Australian Government
Department of Health

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Western NSW
Mental Health and Suicide Prevention Needs Assessment - 2017

Overview

This template is provided to assist Primary Health Networks (PHNs) to fulfil their reporting requirements for Needs Assessment.

Further information for PHNs on the development of needs assessments is provided on the Department's website (www.health.gov.au/PHN), including the *PHN Needs Assessment Guide*, the Mental Health and Drug and Alcohol PHN Circulars, and the Drug and Alcohol Needs Assessment Tool and Checklist (via PHN secure site).

The information provided by PHNs in this report may be used by the Department to inform programme and policy development.

Section 1 – Narrative

Methods

Literature reviews

Literature reviews were conducted to explore and identify the burden of illness, models of care and barriers to accessing services for mental health and suicide prevention. National and international health organisation reports and policy documents were also sourced and contributed to the review.

Quantitative Data

The Western Health Intelligence Unit provided national, state and local quantitative data 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. This was complemented by data from the WNSW PHN Drug and Alcohol Atlas.

Key Stakeholder Interviews

Interviews were conducted with 183 key stakeholders across 16 LGAs. Stakeholders included: consumers, carers and interested community members; service providers from mental health, drug and alcohol and other community services; and GPs and other medical specialists. Modified thematic analysis was applied to recorded interviews to identify common themes related to needs and associated factors, service gaps and strategies for improving outcomes related to drug and alcohol.

Data Triangulation and Validation

The methods included triangulation of data resulting from the quantitative and qualitative results followed by a validation process with WNSW PHN Board and Council Members to identify priorities and confirm key findings.

Opportunities, priorities and options

Aboriginal Health as a Priority

Improving access, and the capacity and quality of mental health and suicide prevention services for Aboriginal people should be a priority in all regional planning. The significant health and social inequities require continued investment and focus across all services

Applying Principles and Evidence

Developing a response to mental health and suicide prevention needs to be guided by evidence and informed by effective public health approaches for a range of health issues. The application of these principles across the service system is key in developing regional plans.

Planning and Commissioning

The findings highlight the need for approaches which support integrated and collaborative care. Addressing the needs is dependent on effective, intersectoral planning. In the absence

of intersectoral planning, it is likely that this needs assessment will result in little change for people experiencing mental illness or for communities in general.

This needs assessment was undertaken by WNSW PHN for the communities within the WNSW PHN region and is not specifically for needs relevant to WNSW PHN commissioned services. It can equally be viewed as a needs assessment to inform all organisations that provide services for people experiencing mental health problems and at risk of suicide.

Stepped Care

The stepped care model is relevant for all mental health and suicide prevention services – clinical and support services - with mechanisms for escalation key to the success of the stepped care model. The stepped care model is relevant for drug and alcohol services. The success of the model is dependent on clear pathways between stages. It is apparent that there are significant challenges in ensuring these pathways are in place for mental health services.

Hub and Spoke Models

Planning services in line with hub and spoke models offers the most likely solution to improve access across the multiple LGAs in the WNSW PHN region. Recruitment and retention of staff is more likely to be successful in a hub and spoke model. The hub and spoke model needs to be factored into commissioning of services, ensuring coverage across communities.

The central role of the GP 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.

Place-based health planning

The WNSW PHN has already considered the application of place-based planning for mental health services to replace the current stratification by service-type and providers. Given the findings of the needs assessment in relation to access and recruitment and retention issues this approach offers benefits for future planning, and has the potential to align with the stepped care model. Given the influence of a range of demographic, access, social and geographic characteristics on mental health and drug and alcohol place-based planning offers a holistic but localised approach to service planning.

The data was identified from NSW Health Stats, the MBS, the Integrated Mental Health Atlas of Western NSW and peer-reviewed literature. Data was provided by WNSW Health Intelligence Unit. There is an absence of relevant service access data for mental health services.

The results of this needs assessment have identified priority groups, service gaps and workforce challenges in relation to mental health and suicide prevention services. There are significant challenges for people in WNSW PHN accessing mental health and suicide prevention services.

Access to specialist mental health services is a significant issue. Hospitalisation rates have been decreasing for mental disorders in rural LHDs in the WNSW PHN region for the general population and for Aboriginal people. These data contrast with trends in the rest of NSW where hospitalisation rates have been increasing over the same time period. There is no evidence that prevalence of disorders requiring hospitalisation or associated factors have decreased in this time period. Nor is there any evidence that access to community services has increased or suddenly become more effective. In the absence of definitive data about these findings it can only be assumed that access to specialist mental health services has reduced in this time. These findings warrant further investigation and explanation

The findings of this needs assessment in relation to access suggest that mental health services are not meeting the needs of the community. Instead of preventing people receiving specialist care when needed, in effect people are being channeled to acute services due to a lack of clinical care at earlier point. People experiencing mild to moderate with escalating symptoms and those with moderate to severe mental illness, including those with complex needs, are becoming increasingly unwell and their symptoms are often escalating to the stage where they need more intensive services including hospital admission. The data on access to services including MHNIP and hospitalisation data reinforce reduced access. This is ineffective, low quality care and an inefficient way to provide services. This gap cannot be addressed unless there is commitment to planning across the primary secondary and tertiary level mental health and a reorientation of the system to a client and carer focus.

There is a significant overlap of people with mental illness and substance misuse problems and suggesting the need for linkage and management of these comorbidities are considered in system and service planning. However service integration across mental health and drug and alcohol services was less than optimal with strong support for integrated planning to address the significant problems associated with access. Despite mental health services and drug and alcohol services being in the one division in LHD services integration between the two fields as being mostly non-existent. Indeed it was perceived that specialist mental health services exclude those with substance abuse problems and addiction services exclude those with mental health conditions.

Section 2 – Outcomes of the health needs analysis

MENTAL HEALTH (INCLUDING SUICIDE PREVENTION) – HEALTH NEEDS ASSESSMENT

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
GEOGRAPHY AND DEMOGRAPHY		
Geography	Largest PHN in NSW	The WNSW PHN covers both Far West and Western NSW Local Health Districts covering a total area of 433,379 square kilometres and is the largest PHN in NSW. The PHN region stretches from Bathurst in the east, and is bounded by the Queensland, South Australian and Victorian borders in the north, west and south
Population	Population overall	The estimated resident population of the WNSW PHN in 2016 was 309,940 people. The LGAs of Bathurst regional (~43,000), Dubbo (~42,000) and Orange (~42,000) have the highest estimated resident population
	Low population density	The FWLHD is the most sparsely populated LHD in NSW and has the highest proportion of Aboriginal residents (9.6%). The majority (62%) of its 28,510 inhabitants live in the City of Broken Hill with the remainder of the population living in agricultural towns along the Murray River, in small remote communities of 80-800 people or on stations throughout the LHD. Broken Hill and Orange are the most densely populated with density ratios of 110.73 and 147.25 respectively. Dubbo's population is has a lower density ratio because it is a geographically more dispersed LGA The WNSW LHD covers around 250,000 square kilometres and includes inner regional, outer regional and remote communities and has a population of 282,100 people.

