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HUNTER NEW ENGLAND AND CENTRAL COAST

An Australian Government Initiative

# MENTAL HEALTH AND SUICIDE PREVENTION NEEDS ASSESSMENT: 2017 UPDATE

Hunter New England and Central Coast Primary Health Network

Australian Government
Department of Health

phn
An Australian Government Initiative

# Primary Health Network

# Needs Assessment Reporting Template

This template must be used to submit the Primary Health Network's (PHN's) Needs Assessment report to the Department of Health (the Department) by **30 March 2016** as required under Item E.5 of the PHN Core Funding Schedule under the Standard Funding Agreement with the Commonwealth. This template should include the needs assessment of primary health care after hours services.

To streamline reporting requirements, the Initial Drug and Alcohol Treatment Needs Assessment Report and Initial Mental Health and Suicide Prevention Needs Assessment Report can be included in this template as long as they are discretely identified with clear headings.

**Name of Primary Health Network**

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|---|
| ***Hunter New England & Central Coast*** |

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

# Section 1 – Narrative

***This section provides PHNs with the opportunity to provide brief narratives on the process and key issues relating to the Needs Assessment.***

***Needs Assessment process and issues***

*– in this section the PHN can provide a summary of the process undertaken; expand on any issues that may not be fully captured in the reporting tables; and identify areas where further developmental work may be required (expand this field as necessary)*

The Mental Health and Suicide Prevention Needs Assessment for Hunter New England and Central Coast (HNECC) Primary Health Network (PHN) is an integrated component of the organisation's Strategic Plan (available at http://www.hneccphn.com.au) and approach to achieving its vision of "Healthy People and Healthy Communities". The Mental Health and Suicide Prevention Needs Assessment, along with other targeted needs assessments and reports, have provided a solid foundation on which to make evidence and resource based decisions.

This Mental Health and Suicide Prevention Needs Assessment provides a comprehensive, defensible and accurate picture of the mental health and suicide prevention needs across our region and aids in the development of an Activity Work Plan to address these priorities. The findings of this needs assessment will be used to inform the development of the Mental Health and Suicide Prevention Regional Plan in collaboration with key stakeholders and the community.

The findings of the Mental Health and Suicide Prevention Needs Assessment are summarised in this template which is a complete re-write from that previously submitted. The comprehensive Mental Health and Suicide Prevention Needs Assessment Report is available at http://www.hneccphn.com.au

This needs assessment will be updated and refreshed as we continue to build upon the information and deepen our knowledge and understanding of the mental health and suicide prevention needs of communities across our region.

**Our Approach for Assessing Needs**

To understand the health status and needs of individuals, populations and communities across the HNECC PHN region, and to ascertain the health infrastructure and understand service availability and gaps, the project team took the following approach:

•Quantitative analysis of prevalence, morbidity and mortality data for the region and where possible by local government area was undertaken by HNECC. A comprehensive review of publicly available data on mental health and suicide in the HNECC PHN region was undertaken.

•National, state and local quantitative information was gathered from various publicly available sources including: Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS), Public Health Information Development Unit (PHIDU), Centre for Epidemiology and Evidence, Australian Indigenous HealthInfoNet and the Commonwealth Department of Health. Internally held local level general practice data, collected using the PenCAT tool, was also used. This information was used to build a profile of the HNECC PHN region, including: demographics; mental health and suicide status and contributing factors; and mental health service usage, access and availability.

•Literature reviews were conducted to explore and identify models of care and barriers to accessing services for mental health. PsychInfo, Cochrane, PubMed and Science Direct databases were used to source full text peer reviewed journal articles published between 2010 and 2017. Over 4,000 articles were gathered from both searches, with over 100 relevant articles identified and used to inform this report.

•An independent consultant undertook the qualitative component of this needs assessment including interviewing and surveying key stakeholders across the HNECC PHN region.
•Qualitative methods were used with interviews and surveys of key stakeholders across all local government areas, this was supplemented by an online forum and surveys hosted through HNECC's online consultation platform http://peoplebank.hneccphn.com.au/ . 294 stakeholders participated in the interviews and 480 participated in the surveys. Across all LGAs in the HNECC PHN region, key stakeholder groups represented included: consumers, carers and community members; service providers from mental health and other community services; GPs and other medical specialists; and HNECC's Clinical Councils and Community Advisory Committees members.

**Prioritisation and Confirmation of Key Health and Service Needs**
Processes of triangulation of data resulting from the quantitative and qualitative methods followed by a validation process were used to identify priorities and confirm key findings. High priority needs identified by the quantitative data analysis were compared with those from the qualitative data results in each of the domains. Where differences in needs were identified, the data were reviewed and where variation remained these were reported as conflicting results. The results of the data triangulation contributed to the identification of priority needs for mental health and for suicide prevention in the HNECC PHN region.

The results of the data triangulation process identified priorities in relation to six key domains:

- mental health
- suicide prevention
- mental health services
- suicide prevention services
- barriers to service access
- workforce

The triangulation of data guided the identification of specific needs within each of these domains. These specific needs formed the basis of an additional survey which aimed to determine if the identified priority needs aligned to the views of HNECC's Clinical Council and Community Advisory Committee members. There were 24 participants in this validation survey. The HNECC Board and its Population Health Innovation Research and Service Design subcommittee were presented with the triangulated health needs and a summary of the evidence. Consideration was given to the impact and severity of each need and capacity to benefit.

**Issues and options analysis**
A rapid literature review aimed at finding high impact review papers and/or Australian examples of successful projects/ pilots/ programs developed to address particular health issues was conducted. Strategies including either research evidence or an evaluation were included. Reviews of literature for mental health burden of illness, service models and barriers guided the needs assessment.

