improved consumer and provider experience
- Improved patient outcomes
- Better care planning, coordination and referral practices
- Better physical health of people with a mental illness
- Improved mental health for those with a chronic illness
- Improvements in the quality of care and its reporting across the service system
- A systematic approach to mental health promotion across the service system.

Key focus area and actions

Key Focus areas	Actions
Implementation of stepped care model across service system	Establish pathways to mental health care to provide a regional, tailored and consistent approach across the clinical and social support service system, in the context of the stepped care model and ensuring a focus on effective transition across the lifespan and across stages of stepped care
	Develop new pathways in the context of the stepped care model and service system with a focus on: • Severe and complex mental health • Young people's mental health (12-25 years) • Children's mental health (less than 12 years) • Older people living with mental illness (65+ years)
	Strengthen early intervention across ages in the context of the stepped care model and service system using partnership approaches tailored to ages, and community needs
A focus on people with moderate to severe mental illness	Strengthen models of care for people with moderate to severe mental illness in the context of stepped care and service system with a focus on recovery
	Support trauma-informed services through capacity building and setting standards of care in services and through commissioning
	Improve the quality of coordination, care planning and shared decision making across the service system by developing, implementing and evaluating standards for care planning and shared decision making across the service system
Integration between mental and physical health	Develop, implement and evaluate a strategy for supporting the mental health of those with chronic physical illness through early intervention and referral pathways
	Ensure the physical health of those with mental illness, especially those with moderate to severe mental illness is regularly assessed and treatment and support provided

	Develop, implement and evaluate innovative approaches to integration between physical and mental health care through commissioned services
	Advocate for a focus on improving mental health assessment, brief intervention and referrals for patients across the general health system through better use of data and capacity building
A focus on the quality of care	Ensure co-design processes and evidence informs service development and implementation
	Ensure commissioning processes explicitly require evidence-based service models and rigorous evaluation models
	Develop, implement and evaluate a clinical governance framework for application across an integrated mental health service system
	Build the capacity of services across the service system to involve those with lived experience in service development and evaluation
	Strengthen the quality of care across the service system to respond to the needs of vulnerable groups and those impacted by trauma through guidelines and standards of care
Service responsiveness to disasters	Strengthen the capacity and agility of services providing mental health support to respond to disasters
	Support the implementation of mental health care services and support to communities affected by disasters through partnerships across the service system
Evidence based mental health promotion	Invest in evidence-based mental health promotion across the service system
	Strengthen partnerships approaches across the service system and with communities to build resilience and mental health literacy

Priority area 2 – Aboriginal mental health and social and emotional wellbeing

What difference will we see?

- Improved mental health and social and emotional wellbeing for Aboriginal people
- Partnerships in service design with the Aboriginal community across the service system
- Care pathways reflect the cultural needs of Aboriginal people
- Better access to care for Aboriginal people through embedded culturally safe practices

Key focus area and actions

Key Focus areas	Actions
Holistic and culturally safe models of care	Plan mental health strategies in partnership with the Aboriginal community and Aboriginal health organisations in the context of holistic models of care
	Ensure referral pathways for access to mental health care are aligned to holistic models of care for Aboriginal people
	Strengthen the integration between physical and mental health in all aspects of clinical care for Aboriginal people accessing mainstream specialist and primary care health services
	Support trauma-informed and culturally safe models of care for mental health services for Aboriginal people
Early intervention	Strengthen access to early intervention models of care for Aboriginal people across all ages tailored to community needs across life stages
	Develop and promote mental health literacy and community-led suicide prevention initiatives tailored to local needs in partnership with Aboriginal communities
Cultural Safety	Strengthen the capacity of mainstream health services to deliver culturally safe, high-quality mental health care for Aboriginal people
	Improve implementation, monitoring and evaluation of cultural frameworks within all services
Capacity building	Work in partnership with Aboriginal communities to build Aboriginal mental health workforce which meets local community needs
	Enhance the capacity of Aboriginal health services and community leaders to address social and emotional wellbeing and support those experiencing mental illness in their communities

Priority area 3 – Access to care

What difference will we see?