Outcomes of the health needs analysis		
	Population Projections	Populations are expected to increase by 20,136 in only 11 of the 28 LGAs within an estimated population increase across the PHN region of 6.3%. The remaining 17 LGAs are expected to decrease with Walgett and Lachlan LGAs expected to have estimated decrease in population of between 18 and 20 percent.
	Aboriginal Population	Compared to NSW (3%) and Australia (3.1%) there is a high proportion (11.6%) of the population in the WNSW PHN who are Aboriginal and Torres Strait Islander.
		Eleven LGAs having more than five times the proportion of Aboriginal and Torres Strait Islander peoples. The Brewarrina LGA has the highest proportion (67.4%) of Aboriginal or Torres Strait Islander population
	Ageing population	The population is ageing with an ageing index in the WNSW PHN of 86.8, higher than NSW (83.8) and Australia (79.7) The Ageing Index is highest in Weddin (149.7) and lowest in Brewarrina
	Culturally and Linguistically Diverse (CALD) Population	All LGAs within the WNSW PHN region have a lower proportion of overseas born populations compared to the Australian (24.6%) and NSW (25.7%)
		The LGA with the highest proportion of overseas born people was Walgett (10.6%), and the lowest was Coonamble
SOCIAL DETERMINANTS		
Socio-economic factors	High levels of socio-economic disadvantage	The Socio-Economic Indexes for Areas (SEIFA) is a set of measures of relative socioeconomic disadvantage and advantage across geographic areas, calculated using variables such as household income, education, employment, occupation and housing. Ten of the LGAs within the WNSW PHN are in the most disadvantaged quintiles in NSW with Brewarrina and Central Darling the most disadvantaged. Only three of the LGAs (excluding unincorporated NSW) are in the fourth quintile indicating less disadvantage
	Indigenous Relative Socioeconomic Outcomes Index	The Indigenous Relative Socioeconomic Outcomes (IRSEO) index is a specific indicator calculated separately for the Aboriginal population in each Indigenous Region and Indigenous Area. Compared to NSW (Index Score 41) and Australia (Index Score 46), the

Outcomes of the health needs analysis		
		majority of Indigenous areas in WNSW PHN have scores indicating significant disadvantage. Only four of the Indigenous areas have scores lower than NSW with Brewarrina and Balranald having the highest level of disadvantage
	Single Parent Families	The WNSW PHN region has a higher percentage of single parent families (27%) than NSW (21.2%) and Australia (21.3%). The LGAs of Brewarrina (42.1%) and Coonamble (37.4%) have the highest proportion of single parent families.
	In need of assistance	The majority of LGAs within the WNSW PHN region had higher proportions of the population needing assistance compared to NSW (5.2%) and Australia (4.6%). Broken Hill had the highest proportion of the population needing assistance at 8.1%, followed by Warrumbungle at 7.5%
	Education	Across the WNSW PHN region the rate of early school leavers per 100 population (48.5) were considerably higher than NSW (37.6) and Australian rates (34.3)
		No LGA had a rate lower than the state or the nation, with Bathurst recording the highest rate at 42.7 per 100 population. Eleven of the LGAs had more than half of their school aged population as early school leavers.
	Employment	The unemployment level for WNSW PHN (4.8%) was slightly lower than the state proportion of 5.1% which is lower than the national rate at 5.7%. However, the unemployment rate varied across LGAs with Walgett recording an 8.6% unemployment rate. The Cobar LGA which has strong mining employment, had a relatively low unemployment rate.
	Employment Benefits	A higher proportion of people in WNSW PHN (6.3%) are on long term unemployment benefits compared with NSW (4.0%) and Australia (4.4%).
		The proportion of young people receiving unemployment benefits in WNSW (6.1%) is also higher compared with NSW (4.0%) and Australia (4.4%)
	Income	The majority of LGAs within the WNSW PHN region reported higher proportions of low individual income per week (<$400 per week) compared to the NSW (39.9%) and Australian (38.9%)

Outcomes of the health needs analysis		
		In WNSW PHN in 2016 over 39% of households received a weekly income of less than $1000 per week compared with NSW (31%). Less than a quarter (23%) of households in WNSW received a weekly income of more than $2000 while over a third (33.4%) of households in NSW received an income at this level
	Welfare dependent families	In 2016, within the WNSW PHN region, the proportion of low income welfare dependent families with children was 13.7% compared with NSW (9.9%) and Australia (10.1%)
		The proportion of children in low income welfare dependent families was 30.1%, higher than the Australian (22.5%) and NSW (22.3%). The LGAs with the highest proportion of children in low income welfare-dependent families were Coonamble (61.2%) and Walgett (55.5%)
MENTAL HEALTH STATUS AND BEHAVIOURS		
Mental and behavioural problems	High or very high levels psychological distress (K10) adults	Eleven percent of people in WNSW PHN had high or very high psychological distress, lower than most other PHNs NSW. However there was some variability across LGAS. Twelve of the PHNS had levels of high or very high psychological distress at rates higher than the whole of the PHN and NSW. The LGAs of Broken Hill and Central Darling both had 13.6% of their population with high or very high psychological distress
		There has been a slight reduction in levels of high or very high psychological distress in the WNSW PHN over the last decade peaking at 13.3% in 2004 and 2005
	Mental and behavioural problems in some communities	The rates of males, females and people with mental and behavioural problems are higher in WNSW PHN compared with NSW and Australia.

Outcomes of the health needs analysis		
		The rates vary across the LGAs. For males, in 2011-2012, Forbes, Lachlan and Wellington all have rates at 13.8%, higher than the regional rate of 13% for males. The rates for females were highest in Broken Hill (17.9%), Central Darling (17.9%) and Wellington (17.1%). The LGAs with the highest rates across the community were Broken Hill (15.8%), Central Darling (15.8%) and Wellington (15.4%) higher than the rates for the WNSW PHN region (14%), NSW (13.1%) and Australia (13.6%).
Suicides	Suicides for adults	The rate of suicides for males is higher than for females in NSW with that trend continuing for many years.
		Over the time the suicide rates for WNSW PHN has been mostly higher than NSW for all persons. The suicide rate for WNSW PHN has shown some decreases in rate since 2011 with increases over the last five years
		The age standardised rate of suicides for WNSW PHN was 10.5/100,000, higher than the NSW rate (9.4/100,000) and lower than the Australian rate (11.2/100,000)
	Suicides by LGA	The rate of suicides in the LGAs of Weddin (30.9/100,000), Lachlan (29.1/100,000) and Cobar (26.7/100,000) were highest in the WNSW PHN
	Suicides - Rural and Remote	The rates of suicide per 100,000 population are higher in outer regional and remote areas compared with more urban areas
		Suicide rates for outer regional and remote areas have been increasing over the last decade, increasing from 6.4/100,000 in 2006 to a rate of 13.8/100,000 people in 2015
		The rates of suicide for outer regional and remote areas are higher than for the rest of NSW
	Suicides - Disadvantage	Rates of suicide in NSW have not shown an association with disadvantage over the last 15 years
POPULATIONS WITH SPECIAL NEEDS		

Outcomes of the health needs analysis		
Aboriginal and Torres Strait Islander people	Psychological Distress	There are no WNSW PHN specific data on levels of high or very high psychological distress for Aboriginal people. Data for NSW indicates there was a decline in in levels of high or very high psychological distress for Aboriginal people between 2003-2004 and 2014-2015. However levels are consistently higher for Aboriginal compared with non-Aboriginal people in NSW across this time period.
	Intentional self-harm hospitalisations	There are no WNSW PHN data for rates of intentional self-harm hospitalisations for Aboriginal peoples. However NSW data in 2015 -2016 indicate the rates for Aboriginal males and females are higher compared with non-Aboriginal males and females. While rates in non-Aboriginal people have remained steady over the last 15 years rates in Aboriginal people have increased
		The rates of intentional self-harm hospitalisations for Aboriginal peoples aged 15-24 years are also higher than for non-Aboriginal peoples in this age category for males and females.
		The rates for Aboriginal peoples aged 15-24 years have increased over the last 15 years for both males and females
	Suicides	The suicide rates for non-Aboriginal peoples in NSW have remained steady for all persons and those in the 15-24 years category over the last 15 years. While there was an initial decline in rates for Aboriginal peoples (all persons and ages 15-24 years) in the last ten years these rates have increased.
		The needs of Aboriginal and Torres Strait Islander people were raised consistently as a high priority for suicide prevention. It was perceived that suicide rates were higher in Aboriginal people, with the impact of intergenerational trauma, racism and drug and alcohol as significant.
Children and young people	Psychological Distress	Data for psychological distress in secondary school students are not available at PHN level. Just over one third (33.8%) of students residing in rural and regional LHDS reported being unhappy, sad or depressed, levels similar to other LHDs.