***Additional Data Needs and Gaps (approximately 400 words)***
*– in this section the PHN can outline any issues experienced in obtaining and using data for the needs assessment. In particular, the PHN can outline any gaps in the data available on the PHN website, and identify any additional data required. The PHN may also provide comment on data accessibility on the PHN website, including the secure access areas. (Expand field as necessary).*

This needs assessment relied heavily on available data at national, state and where possible at a PHN, LGA or SA3 level. These data were complemented by qualitative data from participants from many local communities. Triangulation of data from the quantitative and qualitative findings was supported by an additional step in the validation of findings.

Data on service activity and outcomes were not available to determine whether services are meeting the needs and achieving the client and population outcomes expected by communities as a return on the investment of public money.

**PHN Website accessibility**

The PHN website is an ideal portal for PHNs to retrieve data that supports key priorities. The site has improved over time, and as it continues to grow, accessibility could be greatly improved by:

- Clear labelling of links to data files, including content and publication date
- Publication of data dictionaries and any metadata regarding specific datasets
- Publication of update schedules for each data set
- A subscription service alerting subscribers to new and updated data, including secure data

**Additional data required**

Selected data in this report is presented at a national or state level due to limited availability of more granular mental health data. Where possible, data was sourced at a local level from a variety of publicly available sources.

To enhance and strengthen the understanding of our health landscapes, it would be beneficial to see the following data further developed and made available to PHNs:

• National Health Service Directory - It would be beneficial if names, locations and service delivery details of health services, General Practice, allied health, pharmacies etc. were available for download by PHN region; Website usage statistics with a focus on PHN region would provide insight into directory awareness and relevance (HealthDirect)

• Service utilisation rates for public mental health and community based services, at a local level by diagnosis / presenting issue, gender, age group, Indigenous status and area of residence

***Additional comments or feedback (approximately 500 words)***

*– in this section the PHN can provide any other comments or feedback on the needs assessment process, including any suggestions that may improve the needs assessment process, outputs, or outcomes in future (expand field as necessary).*

**Performance measures**

HNECC is developing a Health Outcomes Framework to support the measurement and reporting of the health and wellbeing outcomes of HNECC activities. In alignment with the Quadruple Aim methodology adopted by HNECC, the Framework will guide efforts in delivering a primary health system that supports HNECC PHN residents to be as healthy as they can be, while enhancing patient experience and care outcomes, improving the experience of the clinician, and driving greater value for investments. To assist in identifying local indicators to measure the attainment of intended outcomes for each activity, we have altered table 3 to reflect the recommended process outlined in the 'PHN Performance Framework'. Under 'Possible Performance Measurement', we have included additional columns to capture the following:

• Availability of appropriate indictors from national datasets. Here suitable indicators from a range of datasets has been included:

- Australian Institute of Health and Welfare (AIHW) – My Healthy Communities reports
- Public Health Information Development unit
- Department of Health/ AIHW PHN data website
- AIHW METeOR – Health Sector National Minimum data sets
- PHN secure data website

•PHN identified outcome measures: e.g. Patient Reported Outcome Measure (PROMs); Patient Reported Experience Measures (PREMs); Clinical outcome measures; Provider experience measures.

• PHN identified process/output measures

The activities of HNECC occur in an environment where multiple programs and policies are simultaneously attempting to achieve improvement across the health system. With this in mind, we have made an attempt to indicate whether changes in a particular national indicator are anticipated to be a direct or indirect result of the contribution of HNECC and its providers. Attributing a change in national indicators directly to the activities of HNECC depends on a number of factors, including the characteristics of the activities pursued, the specification of the indicators and the local context. If an activity is targeting a sub-PHN region, and data to support the measure is available at sub-PHN geography, such as SA3, this has been mentioned.

These suggested possible performance measures have assisted HNECC to align with the Quadruple Aim methodology and relate our activities and associated indicators to the objectives of PHNs, national priority areas, and/or national headline indicators, and will:

- be further developed and refined with assistance from external evaluation experts, initially focussing on the development, collection and analysis of PREMS and PROMs and establishing targets;
- be reviewed by relevant HNECC program managers, who along with relevant stakeholders and service providers, will select the most appropriate local indicator(s) and targets for each activity they undertake that best demonstrate their effect on local priorities, which will be included in HNECC Activity Work Plans; and
- aid in the development of the HNECC PHN Outcomes Framework.

**Attachments**

The HNECC Baseline Needs Assessment has been recently refreshed and an Aboriginal Health and Wellbeing Needs Assessment has been undertaken. For reasons of brevity and to minimise duplication each HNECC activity / opportunity / priority / option has been described in full in one needs assessment template only, with references made to guide the reader to the appropriate template for additional information. Section 4, Table 3, of each of these needs assessment has therefore been added as an Appendix to this report.

# Section 2 – Outcomes of the health needs analysis

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

*Additional rows may be added as required.*

**Table 1**

| Outcomes of the health needs analysis | | |
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| Identified need | Key Issue | Description of Evidence |
| Young people aged 12-25 years | In 2013-14, one in five Australians aged 12-17 years reported high (13.3%) or very high (6.6%) levels of psychological distress as measured using the K10. In NSW, in 2014, 13.3% of secondary school students reported high levels of psychological distress in the previous six months (9.6% of males, 17.2% of females). Of students aged 12-15 years, 14.9% of females and 9.0% of males reported high psychological distress, and of those aged 16-17 years, 22.2% of females and 10.8% of males reported high psychological distress. Female students were more likely to report feeling unhappy, sad or depressed, and feeling nervous, stressed or under pressure, whilst males were more likely to report being in trouble because of bad behaviour.<br><br>Young people aged 12-25 years are a priority population group for mental health and for suicide prevention in the HNECC PHN region. In 2014-15, the rate of hospitalisations due to intentional self-harm for people aged 15-24 years was higher for the HNECC PHN region (392 per 100,000) than NSW (315.9 per 100,000), with the highest rates among females (HNECC PHN: females 550.8 per 100,000; males 242.8 per 100,000. NSW: females 464.4 per 100,000; males 175.6 per 100,000). The suicide related needs of young people aged 12-25 years were identified as high in the HNECC PHN region and were associated with social and geographic isolation, relationship breakdown and bullying at school and through social media.<br><br>There was a common perception across stakeholders that the mental health needs of young people in the HNECC PHN region are increasing. Information was provided about concerns regarding eating disorders | *The mental health of children and adolescents: Report on the second Australian child and adolescent survey of mental health and wellbeing (Lawrence, Johnson, & Hafekost et al., 2015); HealthStats (Centre for Epidemiology and Evidence, 2016).*<br><br>*Stakeholder consultations (2017).*<br><br>*Contractor LF, Celedonia KL, Cruz M, et al. Mental health services for children of substance abusing parents: voices from the community. Community Ment Health J. 2012; 48: 22-8; Gulliver A, Griffiths KM and Christensen H. Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. BMC Psychiatry. 2010; 10: 113; Salloum A, Johnco C, Lewin AB, McBride NM and Storch EA. Barriers to access and participation in community mental health treatment for anxious children. J Affect Disord. 2016; 196: 54-61; Iskra W, Deane FP, Wahlin T and Davis EL. Parental perceptions of barriers to mental health services for young people. Early Interv Psychiatry. 2015; McCann TV and Lubman DI. Young people with depression and their experience accessing an enhanced primary care service for youth with emerging mental health problems: a* |