- Better access to clinical mental health care for children under 12 years and their families
- Better access to perinatal mental health care for women and their families
- Access to intensive care mental health services for adults on the Central Coast
- Access to rehabilitation mental health services in the Central Coast and New England regions
- Better access to services through technology

Key focus area and actions

Key Focus areas	Actions
A focus on the mental health of children under 12 years	Develop, implement and evaluate a strategy for children's mental health services in the context of whole of family and community needs as a partnership between services and across sectors
	Invest in and strengthen access to specialist mental health services for children across the service system including: • Improved access to child psychiatry services across the region including through technology • Support proposals for developing inpatient mental health services for children and young people on the Central Coast as part of a strategic approach to stepped care provided locally for vulnerable populations and their families, which includes the establishment of prioritised pathways to child adolescent inpatient beds in our shared geography
	Build partnerships across the service system to support the mental health for children under 12 years, and their families
Intensive care services	Support proposals for adult inpatient and community mental health adult care on the Central Coast, incorporating expedient access to intensive care and rehabilitation services
Perinatal mental health care	Develop a strategy to improve access to perinatal mental health in the context of stepped care model and service system
	Improve the capacity to respond to the perinatal mental health needs of women and families across the service system
Rehabilitation services	Develop a strategy for whole of system approaches to rehabilitation services for the region, recognising the importance of partnerships across sectors
	Develop and invest in innovative models of care to strengthen access to rehabilitation services for those with moderate to severe mental illness, initially focusing on: • Central Coast

	• New England
Psychosocial support services	Invest in integrated psychosocial support services across the region to meet the needs of people with severe mental illness and reduced psychosocial functional capacity
Optimising use of technology	Improve the options for accessing specialist services through technology with a focus on: • Young people • Children • People with moderate to severe mental illness
	Improve access to specialist mental health services including psychiatrists using technology and supported by referral pathways
	Support services in delivering flexible models of care to consumers in response to disasters, such as the pandemic, through optimising use of technology
	Support innovations in technology for mental health promotion, and early intervention through online resources

Priority area 4 – Importance of general practice

What difference will we see?

- More equitable access to GP mental health care plans across the region
- Improved experiences of GPs in mental health care coordination, referral and care planning
- Prescribing practices for mental illness more closely aligned to national levels
- Trials of shared care models for those with severe mental illness in at least 3 communities.

Key focus area and actions

Key Focus areas	Actions
Capacity in general practice	Support integration within General practice through commissioning and integration strategies
	Strengthen the capacity for GPs to identify, assess and provide evidence-based treatment, support and referral options for mental illness across the stepped care model
	Provide training for GPs to provide care for patients with a mental health crisis
	Provide workforce development opportunities for GPs in specialist mental health clinical services
Improved treatment in general practice	Strengthen care pathways and care navigation for General practice by tailoring to local needs, overcoming barriers to care and support, and ensuring links with support services including NDIS and MyAgedCare
	Improve access to referral options for GPs by investing in technology to support better access to allied health and specialist mental health services
	Develop, implement and evaluate a strategy for better prescribing practices for GPs in the treatment of mental illness as a partnership approach between primary and specialist care and pharmacies
	Strengthen the capacity of GPs to develop and monitor care plans for patients with a mental illness
	Trial shared care models between general practice, specialist mental health services and psychosocial support services for those with moderate to severe mental illness
	Support GPs in care of older people with or at risk of mental illness in the context of the service system including MyAgedCare and aged care facilities

Priority area 5 – Strengthening suicide prevention

What difference will we see?

- Communities across our region applying whole of community approaches to suicide prevention with services and sectors working together
- Improved follow-up care for those presenting to or admitted to hospital for a suicide attempt
- Reductions in presentations to hospital for intentional self-harm
- All mental health clients will have crisis/ safety plans in place
- Safe alternatives to Emergency Departments to support suicide prevention and after care are in place