Outcomes of the health needs analysis		
		These rates were similar to all of NSW amongst students aged 12-17 years with 33.3% feeling of unhappy, sad or depressed in the last six months which were worse than usual, quite bad or almost more than "I could take"
	Suicide main cause of death in adolescents	Suicide was the main cause of death for Australians 15 to 24 years of age (Australian Bureau of Statistics (2015) Causes of death, catalogue no. 3303.0).
	Perceptions	Young people aged 12 – 25 years were identified as a high priority in the thematic analysis. It was perceived that there were more suicides or suicide attempts in this age group.
		Factors similar to those associated with young people and mental illness – bullying, social media, family and relationship breakdown, school pressures, developmental stages and risk taking - were identified as factors contributing to young people being a high priority need for suicide prevention.
		Concerns were also raised about suicide contagion where multiple suicidal behaviours or suicides occur within an accelerated time frame, and sometimes within a defined geographical area occur. A number of examples were provided where these clusters had occurred in communities with a number of young people taking their lives in a short space of time.
		Concerns about impulsivity were raised in the context of suicide and suicidal behaviour in young people. It was suggested by participants that often young people reacted impulsively to events such as relationship breakdowns or family arguments without the intent of completion.
Males aged 25 – 45 years		Participants raised males aged 25-45 risk years a high priority group. It was perceived that suicides were higher amongst males in this age group. Alcohol and other drug use and family breakdown were cited as factors contributing to suicide and suicidal ideation in this age group. The impact of unemployment was also considered a factor for men in this age group

Outcomes of the health needs analysis		
People who are socially isolated and geographically isolated		People who were either socially or geographically isolated were perceived to be at increased risk of suicide. As with other priority groups, factors such as alcohol and other drug use and family breakdown were perceived to contribute to the isolation and suicidal risk. People living in isolated area such as on farms were also considered a high risk.

Section 3 – Outcomes of the service needs analysis

MENTAL HEALTH (INCLUDING SUICIDE PREVENTION) – SERVICE NEEDS ASSESSMENT

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
GEOGRAPHY		
Cross-border flows and access to services in adjacent regions	Complex array of cross-border flow arrangements with three states, multiple PHNs and multiple local health districts.	The PHN shares borders with 3 states: Queensland, South Australia and Victoria. Further, within NSW alone, the PHN shares boundaries with 5 other PHNs and associated local health districts. States have different Mental Health Acts.
		There is an agreement reached between the Far West Local Health District and Ramsay Health in Mildura to improve accessibility to mental health care for the population on the southern border with Victoria.
		However, there are still significant cross-border issues for primary care services including those for commissioned services
Accessing health care	Travelling long distances to access health care	The Accessibility/Remoteness Index for Australia (ARIA) is a geographical approach to defining remoteness calculated by accessibility to some 201 service centres based on road distances. Only three of the 2011 LGAs in the PHN region are considered accessible with none highly accessible. Eleven of the 2011 LGAs are either very remote or remote.

Outcomes of the service needs analysis		
	Difficulty accessing healthcare when needed	According to the 2012 NSW Adult Population Health Survey, respondents living in Far West (FW) and Western NSW Local Health Districts (WNSW LHDs) reported the highest levels of difficulty accessing health care when needed of all NSW LHDs (30.4% and 27.0% (smoothed estimates), respectively)
	Transport	Access to affordable transport to services is a key concern for communities.
SERVICE ACCESS		
Access to mental health professionals	Location of mental health professionals mainly in regional centres, creates challenges for access to more remote communities	The majority of mental health services are located in Orange, Bathurst, Dubbo and Broken Hill. In the Far West, 85% of services Including all residential services are located within Broken Hill. Outreach services to rural and remote areas are mostly provided by the Royal Flying Doctor Service (RFDS) and other NGOs. However, access to psychiatrists and clinical psychologists is limited and some communities have no access to acute or specialised services when needed. In the north of the Far-West, people may travel anything from 3 to 5.5 hours to reach residential care services in Broken Hill.
Diverse and complex array of mental health services	Multiple services for mental health	In addition to the LHDs, Aboriginal Community Controlled Health Organisations (ACCHOs), Marathon Health, General Practice and the RFDS which provide the core base of services, there are a number of other NGOs involved in providing mental health services or services to support people with mental illness. In addition, there is a complex array of funding sources and programs (State and Commonwealth) and an absence of any clear understanding of which organisations are providing what services.
		Funding sources include: Access to Allied Psychological Services, Mental Health Services in Rural and Remote Areas, and the Better Access initiative
		Some of the NGOs providing mental health services in the area include: CareWest, Catholic Health Care Limited, Centacare, Flourish, Grow NSW, House with No Steps,

Outcomes of the service needs analysis		
		Interrelate Family Centres, Lifeline, Mission Australia, NEAMI, OneDoor, Salvation Army, Uniting Care, and Wellways.
		Programs provided by NGOs include: Partners-in-Recovery (PIR), Personal Helpers and Mentors Service (PHaMS), Recovery and Resource Services Program, Mental Health Nurse Incentive Program, Housing and Accommodation Support Initiative (HASI), Family Wellbeing Program (FWB), Targeted Community Care Program, Arts in the Dust, Brighter Futures
		Other services provided by NGOs include: respite and support for carers, help with independent living skills, counselling, employment assistance, housing, advocacy, information, referral, support/self-help groups, residential and day care, suicide prevention
		Communities in the PHN region have many services providing social supports for people experiencing mental illness with a common perception that there are too many services lacking integration between them and with some duplication.
Primary Care	Majority of Care	The majority of care for those with mental illness occurs in primary care settings. Primary healthcare for mental illness covers a range of areas including: psycho-social therapies; diagnosis and treatment for people with common mental disorders. Ideally primary mental health services complement tertiary and secondary level mental health services
	GP Mental Health Services	General practitioners provide a range of services under the MBS by GPs including: preparation or review of a mental health treatment plan; management of a patient's mental health condition; and focused psychological strategies
		In WNSW PHN in 2014-15 GPs provided nearly 37,000 mental health services through the MBS to nearly 22,500 patients, more than a third of MBS mental health services by providers in the region

Outcomes of the service needs analysis		
		There was considerable variation in the age standardised rate of preparation of mental health treatment plans across SA3 areas. Rates of preparation of mental health plans were lower than the Australian rate in four of the eight SA3 areas. The lowest rate of preparation of mental health treatment plans was in the Bourke Coonamble and Lower Murray areas. The highest rate of preparation was in the Broken Hill and Far West area
	Commissioned Services - ATAPS	**Access to Allied Psychological Services Program** (ATAPS) is provided under the Better Access to Services strategy to enable access for people with a clinically diagnosed mental health disorder to assistance for short-term mental health interventions and services through psychiatrists, psychologists, GPs and other eligible allied health providers. ATAPS is targeted at improving access to support and treatment for people who have mild to moderate mental illness.
		The number of patients accessing ATAPs increased has increased over the last five years with an average of 1600 patients accessing these services across the WNSW PHN region every year
		The number of services provided under the program has also increased with an average of 6300 services provided every year.
		Close to a third of people accessing ATAPs in the region were under 18 years (29%). Only 6.6% of people accessing ATAPS were over 65 years
	Commissioned Services - MHNIPs	The Mental Health Nurse Incentive Program (MHNIP) funds community based general practices, private psychiatric practices and other appropriate organisations to employ mental health nurses to help provide coordinated clinical care for people with severe mental disorders.