| Outcomes of the health needs analysis | | |
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| | and increasing levels of self-harm amongst young people in all communities. Services for children and young people up to 18 years of age was a gap identified across all local government areas. It was perceived that the demand for services for children and young people was increasing, with reports of increasing mental illness and self-harming in this age group. Access to child and adolescent mental health services for acute and community based services was reportedly limited with criteria for access limited to those with severe mental illness. For inpatient services, children outside of the Newcastle area had to travel. Access to psychologists who were accredited and/or willing to provide services to children and young people was perceived to be limited in most LGAs. Factors identified by stakeholders as being associated with mental illness in young people included: family dysfunction; lack of hope for future employment; lower high school retention rates; bullying at home, in schools, in sporting teams and cultural groups, particularly through social media; and social isolation.<br><br>Barriers identified as impeding access to mental health care for young people included: a lack of follow-up care after a suicide attempt; stigma associated with mental illness; poor mental health literacy; long waiting lists; expensive treatment; reluctance to engage in treatment; parental stress; lack of mental health professionals to treat children; the shift to prescribing medication to address children's needs rather than considering non-pharmacologic approaches; parents / caregivers distrust of mental health providers; caregiver fear; transport issues; embarrassment; confidentiality concerns; and mistrust. | *qualitative study. BMC Psychiatry. 2012; 12: 96; Asarnow JR, Baraff LJ, Berk M, et al. An emergency department intervention for linking pediatric suicidal patients to follow-up mental health treatment. Psychiatr Serv. 2011; 62: 1303-9.* |
| Males aged 25-65 years | In 2011, in NSW, the greatest burden of disease stemming from mental health for males was amongst those aged 35-39 years (11.1%).<br><br>Males aged 25 - 65 years were identified as a priority population group across the HNECC PHN region. Stakeholders consistently identified this cohort as being at-risk for experiencing mental health problems and priority population group for suicide prevention. For males in this age group, stigma in accessing services and reluctance to discuss mental illness were perceived as contributing to reduced service access and led to men being identified as a key priority group when assessing needs. Across all communities, stakeholders reported that this cohort was most likely to experience suicidal ideation or complete suicide. The highest numbers of suicides in the HNECC PHN region was amongst people aged between 25 and 55 years, with males accounting for four out of five deaths. The suicide related needs of males aged 25-45 years were identified as particularly high and were associated with social and geographic isolation and | *Stakeholder consultations (2017).*<br><br>*HealthStats NSW (Centre for Epidemiology and Evidence, 2016); Hom MA, Stanley IH and Joiner TE, Jr. Evaluating factors and interventions that influence help-seeking and mental health service utilization among suicidal individuals: A review of the literature. Clin Psychol Rev. 2015; 40: 28-39; Rice SM, Telford NR, Rickwood DJ and Parker AG. Young men's access to community-based mental health care: qualitative analysis of barriers and facilitators. J Ment Health. 2017: 1-7; Cullen W, Broderick N, Connolly D and Meagher D. What is the role of general practice in addressing youth mental health? A discussion paper. Ir J Med Sci. 2012; 181: 189-97; Weinberger MI, Nelson CJ and Roth AJ. Self-reported barriers to mental health treatment* |