Key focus area and actions

Key Focus areas	Actions
Community capacity	Build evidence-based community capacity for suicide prevention across the service system, across sectors and in partnership with communities
	Strengthen inter-sectoral collaboration for suicide prevention through building on existing partnerships for suicide prevention (an example is Suicide Prevention Central Coast Alliance) and sharing expertise across the region
	Invest in the development and implementation of suicide prevention planning at local levels
	Support the involvement of those with lived experience in suicide prevention at local levels
	Support opportunities through partnerships with research organisations to build and share knowledge about effective suicide prevention approaches
Workforce capacity	Build workforce capacity for suicide prevention across the service system through skills development
	Support evidence-based and shared protocols for identification and management of people at risk of suicide across the service system
Service responsiveness	Develop, implement and evaluate alternative models of care for those at risk of suicide through service redesign
	Develop, implement and evaluate a culture of service responsiveness to those who present at risk of suicide to health services supported by agreed protocols and pathways
	Strengthen suicide safety planning for all mental health clients across the mental health system
	Support services and communities in in implementing suicide prevention initiatives in response to disasters such as the pandemic
Improved data utility	Continue to support DSM to guide evidence-based suicide prevention initiatives across the region
	Utilise data analytical modelling to contribute to the real time assessment of the effectiveness of suicide prevention initiatives across the region
After care	Strengthen evidence-based aftercare across the system following suicide attempts

	Improve the compliance with follow-up care after presentation and admission to hospital
Postvention	Support evidence-based postvention approaches tailored to and in partnership with local communities

Priority area 6 – Building workforce capacity

What difference will we see?

- Improved rates of mental health staff per head of population
- Increased proportion of peer workforce in mental health services
- Reduced proportion of mental health patients and staff reporting stigmatising behaviours from staff in general health system
- A skilled workforce in integration strategies and in responding to vulnerable groups
- An increase in the proportion of workforce reporting positive experiences and who indicated they are supported to develop their professional capabilities.

Key focus area and actions

Key Focus areas	Actions
A workforce strategy	Strengthen strategic and cross-sectoral approaches to workforce recruitment and retention across the mental health system
	Develop strategies for professional development and mentoring across the mental health system
	Build and support peer support workforce across the mental health system
	Advocate for allocation of training places for junior doctors in mental health services in line with the regional approach
A skilled workforce	Embed integration approaches across service system through workforce policies and procedures
	Focus on reducing stigma across the general and mental health service system workforce
	Build the capacity of the workforce across the clinical, psychosocial and social support service system to respond to the needs of vulnerable groups and those impacted by trauma
	Build the capacity of services across the service system to optimise the use of technology to support service models and access to resources and care
A supported workforce	Embed clinical supervision and mentoring in mental health services across the service system
	Provide opportunities for mental health service providers to work across the service system

Priority area 7 – Planning, innovation and evaluation

What difference will we see?

- All service development occurs within an evidence-based framework and with consumers involved in design and evaluation
- Service planning occurs as a partnership across the service system, in line with scope of this plan
- Innovative models of care are trialed and inform service development
- Services and this plan are evaluated with shared outcomes reported across the service system

Key focus area and actions

Key Focus areas	Actions
Integrated planning	Ensure those with lived experience are at the centre of planning, service development, commissioning and evaluation
	Develop and implement mechanisms for integrated mental health and suicide prevention planning – locally and regionally
	Strengthen system stability through localised place-based planning, governance and service delivery reflecting local needs, with priority in rural areas
Innovation	Support innovative models of care and strategies to meet community needs through investing in pilots, and research aligned to the principles and priorities in this plan
	Trial innovative approaches to planning and resourcing models of care to meet community needs which reflect partnership approaches and support integrated care with priorities in rural LGAs
Evidence-based service delivery	Strengthen evidence-based service delivery through commissioning and evaluation
	Strengthen evidence-based implementation of service models and programs
A focus on rigorous evaluation	Support evaluation of mental health and suicide prevention strategies and services across the service system
	Invest in rigorous evaluation of this mental health and suicide prevention plan
An outcomes focused service system	Co-design robust outcomes and activity measures reflecting improved health for consumers, stepped care and integration across the system
	Improve transparency of outcomes reporting across the service spectrum
	Build the capacity across the service system to collect and efficiently report on mental health agreed outcomes measures
	Improve quality, access and utility of data to support evaluation of suicide prevention initiatives and to support decision making relating to service design and delivery

Implementation, Governance and Evaluation

The impact of this plan will ultimately be down to effective implementation strategies, robust governance and our ability to evaluate progress and outcomes.