Outcomes of the service needs analysis		
		There are a number of MHNIP Nurses providing services at Bathurst, Cowra, Orange, Parkes, Lightning Ridge, Bourke, Walgett, Broken Hill and Cobar
		The number of patients accessing MHNIP services has varied in the last five years, peaking in 2012-13 financial year.
		Similarly the number of services provided under MHNIP has varied with most services provided in 2011-12 and decreasing since that time
		The total number of MHNIP sessions and services in rural areas has decreased each year in this time period. After an initial increase in sessions and services in rural and remote areas in the first year of this time period numbers decreased
Acute Care	Mental Health Hospitalisations	PHNs in regional Australia had higher rates of mental health hospitalisations (999 per 100,000) than those in metropolitan areas (888 per 100,000), however the rate of mental health bed days was greater in metropolitan areas
		At WNSW PHN level SA3 level, the overnight hospitalisations rate per 10,000 people was higher than the national rate (102) in all but one SA3 area (lower Murray) and varied considerably across other areas
		Based on NSW Health data, the rate of mental health hospitalisations has decreased for both males and females in the WNSW PHN region since 2008-2009. This contrasts to the increase in the rate of mental health hospitalisations in the rest of NSW for males and females.
	Mental Health Hospitalisations for Aboriginal people	In NSW compared to other NSW PHNs, WNSW PHN had the lowest hospitalisation rate for mental disorders for male and female Aboriginal people and for non-Aboriginal people.

Outcomes of the service needs analysis		
		Rates in hospitalisation for Aboriginal and non-Aboriginal people have decreased in WNSW PHN and have increased over time for Aboriginal and non-Aboriginal people in all of NSW
		The rate of mental disorder hospitalisation rates per 100,000 people for Aboriginal peoples are more than twice that for non-Aboriginal peoples and have been so in the five 10% years prior to 2015-16.
		Across the region the reduction in hospitalisation rates for Aboriginal peoples is three times the reduction for non-Aboriginal peoples.
		In FWLHD there has been a 43% reduction in hospitalisation rates for Aboriginal peoples, a similar rate to that of non-Aboriginal peoples in this district. In WNSW LHD there has been a 10% reduction in hospitalisation rates for Aboriginal peoples compared with a 2% increase for of non-Aboriginal peoples. In contrast in NSW overall there have been increases in hospitalisation rates of 23% for Aboriginal peoples and 11% for non-Aboriginal peoples.
	Bed Days	The rate of mental health bed days was greater in metropolitan areas compared to regional areas
		The bed day rate for mental health hospitalisations in the WNSW PHN was higher in all but two SA3 areas (lower Murray and Lithgow Mudgee)
	Diagnostic Related Groups	Personality disorders, schizophrenia disorders and major affective orders account for 45% of all mental disorder separations for the PHN. Schizophrenia disorders account for longer average length of stays than other disorders

Outcomes of the service needs analysis		
		In Dubbo and Orange drug intoxication and withdrawal, personality disorders and acute reactions and schizophrenia disorders are in the top 3 DRGs at each
Emergency Care	Emergency department presentations	The rate for Emergency department presentations per 100,000 for the WNSW PHN region have increased for all persons and males and females. The increase between 2011-12 and 2015-16 was 70% for all persons and for 69% for males and 72% for females
	MHEC RAP	The Mental Health Line – 1800 011 511 (known within WNSW as Mental Health Emergency Care Rural Access Program-MHEC RAP) is a State-wide 24-hour Emergency Helpline and Mental Health Information Service. This service provides assessment and referral for mental health clients across WNSW as well as providing advice to service partners by telephone and by videoconference 24hrs a day, 365 days a year. Services include telephone and video link to Bloomfield Hosptial, Orange to provide emergency care and advice across the PHN area. The service also provides mental health information and specialist assistance. (*The Integrated Mental Health Atlas of the Western NSW)*
		There are approximately 52 emergency departments across the region and this service allows mental health assessments to be done online by clinicians into these EDs, reducing the need for care transfers from smaller regional MPS to larger towns with mental health inpatient wards or community mental health teams. (*The Integrated Mental Health Atlas of the Western NSW)*
		The service currently takes approximately 2,000 inbound calls a month. In addition, it makes a substantial number of outbound calls (approximately 6,000 per month). These calls include follow-ups at nights and on weekends on behalf of the community mental health teams that do not operate out of business hours. This service also receives referrals for assessments from GPs and private psychiatrists. It is considered an acute service and an important support to the community mental health teams across the region. (*The Integrated Mental Health Atlas of the Western NSW)*

Outcomes of the service needs analysis		
		During 2016, there was a total of 3,804 contacts made to the Mental Health Emergency Care team from 1,813 unique clients at an average of 2.1 contacts per client. Aboriginal clients represented 27% of the total number of unique clients – a far higher proportion than the population of 11.9% for Western NSW PHN region
		MHEC has a team of approximately 13 equivalent full time staff with a minimum two staff on each shift. A psychiatrist is available three days a week and a registrar Monday through Thursday. Staff also include full time AOD and Mental Health clinicians and a nurse unit manager. (*The Integrated Mental Health Atlas of the Western NSW)*
		Many GPs provided emergency services in rural health services. These GPs often provided services for acutely unwell patients with mental illness. While access was available through MHEC-RAP, experiences with this services were perceived as not always meeting GPs or patient's needs.
Ambulatory Care	Ambulatory Care Utilisation	An ambulatory mental health care service is a specialised mental health service that provides services to people who are not currently admitted to a mental health admitted or residential service. Services are delivered by health professionals with specialist mental health qualifications or training.
		In FWLHD, the LGA of Broken Hill (281.38) had the most number of ambulatory patients per 1,000 population with Balranald having the lowest number of ambulatory patients (69.6)
		The LGA with the highest number of ambulatory patients per 1,000 population in WNSW LHD were Bourke (202.32)
Child and Adolescent Mental Health Services	Specialist Services	In WNSW PHN 13 teams provides services exclusively to children and adolescents across the WNSW PHN region. Five of these teams are provided by the health sector with another eight provided by NGOs. The Bathurst and Dubbo Special Programs Teams provide specialised staff for both older adults and children in the blended team approach.

Outcomes of the service needs analysis		
		This is also the case for the blended community mental health and drug and alcohol service teams at Mudgee, Bourke, Lightening Ridge, Cowra, Parkes, Forbes and Condobolin. There are also many generalist mental health teams that provide services to children and adults, including the Royal Flying Doctors Clinics, Mental Health Emergency Care (MHEC) and some MNIP nurses
		There is one inpatient service (Orange), nine outpatient services and three providing information and referrals
	Headspace	There are five headspace services in the area - in Orange, Bathurst (including satellite at Cowra), Dubbo and recently opened in Broken Hill. The headspace program provides early intervention mental health services to 12-25 year olds, assistance in promoting young peoples' wellbeing in a youth friendly environment.
		A serviced person is classified as the unique count of a young person who has received at least one completed occasion of service. There have been increases in numbers of serviced persons most months in 2017 compared with July to December in 2016.
		Medical care is provided by GPs in Headspace, not psychiatrists, which conflicts with expectations of community members with views commonly expressed that specialist services were part of the model. Rather Headspace provides referral to more specialist services for young people with higher needs through partnerships with private psychiatrists or those in state based mental health services.
		Support for the model of Headspace for young people was strong amongst participants across the WNSW PHN region. Indeed the model was perceived as offering potential for mental health care applicable to all age groups, because of the one-stop shop nature providing a range of primary health care and social services. However, Headspace provides services for those with mild to moderate mental health problems, not for people with high moderate to severe mental illness.