| Outcomes of the health needs analysis | | |
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| | relationship breakdown. It was identified that young men are less likely to seek help than women, which may be due to males feeling more stigma or shame around seeking help. | *among men with prostate cancer. Psychooncology. 2011; 20: 444-6.* |
| Males aged over 80 years | In 2015, the proportion of people aged 65 years+ in the HNECC PHN region was 18.9% (NSW 15.7%; Australia 15%), this proportion was highest in Great Lakes (33.5%), Gloucester (28.4%) and Tenterfield (26.3%) LGAs, and lowest in Singleton (11.3%), Muswellbrook (11.5%) and Maitland (13.4%). Across all communities, older males were identified through interviews with stakeholders as being an at-risk population group for experiencing mental health problems.<br><br>Males aged over 80 years were identified as a priority population group for mental health and suicide prevention in the HNECC PHN region, as this cohort reportedly commonly experience suicidal ideation or complete suicide. On a global level, older people have a higher risk of completed suicide than any other age-group. In Australia, the highest age-specific suicide death rate occurs in males aged 85 years and over. Factors such as grief and loss, adjustment to life in aged care facilities, geographic isolation and social isolation, particularly following the death of a partner, contribute to the high needs of males aged over 80 years.<br><br>Services for older people were recognised as a growing need as the population ages, and the following issues were perceived as significant service gaps for older people in the HNECC PHN region. Older people experiencing mental illness cannot seek support through the NDIS due to the age limit of 18-65 years and need to seek services through myagedcare. Access to services through a GP is available through a chronic care plan but is limited to five services per year, including other allied health, it was perceived that older patients prioritised services such as podiatry and physiotherapy over addressing their mental health needs. Residents of aged care facilities are ineligible for services under the Better Access mental health program. Older people are less likely to seek help for mental illness due to perceived stigma, self-reliance, poor mental health literacy, lack of available transport, service gaps and a lack of professional specialisation in mental health later in life. | *Muir-Cochrane E, O'Kane D, Barkway P, Oster C and Fuller J. Service provision for older people with mental health problems in a rural area of Australia. Aging & Mental Health. 2014; 18: 759-66; Deuter K, Procter N and Rogers J. The emergency telephone conversation in the context of the older person in suicidal crisis: A qualitative study. Crisis: The Journal of Crisis Intervention and Suicide Prevention. 2013; 34: 262-72; 3303.0 - Causes of Death, Australia 2015. Canberra: Australian Bureau of Statistics, 2016; Deuter K, Procter N and Rogers J. The emergency telephone conversation in the context of the older person in suicidal crisis: A qualitative study. Crisis: The Journal of Crisis Intervention and Suicide Prevention. 2013; 34: 262-72;*<br><br>*Stakeholder consultations (2017).*<br><br>*Social health atlas of Australia Data by Primary Health Network (incl. local government areas) (PHIDU, 2017)* |
| Aboriginal and Torres Strait Islander people | In 2015, the Aboriginal and Torres Strait Islander ERP for the HNECC PHN region was 63,900 or 5.1%, compared to 3.1% nationally. In 2012-13, in Australia, 30% of Aboriginal people reported high or very high psychological distress, 2.7 times higher than for non-Indigenous people. These levels were higher for | *Social health atlas of Australia Data by Primary Health Network (incl. local government areas) (PHIDU, 2017); The health and welfare of Australia's Aboriginal and Torres Strait Islander people (AIHW, 2015); PAT CAT Tool* |

| Outcomes of the health needs analysis | | |
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| | Aboriginal women (36%) than men (24%). Aboriginal people who had been removed from their natural family (48%) were more likely to experience high or very high psychological distress (35%) than those who had not (29%). This was also seen among those who had relatives removed (34%) compared to those who had not (26%).<br><br>Stakeholders from across the HNECC PHN region consider the mental health needs of Aboriginal people to be a priority across all LGAs. The impact of inter-generational trauma on Aboriginal communities and the associated impact on mental health was highlighted. Intergenerational trauma was perceived to contribute to a range of other associated health and social problems including drug and alcohol use, family dysfunction and domestic violence. It was perceived that there was a need for more than 12 sessions maximum available under different allied health access programs for clients who had experienced trauma and abuse, particularly Aboriginal and Torres Strait Islander clients.<br><br>In NSW, in 2014-15, the rate of hospitalisations for intentional self-harm for Aboriginal people was 354.3 per 100,000 (females: 417.9 per 100,000; males: 290.9 per 100,000), substantially higher than the rate for non-Indigenous people. The rate of hospitalisations for intentional self-harm for Aboriginal people aged 15-24 years was 641.4 per 100,000 (females: 859.4 per 100,000; males: 436.4 per 100,000). In 2011-12 to 2012-13, in NSW, the hospitalisation rate for mental health conditions was 23 per 1,000 for Aboriginal people, compared to 12 per 1,000 for non-Indigenous people. Between 2004-05 and 2012-13, in NSW, the hospitalisation rate for mental health conditions for Aboriginal people increased from 25 to 29 per 1,000, and the rate difference between Aboriginal people and non-Indigenous people decreased by 5%.<br><br>Aboriginal males are less likely than females to seek help from mental health services and are more likely to contact services when they are acutely unwell. Although Aboriginal people access mental health services at a higher rate than the non-Indigenous population, there is likely to be many Aboriginal people who need services but do not access them, with underutilisation largely attributed to cultural inappropriateness. Certain practices can cause distress to Aboriginal clients, such as maintaining direct eye contact during conversations and seeing health professionals in a closed environment, and often patients do not understand clinicians. The lack of Aboriginal staff in mental health services compounds the barriers to | *(HNECC PHN, 2017); Centre for Epidemiology and Evidence. HealthStats NSW. 2016; Isaacs AN, Maybery D and Gruis H. Mental health services for aboriginal men: mismatches and solutions. Int J Ment Health Nurs. 2012; 21: 400-8; Isaacs AN, Pyett P, Oakley-Browne MA, Gruis H and Waples-Crowe P. Barriers and facilitators to the utilization of adult mental health services by Australia's Indigenous people: seeking a way forward. Int J Ment Health Nurs. 2010; 19: 75-82; Australian Institute of Health and Welfare. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Canberra: ACT2016; Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report: New South Wales. Canberra: ACT2015.*<br><br>*Stakeholder consultations (2017).* |