Mental health and suicide prevention is everyone's business in our communities. We have already made progress in enhancing our capacity to improve our response across the system. Our ability to strengthen and sustain engagement and partnerships with consumers and carers, service providers across the system and sectors, and with the community will be critical to its success.

Implementation

This high-level regional plan will be supported by an implementation plan to guide specific actions and specify timeframes to achieve these agreed actions. The implementation plan will include key milestones as indicators of the progress of implementation, as well as allocating responsibility for carriage of actions under each focus area. We acknowledge that the implementation will take time and will require a staged approach and evidence-based implementation strategies.

Many of the actions in this plan are interrelated and require complex change across the service system. We recognise that the partner organisations have distinct core business foci and accountability to different levels of government, funding streams and funding bodies, which may conflict with reforms needed to achieve integration. Managing the challenges presented by these differences will also take time, be factored into the staged approach to implementation and require strong governance both locally and across the region. Despite these challenges, and guided by evidence that demonstrates the importance of integration for achieving better patient and community outcomes, the implementation will strive to overcome the challenges to achieve the goals of this plan through a shared commitment to meeting community needs.

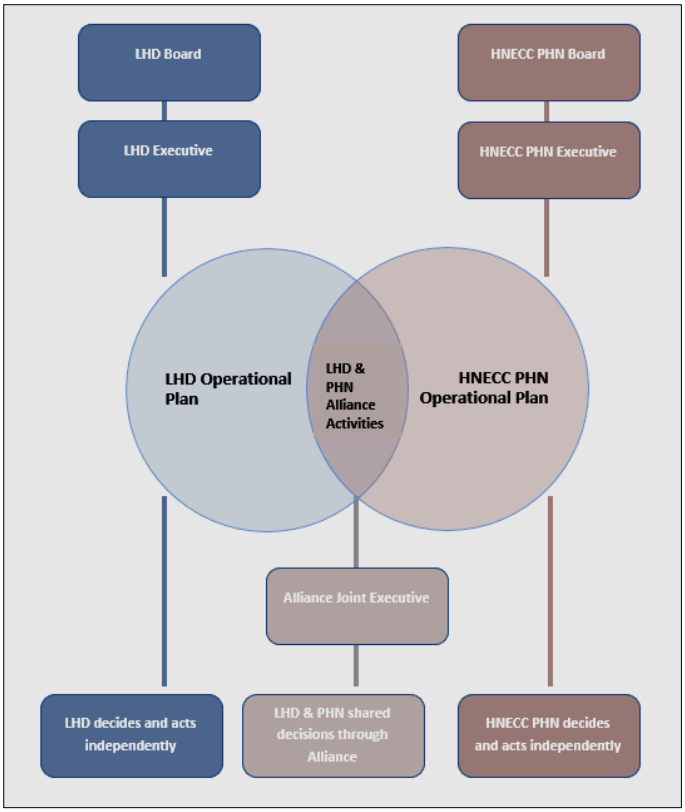
The plan is defined by the need for collaboration across services and sectors and with consumers and carers. To be effective, these partnerships take time, resources and energy. Importantly they require commitment to shared goals and recognition of the strengths of each partner. Implementation will ensure the time and resources are allocated to support partnerships to establish and be sustained.

Governance

Senior leaders from CCLHD, HNELHD and HNECC PHN have overseen the development and finalisation of this plan. This reflects each organisation's commitment to mental health and suicide prevention across the region.

Our plan aligns with the approach taken under the Alliance model (Figure 6), as the partnership approach for service development and integration. The Alliance model, in place in the Hunter/ New England and Central Coast regions, acknowledges the core business responsibilities of our three organisations. In line with the scope of our plan, this model also recognises the importance of the interface of our core activities as a means to support better integration and improved mental health and wellbeing outcomes for people and communities. The activities associated with the implementation of this plan will sit within this interface, acknowledging that implementation will be shared and oversight provided by the existing governance structures.