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		The headspace model was widely supported by stakeholders to the extent that in most communities across the WNSW PHN region there is the expectation that this service is required. However difficulties with the ability to recruit, retain and fund staff for such a service means that this is highly unlikely.
	Intentional Self-Harm Hospitalisations – Young People	Most participants identified services for children and young people up to 18 years of age as a gap identified across all communities despite demand increasing. Child and adolescent mental health services (CAMHS) provided by LHDs were acknowledged as a key service.
		While the NSW PHN intentional self-harm hospitalisation rate for all persons in the 15-24 year age group was lower than or all NSW PHNs, the rate for males in this age group was higher than all PHNs. The rate of hospitalisation due to intentional self-harm for females was lower than all PHNs
		In WNSW PHN, there have been some downward trends in rates of intentional self-harm hospitalisations in both genders over the last 15 years in males and females in the 15-24 age groups and for all ages.
		Young people in the 15-24 age groups have higher rates of hospitalisations due to intentional self-harm hospitalisations compared to other ages
		Females have higher rates of hospitalisations due to intentional self-harm compared with males.
Suicide and self-harm service access	Intentional Self-Harm Hospitalisations	In 2015-16, the rate of hospitalisation due to intentional self-harm was consistently was lower for all persons in the WNSW PHN region compared to NSW, and rates were higher

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		for females than males. The rate of hospitalisation due to intentional self-harm in WNSW PHN for males and females of all ages was lower than all other NSW PHNS.
	Factors associated with mental illness	Across the WNSW PHN the rate of intentional self-harm hospitalisations was 147/100,000 people, in comparison at national level the rates of intentional self-harm hospitalisations was higher at 161/100,000 people
Suicide Prevention	Suicide Prevention Needs	Some communities had established suicide prevention committees. For those working in the area of community based suicide prevention there were concerns that these approaches lacked an evidentiary base.
		Participants reported on a range of strategies aimed at preventing suicide. Mostly these were based on one on one clinical or support interaction with at risk clients.
		The capacity of services to manage patients at risk of suicide was identified as a concern. Participants expressed concern about the way LHD mental health services managed patients expressing suicidal ideation. People at risk were not often not admitted, but were observed in Emergency Departments and then sent home. Service providers in LHD mental health services indicated that non-admission to an acute unit or observation in an ED was often appropriate. They indicated that this time may be sufficient to provide the needed care for patients and reduce the crisis situation which prompted suicidal ideation. If admitted or following presentation, it was perceived that patients were discharged quickly, often after hours in the absence of options for people to return home, with little or no-follow up and no connection with other services.
	Follow-up Care	It was acknowledged by a number of LHD mental health service providers that follow-up care needed improving. Concerningly, GPs reported rarely receiving information about patients presenting to hospital with suicidal ideation or following a suicide attempt. If

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		information was received it was often weeks after the patient had presented to an ED, thus preventing intervention by the GP at that window of opportunities following discharge.
	Capacity of GPs	The capacity of GPs to provide care for people with suicidal ideation was identified especially by some younger participants. Examples were provided where GPs excelled in managing suicide risk in young people, demonstrating high levels of skills, empathy and commitment in relation to suicidal ideation. However it was suggested that some GPs lacked the skills in identifying a patient at risk of suicide, and often ignored risk factors.
		Some young people expressed concern about the attitudes of some GPs towards suicide. Young people reported experiences with GPs dismissing suicide attempts as attention seeking behaviour; offering no support, referrals or understanding; and neglecting to explore the contributory factors.
	Capacity of support services	The capacity of support services to recognise suicide risk in clients was also raised as a need. Training of staff in mental health was often insufficient to allow support service staff to identify risks and associated factors, and to escalate concerns to clinicians to help manage patients at risk. Staff in these services commonly indicated that they felt they were required to operate beyond their scope of practice in supporting people with mental illness and especially for those at risk of suicide.
	Capacity of Other Agencies	Service providers from sectors across the community (e.g. education sector, police, workplaces and community groups) indicated they felt they did not have the capacity to always identify those at risk of suicide or expressing suicidal ideation, or to provide services and support for those who had attempted suicide. It was acknowledged that there was increased recognition of the role of these sectors across the community to address suicide.

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Post-vention Suicide Needs	Current Approaches	A number of communities have established post-vention committees following suicides in their communities. 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.
		Schools also reported post-vention strategies with support often provided by Headspace at state level.
Telehealth	Intentional Self-Harm Hospitalisations – Rural and Remote Areas Intentional Self-Harm Hospitalisations - Disadvantage Intentional Self-Harm Hospitalisations – LGA and SA3 Intentional Self harm bed-days	The rates of intentional self-harm hospitalisations for males 15-24 years are higher in areas that are outer regional and remote than those in major cities, inner regional areas and overall. For females 15-24 years, rates of intentional self-harm hospitalisations are higher in regional and remote areas than major cities and overall
		While there are no available data for WNSW PHN in terms of socio economic status, data for NSW shows that all people and those in the 15-24 age groups who are more disadvantaged (4th and 5th quintiles) have higher rates of intentional self-harm hospitalisations
		In 2014-15, the rate of intentional self-harm hospitalisations were significantly higher (1% level) than the state average in Broken Hill LGA for all persons and were significantly lower (1% level) than the state in Western Plains LGA and Mid-Western LGA
		Except for the LGA of Wentworth intentional self-harm hospitalisations are higher in the western part of the PHN compared to the Eastern part
		The SA3 area of Broken Hill and the Far West has the highest rate of intentional self-harm hospitalisations (242/100,000) with Lithgow Mudgee having the highest number of hospitalisations.
		Across the WNSW PHN the rate of intentional self-harm bed days was 875 bed days per 100,000 people slightly higher than the national rate of 838/100,000 people

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		The SA3 areas of Orange (2033 bed days per 100,000) and Broken Hill Far West (1040 bed days per 100,000) have the highest rate of bed days per 100,000 people with residents of Orange having the highest number of bed days (1,142).
Medication Use	Antidepressant Medication	For those in the 18-64 years and those over 65 years, the SA3 including Broken Hill and the Far West had the highest prescribing rate.
		In younger people the highest prescribing rate for antidepressants was in Orange
	Antipsychotic Medication	Antipsychotics are used to treat psychotic disorders and classified as conventional (first generation) antipsychotics or atypical antipsychotics. More than 90% of inpatients may be prescribed psychotropic medicines in Australia, and are also used commonly outside of hospital
		In WNSW PHN there is considerable variation in the age-standardised prescribing rates for antipsychotic medications across the SA3 areas and across age groups.
		In those under 18 years rates range from 1500 in Lower Murray to nearly 5000 per 100,000 population in Dubbo. Similarly this variation occurs in the 18-64 age category with the lowest prescribing rate also in Lower Murray with the highest in Broken Hill and the Far West. For those over 65 years the prescribing rates for antipsychotics is again Lower Murray with the highest in Lachlan Valley.
	Anxiolytic medications	Anxiolytic medications are used to treat anxiety disorders. While the use of antidepressant and antipsychotic medications have risen in the past decades, there have been recent declines in anxiolytics prescribing.
		Prescribing rates for anxiolytic medicines for those between 18 and 64 years also vary across the SA3 areas of WNSW PHN varying between nearly 11,000 (Lachlan Valley) and