| Outcomes of the health needs analysis | | |
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| | accessing treatment, with greater involvement from Aboriginal communities in services significantly improving treatment initiation and engagement with services. | |
| Older people residing in aged care facilities | The mental health needs of older people in the HNECC PHN region, and particularly older males, were frequently mentioned by stakeholders as increasing with the ageing population. Older people have a higher risk of completed suicide than any other group worldwide and often complete suicide on their first attempt. Service providers indicated that older people who were socially isolated, especially after the death of a partner, had high mental health and suicide prevention needs. The mental health needs of older people in aged care facilities were also identified as significant and national data indicates that over half of all permanent aged care residents experience symptoms of depression. Factors associated with these needs included: grief and loss after the death of partner; adjustment to life in aged care facilities; loss of local community connection when the facility was located distantly to their previous home; and social and sometimes geographic isolation from family. | *Depression in residential aged care 2008–2012. . Canberra: Australian Institute of Health and Welfare; Australian Institute of Health and Welfare. Australia's Health 2016. Canberra: ACT2016; Australian Institute of Health and Welfare. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Canberra: ACT2016; Muir-Cochrane E, O'Kane D, Barkway P, Oster C and Fuller J. Service provision for older people with mental health problems in a rural area of Australia. Aging Ment Health. 2014; 18: 759-66.*<br><br>*Stakeholder consultations (2017).* |
| Members of the LGBTIQ community | Members of the LGBTIQ community in Australia experience mental illness at higher rates than other Australians. A higher proportion of this community meet criteria for experiencing a major depressive disorder and report high or very high levels of psychological distress compared to heterosexual Australians. These differences between the LGBTIQ and heterosexual communities are magnified in young people. Members of the LGBTIQ community also report suicidal ideation and suicide attempts at higher levels than heterosexual people, with attempts at younger ages.<br><br>The needs of the LGBTIQ community were identified as significant by stakeholders across the HNECC PHN region. Factors including stigma, discrimination, and community and service awareness and respect were associated with higher levels of mental ill-health for this community. For people who are transgender and intersex, discrimination and stigma by service providers were identified as significant factors affecting their mental health. The mental health and suicide needs of younger LGBTIQ people were also highlighted by stakeholders with factors such as difficulties in coming out, stigma, discrimination, acceptance and isolation, contributing to mental ill-health and suicide. Stakeholders reported that some services refused access, or refused to acknowledge transgender people by offering gender appropriate services based on sexual and gender diversity. | *Rosenstreich G. LGBTI People Mental Health and Suicide. Revised 2nd Edition. Sydney: National LGBTI Health Alliance, 2013. Table 21: Profile of Headspace clients by population group, Q1-Q3 2016/17.*<br><br>*Stakeholder consultations (2017).* |

| Outcomes of the health needs analysis | | |
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| People experiencing chronic and episodic moderate to severe mental illness, including those experiencing other health and social problems | In 2014-15, in the HNECC PHN region, the rate at which people aged 18 years and over experienced high or very high psychological distress was higher than the NSW and Australian averages at 12.2 per 100. In 2013-2015, in the HNECC PHN region, high psychological distress was more common in males (7.7 per 100) than in females (6.0 per 100), whilst very high psychological distress was more common in females (5.6 per 100) than males (2.9 per 100). Rates of high or very high psychological stress were greatest in Cessnock (15.2 per 100), Wyong (13.8 per 100) and Muswellbrook (13.7 per 100) LGAs, and lowest in Walcha (7.1 per 100), Guyra (8.2 per 100) and Uralla (8.4 per 100).<br><br>In 2011-12, the rate at which people experienced chronic mental and behavioural disorders within the HNECC PHN region was 14.4 per 100, higher than the national (13.6) and state rates (13.1 per 100). The rate of females experiencing mental and behavioural problems in the HNECC PHN region was higher than in males (15.6 per 100 and 13.2 per 100 respectively). LGAs with the highest rate of people experiencing mental and behavioural problems were Great Lakes (16.3 per 100), Greater Taree (16.2 per 100) and Wyong (15.6 per 100), and the lowest were Walcha (12.1 per 100), Singleton (12.3 per 100) and Upper Hunter Shire (12.8 per 100).<br><br>The needs of people experiencing moderate to severe mental illness, including episodic and chronic mental illness, were identified as the highest priority need by stakeholders across all LGAs comprising the HNECC PHN region. This included those people experiencing other complex health and social problems such as physical illness, drug and alcohol misuse, access to sustained housing, unemployment and difficulties in daily living. | *Social health atlas of Australia Data by Primary Health Network (incl. local government areas) (PHIDU, 2017); HealthStats NSW (Centre for Epidemiology and Evidence, 2016).*<br><br>*Stakeholder consultations (2017).* |
| Stigma encountered by people experiencing mental illness including in relation to help seeking | Stigma associated with experiencing mental illness was identified by stakeholders across the HNECC PHN region as impacting on help seeking and engagement with services, including stigma in the general community and on the behalf of service providers. In accordance with the literature, stigma related to mental illness was commonly reported as a barrier to help seeking. Males, particularly rural males, were reported to be reluctant to seek care due to the stigma associated with needing help. Stigma was also reported to be a barrier to treatment for adolescents and young people, males, members of the LGBTIQ community and older people. Stigma has been identified as a major barrier in implementing evidence-based interventions in schools and a barrier in seeking help due to fear of being shamed or socially excluded. | *Fazel M, Hoagwood K, Stephan S and Ford T. Mental health interventions in schools in high-income countries. The Lancet Psychiatry. 2014; 1: 377-87; Roman J, Griswold K, Smith S and Servoss T. How patients view primary care: differences by minority status after psychiatric emergency. Journal of cultural diversity 15: 56-60 (2017); Nakash O, Nagar M, Danilovich E, et al. Ethnic disparities in mental health treatment gap in a community-based survey and in access to care in psychiatric clinics. Int J Soc Psychiatry. 2014; 60: 575-83; Polaha J, Williams SL, Heflinger CA and Studts CR. The Perceived Stigma of Mental Health Services Among Rural Parents of Children With* |

| Outcomes of the health needs analysis | | |
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| | | *Psychosocial Concerns. J Pediatr Psychol. 2015; 40: 1095-104; 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. Canberra: ACT2015; Lingley-Pottie P, McGrath PJ and Andreou P. Barriers to mental health care: perceived delivery system differences. ANS Adv Nurs Sci. 2013; 36: 51-61.*<br><br>*Stakeholder consultations (2017).* |