Figure 6: Alliance Collaborative Model



In the implementation phase, oversight will be provided by an expanded partnership group involving representatives of key service stakeholders and consumers. This partnership group will be supported by working parties, relevant to each of the priority areas, with critical stakeholders from appropriate services, sectors and consumers and carers, tasked with the responsibility of overseeing the delivery of the focus areas and key actions within the plan. Key responsibilities of the partnership group are:

- Monitor the implementation of the regional plan and report on progress to the Alliances, and the Chief Executives of each of the partner organisation
- Oversee the appointment and roles of working parties to ensure effective implementation of specific focus areas identified in the regional plan
- Undertake a strategic midterm and final review of the plan in the context of emerging needs
- Oversee the evaluation of the plan and its focus areas
- Advocate for resources required to deliver the plan in line with partner organisations
- Ensure reporting on the implementation of the plan occurs and is provided to key stakeholders

The role of working parties will be tailored to the specific priority areas. Common across these roles is the need to:

- Ensure representative membership across key stakeholder groups including consumers with lived experience
- Drive the implementation of the priorities, key focus areas and actions within the regional plan
- Provide strategic advice to the partnership group regarding impediments to implementation, solutions and resource requirements
- Report on progress against key milestones outlined in the implementation plan in line with timeframes through Alliance structures
- Make recommendations to the partnership group regarding mid-term and final review of the plan
- Support the evaluation of the plan in each of the priority areas

Other working parties will be co-opted by the partnership group to meet emerging needs for mental health and suicide prevention.

These governance committees will be guided by the commitments and principles outlined in this regional plan. They will report on progress of implementation to the Alliances and Chief Executives of the partnership.

Evaluation

A robust evaluation framework will underpin this regional plan, which will be in place from the commencement phase of implementation. Informed by rigorous methodology, the evaluation framework will examine the effectiveness, efficiency and acceptability of the regional plan through examining inputs, activities, outputs and outcomes from the plan and each of the priority areas. The framework will be developed in the context of the service system, partnerships across sectors and the Quadruple Aim Framework[44].

An evaluation of the plan will occur in the final year of its implementation. This evaluation will examine the outputs and outcomes of the plan and each of its priority areas. Contributing to the final evaluation will be the monitoring and review strategies that occur as the implementation is occurring.

References

1. The Fifth National Mental Health and Suicide Prevention Plan. Canberra: Department of Health, 2017.
2. Mental Health and Suicide Prevention Needs Assessment Newcastle NSW: Hunter New England and Central Coast Primary Health Network, 2017.
3. The National Review of Mental Health Programmes and Services. Sydney: National Mental Health Commission, 2014.
4. Ho FY-Y, Yeung W-F, Ng TH-Y and Chan CS. The Efficacy and Cost-Effectiveness of Stepped Care Prevention and Treatment for Depressive and/or Anxiety Disorders: A Systematic Review and Meta-Analysis. Scientific Reports. 2016; 6: 29281.
5. Van Straten A, Seekles W, van 't Veer-Tazelaar NJ, Beekman A and Cuijpers P. Stepped care for depression in primary care: what should be offered and how. Medical Journal of Australia. 2010; 192: S36-S9.
6. Primary Mental Health Care Flexible Funding Pool Program Guide: Stepped Care. Canberra: Australian Government Department of Health, 2019.
7. Milner A and De Leo D. Who Seeks Treatment Where? Suicidal Behaviors and Health Care The Journal of Nervous and Mental Disease. 2010; 198: 412-9.
8. Sveticic J, Milner A and De Leo D. Contacts with mental health services before suicide: a comparison of Indigenous with non-Indigenous Australians. General Hospital Psychiatry. 2012; 34: 185-91.
9. Skinner A, Atkinson J, Lawson K, Heath J and Carter S. Dynamic simulation modelling for suicide prevention. Newcastle NSW: Key Insights, 2020.
10. Causes of Death, Australia 2018. Canberra: Australian Bureau of Statistics, 2019.
11. Strategic Framework for Suicide Prevention in NSW 2018–2023. Sydney: Mental Health Commission of NSW, 2018.
12. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Canberra: Australian Institute of Health and Welfare, 2016.
13. National Coronial Information System Suicide Data by PHN, 2016. Melbourne: National Coronial Information System, 2016.
14. National Health Survey: Mental Health and co-existing physical health conditions, Australia, 2014-15 Canberra, ACT: Australian Bureau of Statistics, 2016.
15. Social Health Atlas of Australia: Data by Primary Health Network (incl. Local Government Areas). Adelaide: Torrens University, 2020.
16. NSW Seasonal Update - December 2019. Sydney, NSW: Department of Primary Industries, 2020.
17. Hunter New England and Central Coast PHN Profile. Canberra: Australian Government Department of Health.
18. Hunter New England Central Coast Primary Health Network Health Profile. Newcastle NSW: Hunter New England Central Coast Primary Health Network
19. Centre for Epidemiology and Evidence. Sydney: HealthStats NSW, NSW Ministry of Health.
20. National Survey of Mental Health and Wellbeing 2007: Summary of results. Canberra: Australian Bureau of Statistics, 2008.
21. Alcohol, tobacco and drug use in Australia. Canberra: Australian Institute of Health and Welfare, 2017.
22. Stavrou E, Poynton S and Weatherburn D. Intimate partner violence against women in Australia: related factors and help-seeking behaviours Sydney: Crime and Justice Bulletin (200), NSW Bureau of Crime Statistics and Research, 2016.
23. BOSCAR LGA crime tools. Sydney 2020.