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		nearly 16,000 (Broken Hill). For people over 65 years, rates vary from between 18,589 in the Lachlan Valley and 30,550 in Bathurst
Factors associated with mental health	Positive Mental Health	The sense of community connectedness in rural and remote communities was particularly strong, especially in Aboriginal communities. This sense of community connectedness was often demonstrated in times of crisis such as natural disasters. Opportunities for harnessing the connection that occurs in these times was seen as a way of supporting the mental health of the community.
		22% of the people in WNSW PHN do voluntary work compared to NSW (17%) and Australia (18%)
		The majority of people in the region (94%) indicated they would able to get support in times of crisis from persons outside the household, a rate similar to Australia and NSW
		Sport and cultural activities also supported positive mental health. Given the numbers of people in communities who are connected with sport and cultural activities, the potential for improving their capacity to address mental health and mental illness was a common theme.
	Mental Illness	There were a number of factors specific to the WNSW PHN communities that were perceived as being associated with mental illness including: • high levels of socioeconomic disadvantage • living in remote communities, in part due to lack of service access • interplay of factors that contributed to mental illness including: high levels of unemployment; lack of hope for future employment after job losses; impact of natural disasters such as floods, drought and fires; family dysfunction; domestic violence; drug and alcohol use; social and geographic isolation; costs of services; and lack of transport to services.
	Stigma	Stigma related to mental illness was commonly reported as a barrier to help seeking. Males were reported to be reluctant to seek care due to the stigma associated with

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		needing help. Clients and carers in rural communities reported stigma as a significant problem for rural males. These barriers were compounded by general stigma in the community about mental illness and in some service providers.
Service Gaps	Mild to moderate mental illness, with escalating symptoms	Timely access to allied health service such as psychologists for those with a mild to moderate mental illness was identified as a key service gaps due to a number of interrelated factors: • Insufficient numbers of clinical psychologists and social workers in the WNSW PHN regions to meet population need especially in rural and remote communities. • Significant gap payment which reduced access for people who were unable to afford the gap fee • Number of psychologists who were in sole private practices, and in the absence of a current service navigation system access was difficult for those referring and for patients. • Number of psychologists who were in sole private practices, and in the absence of a current service navigation system access was difficult for those referring and for patients.
		These factors meant that early intervention was not possible for those people experiencing escalating symptoms.
		In many communities with psychologists or social workers there was only one provider. This limited the choice for consumers and was also considered a barrier to service access.
	Capacity of GPS	Clients and carers commonly indicated that the GP was critical in ensuring a comprehensive and supportive approach to care.
		There were concerns that the model of care in many general practice did not support effective mental health care. Few practices had mental health clinicians (nurses or allied health) working in them and this was raised as significant service need by service providers

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		and consumers. While practice nurses are more common in general practice they often do not have the required credentials to provide mental health care. Mental health clinicians could undertake roles including assessment, brief interventions, support with medication review (mental health nurse role), referral and preparing and monitoring mental health plans, and ongoing management especially for people with severe mental illness and other complex problems. It was perceived that if there was a commitment to strengthening the role of general practice in mental health care there is a need to ensure that multidisciplinary teams located in general practice are supported.
		Time barriers to providing mental health care in general practice were commonly raised. It was recognised that GPs are under significant time pressures. Mental health care takes more time and many GPs were perceived as not having the times to provide optimal care for mental illness patients because of other demands on their time.
		Access by GPs to psychiatrists through telehealth was perceived as having the potential to enhance the capacity of GPs to provide care for patients experiencing mental illness. However, this was perceived as mostly unavailable unless in extreme emergencies. Many GPs provided emergency services in rural health services. These GPs often provided services for acutely unwell patients with mental illness. While access was available through MHEC-RAP, experiences with this services were perceived as not always meeting GPs or patient's needs.
		Concerns were expressed about the knowledge, skills and attitudes of some GPs in providing care for mental illness. Some consumers actively sought out GPs were had the skills in and positive attitudes towards mental health, but these were not always available. Despite financial incentives and other support being provided for GPs in mental health plans, there were concerns about their use and the quality of information provided. Many service providers who received mental health care plans from GPs indicated they were

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		completed poorly, often having very limited information about the patient and the reasons for referral. This meant that the patients often had to repeat all the information to the service providers.
		There was also a common view by consumers, carers and some service providers 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. This was in spite of evidence that indicated the potential for other therapies.
	Capacity of Aboriginal Medical Services	Aboriginal Medical Services (AMS) play a crucial role in primary health care for Aboriginal people in many communities. Indeed many AMS play this key role for non-Aboriginal community members as well.
		Many of the AMS provide Social and Emotional Well-being services tailored to the needs of Aboriginal people. While the important role of these services and programs was recognised and supported, the need for strengthening their roles and expanding these services was recognised.
		There was a need for training in culturally appropriate approaches to mental illness for their community members.
	Capacity of Allied Health Services	The capacity of provisional psychologists to meet the needs of people experiencing mental illness, especially those with severe and complex illness, was raised as a concern by many consumers and by some service providers. It was perceived that some organisations relied heavily on provisional psychologists to provide clinical care to people experiencing mental illness including those with severe and complex illness. Despite strict requirements of the Australian Psychological Society, this was suggested as occurring in the absence of supervision by an approved 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.

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		Under the different allied health access programs, the clients are eligible for 6 sessions per annum with an additional 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 complex problems, required more than the system allowed. This was particularly relevant for clients who had experienced trauma and abuse, and especially for Aboriginal and Torres Strait Islander clients given the significant impact of inter-generational trauma. The need for more than the 12 sessions maximum was required but not available under current programs unless paid for privately.
	Capacity of Community Support Services	The capacity of staff providing support in NGOs was also raised as an area of concern. While their role was recognised as key in social support by the majority of service providers and by consumers and carers, it was perceived that often their skills and experience in working with people with severe mental illness and complex needs was limited. Staff were often welfare trained without the mental health specific expertise.
		There were views expressed by staff from within support services and by external service providers that staff were often having to work beyond their level of qualification and scope of practice in order to support people experiencing severe mental illness and other complex problems. This was more likely to be a concern in services that did not have access to clinical input and where options for supervision and case review were not routinely provided. It was also perceived that there was no mechanism for escalating those clients with deteriorating mental health.
	E-Health options	E-health options were widely supported but mainly for, and by, young people and males. Barriers to accessing E-health options were identified especially in rural areas. These barriers related to internet coverage with connectivity and speed raised as a significant barrier.

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	Acute and chronic severe mental illness	It was perceived that there was a significant clinical service gap for people experiencing severe mental illness, both acute and chronic, including those with other complex health and social problems.
		In most communities the social support needs of these people were being met.
		Access to specialist clinical services for these people had reduced in recent years across all communities with specialist services in the LHD only being provided for people who are acutely unwell. It was perceived that LHD mental health services have become increasingly restrictive in their criteria with staff in the LHD mental health services describing criteria for accessing their services was for a patient to be “homicidal, suicidal or seriously self-harming”. Indeed it was often stated that the priority of these specialist mental health services provided through the LHD was to prevent rather than support access. That this had occurred in the absence of any planning across mental health services was raised as concerning.
		The clinical care for people experiencing these mental illnesses was often dependent on general practitioners, stretching the capacity of primary care, especially when a person’s symptoms were escalating. In the absence of complementary specialist services this was perceived to result in poor outcomes for consumers, family, carers, and the community, and frustration for clinicians.
		There was a perception that services for those who were acutely unwell were lacking with reliance on the mental health lines or local emergency departments. Experience with the mental health line was commonly described as poor by consumers and service providers. Wait times on the mental health phone lines was a challenge for providers and consumers.
	Access to Emergency Care	Use of MHEC-RAP was commonly and strongly criticised by service providers and community members due to: waiting times on the phone; access to services rarely