# Section 3 – Outcomes of the service needs analysis

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

*Additional rows may be added as required.*

**Table 2**

| Outcomes of the service needs analysis | | |
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| Identified need | Key Issue | Description of Evidence |
| Costs to access mental health and suicide prevention services | Costs for allied health services have been identified as a barrier to accessing services for mental illness and suicide prevention. In 2015-16, in the HNECC PHN region, 5.4% of adults did not see or delayed seeing a GP due to cost in the preceding 12 months (national 4.1%). 9.1% of adults delayed or avoided filling a prescription due to cost in the preceding 12 months (national 7.6%). In 2014, LGAs with the highest rate of people finding cost of services a barrier were Great Lakes (3.9 per 100), Armidale Dumaresq (3.7 per 100), and Cessnock (3.4 per 100); and the lowest were Lake Macquarie and Uralla (both 1.7 per 100).<br><br>Stakeholder engagement across the HNECC PHN region showed that many consumers, clients and carers indicated that cost was a significant barrier to accessing mental health care. Eighty-one percent of service providers and 71% of consumers, clients and community members reported cost as a barrier to accessing services. Many GPs, psychiatrists and private allied health staff charged a gap payment on top of the Medicare rebate with few bulk-billing. The cumulative effect of these costs is considerable especially for those with moderate to severe mental illness, who are reliant on welfare payments as work is limited as a result of their illness. Service providers commonly indicated that their decisions about referral were made on knowledge about service costs rather than on care needs. Consumers also reported making choices about accessing care based on cost with some waiting until their symptoms deteriorated before seeking care which often resulted in the need for more intensive help through specialist services such as in acute wards. Service providers indicated that this was an expensive way for the system to provide services. There is also a cost disincentive for services to take on patients with complex needs as billing is the same whether the patient requires treatment for less complicated or more complex needs. | *Stakeholder consultations (2017).*<br><br>*My healthy communities (AIHW, 2017); Social health atlas of Australia Data by Primary Health Network (incl. local government areas) (PHIDU, 2017); Iskra W, Deane FP, Wahlin T and Davis EL. Parental perceptions of barriers to mental health services for young people. Early Interv Psychiatry. 2015;* |
| Transport to services | In 2014, in the HNECC PHN region, the rate of people who often had difficulty or could not get to places as needed with transport was 4.1 per 100, compared to 4.0 per 100 Australia- | *Stakeholder consultations (2017).* |

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| | wide, and 4.3 per 100 for NSW. LGAs with the highest rate of people encountering transportation barriers were Moree Plains (4.7 per 100), Wyong (4.6 per 100) and Liverpool Plains (4.5 per 100); and those with the lowest rate were Uralla (3.5 per 100), Singleton and Walcha (both 3.6 per 100).<br><br>Transport to services has been identified as a barrier to accessing services for mental illness and suicide prevention throughout the HNECC PHN region, with public transport limited or unavailable in many communities. The availability of transport is a barrier to engagement in mental health services particularly for low-income individuals, adolescents and frail older people. Stakeholder engagement showed that the challenges that transport presented was not in rural areas alone but also in urban areas. Clients often had to rely on public transport to access specialist clinical services distant to their home, leading to the need for whole day or overnight stays. Community transport, while available, was often charged at a prohibitive cost and consumers reported experiencing stigmatising attitudes when requesting access. | *Social health atlas of Australia Data by Primary Health Network (incl. local government areas) (PHIDU, 2017); Gopalan G, Goldstein L, Klingenstein K, Sicher C, Blake C and McKay MM. Engaging families into child mental health treatment: updates and special considerations. J Can Acad Child Adolesc Psychiatry. 2010; 19: 182-96; Gulliver A, Griffiths KM and Christensen H. Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. BMC Psychiatry. 2010; 10: 113; Perkins D, Fuller J, Kelly BJ, et al. Factors associated with reported service use for mental health problems by residents of rural and remote communities: cross-sectional findings from a baseline survey. BMC Health Serv Res. 2013; 13: 157; Santiago CD, Kaltman S and Miranda J. Poverty and mental health: how do low-income adults and children fare in psychotherapy? J Clin Psychol. 2013; 69: 115-26; Muir-Cochrane E, O'Kane D, Barkway P, Oster C and Fuller J. Service provision for older people with mental health problems in a rural area of Australia. Aging Ment Health. 2014; 18: 759-66.* |
| Services for people experiencing chronic and episodic moderate to severe mental illness, including those experiencing other health and social problems | The most common service gap reported by stakeholders in the HNECC PHN region was for people experiencing moderate to severe mental illness, both episodic and chronic, including those experiencing other complex health and social problems. Clinical care for people experiencing severe mental illness is not available. Providing care for this population group is stretching the capacity of primary care, with specialist services in the LHD only available for people who are acutely unwell. The need to strengthen the capacity of services to provide care for people with severe mental illness and other complexities was recognised as a priority.<br><br>It was perceived that the capacity of some services to provide the breadth of services for people experiencing moderate to severe mental illness was limited, with few providing seamless access to clinical, therapeutic and support services. Referral between services was described as difficult, with challenges around information sharing, case management and role delineation. If someone was triaged as meeting criteria for state mental health services and | *Stakeholder consultations (2017).*<br><br>*Clinical and committee members, June 2017; Reilly S, Planner C, Gask L, et al. Collaborative care approaches for people with severe mental illness. Cochrane Database of Systematic Reviews: (2013); Andrade LH, Alonso J, Mneimneh Z, et al. Barriers to mental health treatment: results from the WHO World Mental Health surveys. Psychol Med. 2014; 44: 1303-17.* |

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| | presented to an acute facility, they were often either not admitted or discharged early (often late at night and far from home without transport). The mental health line, the initial point of access for someone experiencing acute mental health symptoms, was criticised by service providers and community members due to long delays on the phone and most people eventually being deemed ineligible for state based mental health services.<br><br>Many community based service providers indicated they felt ill-equipped to provide the type and intensity of services needed by these consumers. The need to strengthen the capacity of community based social support services to provide care for people with severe mental illness and other complexities, was recognised as a priority. This includes strengthening approaches to quality and governance across services. Support service staff were often welfare trained without the mental health specific expertise, and were often working beyond their level of qualification and scope of practice to support this cohort. It was also perceived that there was no mechanism for escalating clients with deteriorating mental health.<br><br>With general practice playing a central role in mental health care, the capacity of this key service to provide care for people with mental illness was a high priority service need. Specific areas of capacity building required include training GPs in mental health with a focus on skills, knowledge and attitudes towards mental illness across population groups; and improving the capacity of general practice to provide care through practice nurses and allied health staff.<br><br>Under the different allied health access programs, clients are eligible for 6 sessions per year with an additional four to six under exceptional circumstances. It was perceived that this was too restrictive with allied health professionals commonly indicated that clients experiencing mental illness, especially severe mental illness and other complexities, required more sessions. This was particularly relevant for clients who had experienced trauma and abuse, and especially for Aboriginal and Torres Strait Islander clients experiencing intergenerational trauma. | |