24. People with disability in Australia. Canberra: Australian Institute of Health and Welfare, 2019.
25. Lawrence D, Johnson S, Hafekost J, et al. The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra2015.
26. Hughes K, Bellis MA, Hardcastle KA, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. The Lancet Public Health. 2017; 2: e356-e66.
27. Walsh P, McHugh M, Blunden H and Katz I. Literature Review: Factors Influencing the Outcomes of Children and Young People in Out-of-Home Care. Pathways of Care Longitudinal Study: Research Report Number 6. Sydney: NSW Department of Family and Community Services. , 2018.
28. 2017-18 FACS Annual Report Highlights. Sydney: NSW Family and Community Services, 2018.
29. Skerrett DM, Kõlves K and De Leo D. Are LGBT Populations at a Higher Risk for Suicidal Behaviors in Australia? Research Findings and Implications. Journal of Homosexuality. 2015; 62: 883-901.
30. Harris B, Duggan M, Batterham P, et al. Australia's Mental and Physical Health Tracker: Background Paper. Melbourne: Australian Health Policy Collaboration, 2018.
31. Mental health services—in brief 2019. Canberra, ACT: Australian Institute of Health and Welfare 2019
32. What is primary care mental health?: WHO and Wonca Working Party on Mental Health. Mental health in family medicine. 2008; 5: 9-13.
33. National Aboriginal and Torres Strait Islander Health Plan 2013–2023. Canberra: Department of Health and Ageing, 2013.
34. Aboriginal Health and Wellbeing Needs Assessment Report
Newcastle. NSW: Hunter New England and Central Coast Primary Health Network, 2017.
35. NSW State Health Plan: towards 2021. Sydney: NSW Ministry of Health, 2014.
36. Goodwin N. Understanding Integrated Care. International Journal of Integrated Care. 2016; 16: 6.
37. Kelly BJ, Perkins DA, Fuller JD and Parker SM. Shared care in mental illness: A rapid review to inform implementation. International Journal of Mental Health Systems. 2011; 5: 31.
38. Mental health services in Australia: Overnight admitted mental health-related care. Canberra: Australian Institute of Health and Welfare, 2020.
39. Medicare-subsidised GP, allied health, diagnostic imaging and specialist health care, by Primary Health Network (PHN) area, 2013–14 to 2017–18Canberra: Australian Institute of Health and Welfare, 2019.
40. Mental health services in Australia: Mental health-related prescriptions. Canberra: Australian Institute of Health and Welfare, 2020.
41. Australian Atlas of Healthcare Variation. Sydney, NSW: Australian Commission on Safety and Quality in Health Care and National Health Performance Authority 2015.
42. National Health Workforce Dataset 2011-2017. Canberra: Australian Institute of Health and Welfare, 2020.
43. Living Well: A Strategic Plan for Mental Health in NSW. Sydney: NSW Mental Health Commission, 2014.
44. Bodenheimer T and Sinsky C. From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. The Annals of Family Medicine. 2014; 12: 573-6.

PRIMARY HEALTH NETWORK

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HUNTER NEW ENGLAND AND CENTRAL COAST
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