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		occurred after calling the line, with most people reporting that their clients or the consumers were deemed ineligible for state based mental health services.
	Early Intervention Services	Lack of access to early intervention services was a key finding from the interviews. Early intervention needed to be viewed in its broadest sense: early intervention to prevent onset of mental illness; early intervention to prevent deterioration of mental illness; early intervention to support recovery; and specifically, early intervention for those experiencing first onset of psychosis.
		These services were perceived to be either unavailable or difficult to access. For people needing access to services, especially when they feel their symptoms were worsening, the process of accessing care was difficult. Triaging through phone lines and having to talk with multiple providers so they can make a decision was frustrating for clients.
		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.
	Mental Health Promotion and Prevention	The findings of this needs assessment indicate that there are some approaches to mental health promotion in the WNSW PHN region as demonstrated through school link coordinators and staff in the Rural Adversity Mental Health Program (RAMHP).
		There appears to be no systematic approach to mental health prevention and promotion which is aligned to evidence-based frameworks. Rather, there is a reliance on delivery of training programs across different settings such as schools, workplaces and sporting groups. This is not to say that this is not a worthwhile approach, however overreliance on training misses opportunities for other mental health promotion strategies.
	Role of Carers	The role of carers is key in the care of people with mental illness, recognised in many including the most recent National Mental Health Care Plan

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		There is a lack of recognition of cares' role in the for people experiencing mental illness.
		Carers raised issues relating to a culture of not involving them in the care of their family members, and a lack of respect for their role.
		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 experiencing severe and complex mental illness.
SYSTEM ISSUES		
Coordination and Integration	Lack of integration and coordinated care	Integration between primary care and specialist services is a key feature of effective mental health services. Integration requires informal and formal communication as well as more structured referral pathways and patient information sharing. This is an areas where the majority of participants perceived significant gaps.
		GPs and other service providers indicated they rarely received any communication about patients from specialist services. Some commented that if it was received, it occurred weeks after discharge. The delay in providing clinical information resulted in missing the window of opportunity following discharge for maximising recovery.
		Many allied health staff indicated that the quality of mental health care plans was poor, indicating they often received mental health care plans which contained information limited to patient name and a couple of ticked boxes.
		Despite evidence for the need for comprehensive health and social services, there were few services that provided seamless access to clinical, therapeutic and support services. Referral between services was often described as difficult, with challenges around information sharing, case management and role delineation.
		For people experiencing mental illness and concurrent drug and alcohol problems, services were perceived as limited. Despite mental health services and drug and alcohol services being in the one division in LHD services integration between the two fields as

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		being mostly non-existent. Indeed it was perceived that specialist mental health services exclude those with substance abuse problems and addiction services exclude those with mental health conditions
		Many community based service providers indicated that they were providing care and support for many clients with co-existing drug and alcohol problems who were not accessing services for substance misuse. They identified that in many cases underlying mental health problems were a significant contributory factor to substance use.
	Service Navigation	There are many discrete services providing care and support for people experiencing mental illness, each targeting different population groups and different health and social dimensions of mental health. Navigating the service system was commonly described as a "nightmare" for service providers, GPs, consumers and carers.
	Service Stability	There have been significant changes in the service system in the past five years for a number of reasons: transition from Medicare Locals to Primary Health Networks; changes in the names and focus of services in the last few years, for example Richmond PRA became Flourish Australia and Schizophrenia Fellowship has become Onedoor Mental Health; there are now many private allied health providers delivering mental health services to the community supported through programs such as ATAPS and MHNIP, and the MBS; the National Disability Insurance Scheme (NDIS) with many of the non-government services which provided support services for people with a mental illness now requiring clients between 18 and 65 years of age to have an NDIS plan to access support services.
		This instability in the service system is impacting on referral pathways, access to care and on recruitment and retention of staff and on care for clients and ultimately on outcomes.
Cost and Transport Barriers	Costs	Cost was reported as a significant barrier to accessing services by clients and carers. Many GPs, psychiatrists and private allied health staff charged a gap payment on top of the Medicare rebate with few reportedly bulk billing. Many consumers, clients and carers

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		indicated that cost was a barrier to accessing mental health care. Over the year these costs were significant especially for those with moderate to severe mental illness, where work was limited as a result of their illness and were thus reliant on welfare payments.
		Decisions about referral by service providers were sometimes made on knowledge about service costs rather than on care needs. Some consumers reported making choices about accessing care based on cost with some waiting until their symptoms deteriorated before seeking care. This perception also aligned with the views of service providers and some GPs.
	Transport	Transport was another system related challenge occurring in rural and remote areas alone but also in more urban areas. Clients often had to rely on public transport to access specialist clinical services distant to their home
Service Quality	Lack of focus on service quality	Concerns were raised about the quality of services by many interview participants especially in relation to the quality of services provided by LHD mental health services, especially in the acute setting.
		A quality framework including an approach to manage clinical risk was considered imperative but was not a focus of many services.
		There were also few examples of services reporting client outcomes, and clinical and client experience, with a reliance on activity reporting.
		There were concerns about service quality in services that relied on provisional psychologists. It was suggested that the sessional payment structure used in the commissioning of services contributed to over-reliance on provisional psychologists. Costs per session were less with provisional staff but did not necessarily result in quality and improved outcomes for clients. It was also suggested that recruitment of provisional psychologist was easier than more experienced psychologists.

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Service Models	Service Model across health services	The findings from the interviews demonstrate that there is no clarity about the service model overall at a system level across the WNSW PHN region, or for service models within local government areas. Rather, there are many services operating separately with limited efforts to provide care in partnership unless under an agreed consortia model.
	Stepped Care	There was in principle support for a stepped care model. However most service providers, clients, carers and community members perceived that such a model was not in place. Rather there was a disparate array of services with little alignment to a stepped care model and most importantly no clear linkages between steps.
		A stepped care model is dependent on effective integration and collaboration between service providers across the mental health system to allow smooth transition between steps. Collaboration is dependent on developing and sustaining effective partnerships between service providers. With many services funded on a sessional basis, concerns were expressed by service providers the need for partnerships was neglected under this model. Reliance on sessional funding was perceived to be a significant system barrier to collaborative and integrated care.
		Barriers to operating a stepped care model which were reported by interview participants included: access to specialist services when needed, such as those provided through state services, was challenging; there was a disparate array of NGO services with poor access to clinical care and shared information was difficult due to confidentiality concerns; and follow-up care after a hospital visit was very limited.
		While most clinicians supported the stepped care model and were aware of the WNSW PHN framework, concerns were expressed about the complicated nature of this model with preference to the five steps outlined in many of the policy documents and literature.
	Hub and Spoke Model	The hub and spoke model appears to be accepted conceptually by service providers, particularly in rural areas where this model has been applied in other areas of health

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		including in drug and alcohol. In mental health however, like other chronic disease care, services are required to provide collaborative care irrespective of organisational boundaries. Care under this model was perceived to be harder when it is provided across multiple organisations all operating different hub and spoke models.
		The GP plays a central role as the primary care provider for mental health, and in a hub and spoke model would have ready access to specialist psychiatric advice as needed. This model was identified by service providers as being provided in areas such as intensive care, emergency and stroke care. However, this hub and spoke model was not consistently applied across all areas of the WNSW PHN region for mental health care. In particular, GP access to psychiatric specialist advice was reported as limited in most areas.
		Contractually some hub sites are supposed to be providing outreach services to spokes. However, it was identified by interview participants in both hub and spoke sites that the demands of the hub sites dominated decisions about care to other locations. There was a perception that often clients in spoke sites missed out on services because the hub sites were so busy that there was insufficient time and staff to provide the contracted outreach services.
Workforce	Workforce shortages	Despite an increase of 4.3% in numbers of medical practitioners between 2013 and 2015 the proportion of medical practitioners in WNSW PHN (12.4%) is lower than the proportion for NSW (17.4%).
		Nurses and midwives comprise the most significant practitioner type in WNSW PHN and in NSW.
		Psychologists represent 4% of the registered practitioners in WNSW PHN, lower than NSW (6%) with growth of 5% in the between 2013 and 2015
		The proportion of the workforce over 55 years for all practitioners is higher in WNSW PHN compared to NSW.