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| | Factors contributing to the unmet needs of this priority group include: access, waiting times and cost barriers for psychiatrists across communities; patient and service provider experience of the mental health line; reduced access to experienced psychologists across communities; gaps in case management and follow-up; and a lack of focus across all services on prevention and early intervention to reduce the need for more intensive services. The gaps in the current system tend to channel people into the acute setting. | |
| Support for GPs to play a central role in mental health care including through enhanced stability of the mental health support service system and associated pathways to care and 24hr psychiatry access | In 2015-16, in the HNECC PHN region, 1,644 GPs provided 189,176 mental health services through the MBS to 109,622 patients. The average number of providers in the HNECC PHN region was 132.1 per 100,000 and ranged from 106.4 per 100,000 in Lower Hunter SA3 to 172.8 per 100,000 in Great Lakes. In 2013-14, in the HNECC PHN region, 24.6% of adults felt they waited longer than acceptable to get an appointment with a GP (national 22.6%).<br><br>Concerns about the capacity of GPs to provide mental health care were raised by consumers and some service providers. Many consumers and carers expressed concern about the attitudes of GPs to mental illness and to those experiencing mental illness, which affected their willingness to provide appropriate care, including mental health care plans. There was also a perception that GPs often relied on medication as the first treatment option for depression and anxiety, and as an alternative to preparing a mental health care plan. The capacity challenges of GPs related to time, knowledge, skill, interest and attitude. Clients and carers commonly indicated that the GP was critical in ensuring a comprehensive and supportive approach to care, however the attitudes of GPs could compromise care. Indeed, some clients and carers indicated that GPs use of mental health care plans was dependent on the attitude of the GP to mental illness, rather than the symptoms of the patient and the evidence for care. While it was recognised that GPs play a key role in managing mental ill-health, the need for other staff in general practice such as practice nurses and other allied health providers to provide care for people experiencing a mental illness was common. The central role of the GP in the provision of mental health care needs to be a key tenet of service models. However, for GPs to undertake this central role, this needs to occur in the context of support and capacity building across the service system. | *PHN MBS data (Australian Government Department of Health, 2017); My healthy communities (AIHW, 2017); Reilly S, Planner C, Gask L, et al. Collaborative care approaches for people with severe mental illness. Cochrane Database of Systematic Reviews: (2013); Reilly S, Planner C, Gask L, et al. Collaborative care approaches for people with severe mental illness. Cochrane Database of Systematic Reviews: (2013).*<br><br>*Stakeholder consultations (2017).* |

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| | The capacity of GPs to provide care for people with suicidal ideation was also an area of concern. This was raised by many interview participants but particularly young people. It was perceived that some GPs lacked the skills in identifying a patient at risk of suicide, often ignored risk factors and were reluctant to have the conversation about suicide. Further, some young people expressed concern about the attitudes of some GPs towards suicide.<br><br>Given the lack of services for people with severe mental illness and with complex health and social problems, stakeholders reported a reliance on primary care to provide the necessary care, which was perceived to be beyond the capacity of primary care particularly when a person's symptoms were escalating, resulting in poor outcomes for everyone involved. It is suggested that a major issue is that many GPs feel that physical health problems are their focus and view the treatment of mental health, particularly severe mental illness, as the role of mental health professionals. It was perceived by clients, carers and service providers, including GPs, that this was beyond the capacity of primary care, especially in instances where a person's symptoms were escalating. | |
| Access to psychiatrists across the region | In 2014-15, in the HNECC PHN region, a total of 493,054 patients received 1,637,337 psychiatry services through the MBS. The number of patients receiving a psychiatric service in the HNECC PHN region was 1,335 per 100,000, ranging from 355 per 100,000 in Moree-Narrabri SA3 to 2,186 per 100,000 in Taree-Gloucester. The number of psychiatry services delivered under MBS in the HNECC PHN region was 6,495 per 100,000, ranging from 2,040 per 100,000 in Moree-Narrabri SA3 to 9,161 per 100,000 in Newcastle.<br><br>According to stakeholder engagement, access to psychiatrists across the HNECC PHN region, especially in rural areas, was a high need with insufficient numbers to meet needs and costs due to gap payment a significant barrier to care. Waiting lists to see psychiatrists were common, and were longer for those who bulk billed. The ability of consumers to access psychiatrists in a timely manner was an issue and was identified as the most common workforce need. This need was relevant across all ages and especially for children and young | *PHN MBS data (Australian Government Department of Health, 2017);*<br><br>*Stakeholder consultations (2017).* |

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| | people with few child psychiatrists available across the region. Access to child psychiatrists was mainly in Newcastle and for those with severe mental illness.<br><br>Access by GPs to psychiatrists through telehealth was thought to enhance services, particularly in rural area, but this was mostly unavailable. In many rural communities there was reliance on fly-in fly-out psychiatrists to provide specialist medical input, with access to care only available on days when the specialist was in town. Retention of mental health staff and in particular psychiatrists was as a concern, affecting continuity of care. | |
| Enhanced capacity of services to recruit and retain allied health staff | There is a need to strengthen the capacity of services to recruit and retain allied health staff, particularly psychiatrists and psychologists, especially in rural areas. Some strategies are in place to attract psychiatrists but such incentives are not available for psychologists. There was a strong and common view that there needs to be investigation into incentives to attract health staff to rural communities. Examples were provided for other professions such as teachers and police who are offered housing rental concessions as a way of attracting them to rural areas. It was perceived that there was significant turnover in mental health staff which affected continuity of care. Reliance on provisional psychologists was perceived as impacting on their retention. Service providers indicated that the challenges faced by provisional psychologists in terms of case complexity, and lack of support, resulted in many leaving services. | *Stakeholder consultations (2017).* |
| The availability of early intervention services | The lack of early intervention approaches and services was identified as a high service need, especially for young people and for people experiencing early psychosis. Stakeholders indicated that there was a need to increase access to early intervention services in order to improve mental health across the HNECC PHN region. This included: early intervention to prevent onset of mental illness; prevent deterioration of mental illness; support recovery; and specifically, for those experiencing first onset of psychosis. These services were perceived to be mostly unavailable. It was also recognised that there needed to be a significant shift in the whole way services are delivered to ensure early intervention was applied across the service system. The potential for early intervention for mental illness by identifying associated factors and intervening before symptoms manifest or conditions deteriorate is yet to be realised. There a need for a stronger focus across all services in prevention and early | *Stakeholder consultations (2017).* |

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| | intervention with the aim of trying to prevent people requiring more intensive services rather than the current system, which due to service gaps channels people into the acute setting. | |
| Cross-sectoral mental health promotion and prevention, and suicide prevention strategies | The availability of mental health promotion and prevention services was identified by stakeholders as a key service gap. In particular, the need to ensure evidence-based and systematic approaches to mental health promotion and prevention, and suicide prevention, with an emphasis on strategies which are broader than education and training. Such initiatives need to be implemented across sectors including: youth specific services, education and training sectors, community and sporting groups, workplaces, aged care facilities and general health system. | *World Health Organization. The Ottawa Charter for Health Promotion. Geneva, Switzerland: WHO, 1986; Hunter Institute of Mental Health. Prevention First: A Prevention and Promotion Framework for Mental Health. . Newcastle, Australia2015.*<br><br>*Stakeholder consultations (2017).* |
| Enhanced capacity of service to develop and implement an approach to quality incorporating service improvement plans, clinical governance frameworks, case review policies and procedures, and clinical supervision | The findings of this needs assessment indicate inconsistencies in approaches to quality and to quality improvement across all services throughout the HNECC PHN region. There is a need for frameworks aligned to clinical governance approaches across the mental health service system, including support services, with support for case review and clinical supervision to manage risk.<br><br>The quality of services was perceived as variable by stakeholders, with many indicating there was a need to improve the quality of mental health treatment services available. In particular, concerns were expressed about the quality of services provided by LHD mental health services, especially in the acute setting. Other concerns about service quality related to the lack of experienced clinical staff in some organisations, with reliance on staff such as provisional psychologists. This was suggested as occurring in the absence of supervision by an experienced psychologist and thus affected quality of care. It was also perceived by some service providers as being a way for some organisations to reduce session costs but neglected quality of care.<br><br>Few support services appeared to have a systematic approach to quality. A quality framework including an approach to manage clinical risk was considered imperative for all services but was not a focus of many services. Stakeholders provided examples here mechanisms for | *Stakeholder consultations (2017).* |

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| | escalating clients' needs to more specialist services were not available in some services. In addition, there were few examples of services reporting client outcomes, and clinical and client experience, with a reliance on activity reporting. | |
| Support for families and carers of people living with mental illness | Support services for families and carers of people living with mental illness was identified by stakeholder as a high need across communities throughout the HNECC PHN region. This was about providing direct support, but more importantly recognising and respecting the key role that families and carers play in caring for people experiencing mental illness, and involving them in decision making about care. There was a common and strong perception by carers that there is a lack of recognition of their role in the care they provide for family members and friends. While this was often explained to them by service providers as relating to confidentiality, it was suggested that their involvement in care was likely to result in better outcomes for the patient and for the carers. Some service providers, especially those in the LHD mental health services recognised there was a need to strengthen the involvement of carers in care planning for patients especially those with severe and complex mental illness. Family members and carers are key members of support teams for people experiencing severe mental illness, and services need to recognise their role in order to provide optimal care. The impact on family and carers of someone with severe mental illness is significant, and support for carers and family members should be a key element of services across the region. | *Stakeholder consultations (2017).* |
| Greater capacity for communities to implement evidence-based post-vention strategies | Stakeholders identified a lack of services, or lack of awareness of services, for family and friends after a suicide attempt. The provision of support for families following a suicide attempt or completed suicide was also perceived as a significant system challenge and a barrier to addressing suicide. It was perceived that families were often the best placed to provide support for a loved one following a suicide attempt. However, the claimed need for privacy and confidentiality was used as a barrier to involving families. This was considered a significant barrier to recovery for both the person who had attempted suicide and the family.<br><br>In partnership with organisations such as Lifeline Hunter and United Synergies, a number of communities in the HNECC PHN region have implemented strategies to support families, | *Stakeholder consultations (2017).* |

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| | friends and colleagues of people after a suicide. Other communities such as Maitland and Lake Macquarie have established suicide prevention networks without organisational support, with membership from those affected by the suicide of a family member or friend. In the Upper Hunter, Where There's a Will has been established as a not for profit charity with a focus on suicide prevention. Schools also reported post-vention strategies with support often provided by Headspace at state level. However, these strategies are not in place in every community and the capacity of communities to respond following a suicide was identified as an area of need. | |
| Simplification of the credentialing process for mental health nurses to work in general practice | While the role of mental health nurses in general practice was widely supported it was acknowledged that there were few credentialed nurses who could work in these roles. There are substantial barriers to gaining the required credentials to provide mental health nursing care in general practice which has resulted in few nurses completing the required training. Further the pay differential between mental health nurses in general practice and those working in LHD mental health services was a factor limiting supply. Stakeholders have indicated that the role of general practice in mental health care is to be strengthened, there is a need to support multidisciplinary teams located in general practice. | *Stakeholder consultations (2017).* |

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HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

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

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