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	Workforce Challenges by LGA	The FTE/100,000 rates for GPs is below the state average in only six of the LGAs.
		For nurses, 11 of the LGAs have FTE/100,000 rates below the state average (statistically significant to 95% C.I.). Eight of the LGAs have FTE/100,000 rates for nurses above the NSW rate (statistically significant to 95% C.I.)
		Eleven of the LGAs (2011 boundaries) and the WNSW PHN area overall have psychologists at FTE/100,000 rates below the state average (statistically significant to 95% C.I.).
	Aboriginal Workforce	Nurses and midwives represented 65% of the total Aboriginal practitioners in WNSW PHN in 2015. However the Aboriginal nurses represented only 3% of the total of nurses in the WNSW PHN area.).
		The majority of Aboriginal health workforce s are female, and across all practitioners (**Error! Reference source not found.**). The proportion of females across all practitioners is similar to that for NSW
		There were 65 Aboriginal Health practitioners in the WNSW PHN area in 2015 and the numbers have increased by 3% since 2013.
		There were only 3 Aboriginal psychologists in the WNSW PHN (**Error! Reference source not found.**
		The proportion of the psychologists, nursing and Aboriginal practitioner workforce over 55 years is higher for WNSW PHN compared to NSW
Perceptions of Workforce Needs	Access	Timely access to clinicians, particularly experienced psychologists, psychiatrists, mental health nurses and other allied health providers was raised as the most common workforce need.
		Lack of timely access was perceived to relate to: insufficient numbers in all communities, especially in rural and remote areas, the numbers of fly-in fly-out (FIFO) or drive-in drive-

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		out (DIDO) workers usually only for a few days a week. As a result waiting lists to see psychologists and psychiatrists were common, and especially for those who bulk billed
		The cost of accessing services provided by psychologists and psychiatrists was raised as a significant access barrier. Many of these clinicians bulk-billed and clients/patients has to pay a gap payment above the rebateable fee. This was perceived as preventing access as many clients whose mental illness impacted on their employment were unable to access services.
		Access to mental health clinicians within general practice was limited. Few general practices had psychologists or social workers in the practice. There was reliance on referring clients to those clinicians in other services external to the practice. Linkages between GPs and psychologists was perceived as often being reliant on relationships between the clinicians, a necessary but insufficient approach to ensure coordinated care.
		While the role of mental health nurses in general practice was widely supported there were few credentialed nurses who could work in these roles. The process of attaining credentials to be an accredited a mental health nurse in general practice was perceived as difficult, although supported by those who had achieved this status. Further the pay differential between mental health nurses in general practice and those working in LHD mental health services was a factor in limiting the supply.
		Timely and affordable access to psychiatrists for adults, children and young people was raised as a particular concern with a common perception. Access to psychiatrists was limited in most communities outside Orange, Dubbo and Broken Hill, with some smaller communities having FIFO access infrequently.
		Access to child psychiatrists was mainly in Orange and for those with severe mental illness.
	Quality	There were a number of concerns raised about the quality of psychiatric care. A number of consumers raised concerns especially in relation to psychiatric care in LHD services. Many

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		of these concerns were raised in the context of the general perception that LHD mental health services were perceived as trying to minimise access, regardless of acuity. This meant that the focus of psychiatrists in acute setting was on dealing with the presenting problem in isolation from contributory factors, without thorough assessment and without strategies for ongoing care.
		Some consumers and carers raised concerns about the level of experience of some psychologists. These views were reinforced by some service providers who indicated that some services were over-reliant on provisional psychologists with these clinicians facing challenges in terms of the complexity of clients they were providing care for, often with minimal support, and impacting on retention.
		Community support staff provide a key role in providing services to clients experiencing mental illness who require support for daily functioning and for quality of life. Participants recognised this vital role but many indicated that their capacity to work with clients experiencing mental illness and other complex conditions was often limited because of their lack of understanding of mental illness. Because staff in these services often operated without access to clinical advice, escalating symptoms were often misinterpreted as poor behaviour. This was often exacerbated by poor linkages between these.
	Recruitment and Retention	There were concerns about the retention of mental health clinicians with a common perception that there was significant turnover affecting continuity of care. Factors contributing to turnover included: clinicians as sole providers in some communities with limited collegial and professional support; short term and changing nature of funding impacting on service stability and resulting in many short term contracts; the competitive nature of funding bringing new organisations into the market and poaching staff; and lack of career pathways in some organisations.

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		The incentives provided to a range of health and other professionals were often mentioned by participants. Police and teachers are provided incentives, such as rent and travel subsidies, to move to rural and remote areas for a set amount of time. Incentives are also in place to attract psychiatrist. However incentives are not commonly available for other health professionals such as psychologists. A small number of organisations had developed their own incentive schemes for nurses and allied health staff but these were not common and required funding flexibility. There was a strong and common view that there needs to be investigation into incentives to attract health staff to rural communities.
Data and information and technology	Internet access	There is also an increasing number of internet based treatment options for people with a mental illness and with substance abuse problems
		Between 2011 and 2016 there have been an additional 7,440 households with internet connection across the region. However the proportion of households with internet connection in Western NSW PHN (67.7%) is lower than the proportion in NSW (78.2%)
		There is significant variation in the proportion of households with internet connection across LGAs with Central Darling (47.1%) and Brewarrina (51.2%) having the lowest proportion of households with connections
		There were barriers related to internet coverage with connectivity and speed raised as significant.
SPECIFIC CHALLENGES AND GAPS IN RELATION TO GROUPS WITH SPECIAL NEEDS		

Section 4 – Opportunities, priorities and options

The opportunities, priorities and options noted below have been derived from the needs assessment and focus on the six funding priority areas identified by the Commonwealth. The utility of the needs assessment was adversely affected by the shortness of the timeframe available to provide the material. This meant that the necessary consultation and community inquiry needed to exhaustively collate a contemporary assessment of service gaps and needs was not conducted. This may have adversely effected the comprehensive articulation of service need in Aboriginal communities as typically this work is sensitive, time intensive and engaging of local Elders and community leaders. It should also be noted that there are a range of needs that relate to the integration with other service domains outside of a primary health setting such as people with a mental illness or comorbidity in the justice system, that will be prominent in the comprehensive needs assessment that informs the Regional Mental Health and Suicide Prevention Plan in March 2017. It is also likely that the fuller community consultation and needs analysis may identify a number of gaps and service enhancement opportunities not noted in this initial needs assessment.

MENTAL HEALTH (INCLUDING SUICIDE PREVENTION) – OPPORTUNITIES, PRIORITIES & OPTIONS

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
1. Improve targeting of psychological interventions to most appropriately support people with or at risk of mild mental illness at the local level through the development and/or commissioning of **low intensity mental health services**				
Priority Groups include: • Aboriginal and Torres Strait Islander people	WNSW should ensure that mental health services commissioned by the PHN demonstrate the	Improved access to psychological therapy	Number of mental health care plans	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
• Young people aged 12 – 25 years • Males aged 25 - 65 years • People experiencing mild to moderate mental illness, with escalating symptoms	appropriate targeting of these priority groups and report on activity and outcomes in relation to these priorities		Number of people receiving 6 sessions through ATAPs Number of people receiving MBS item services related to psychological therapy Waiting times for services	
Increasing capacity of services	In order to provide holistic care and to support early intervention for the people of Western NSW PHN region, the factors associated with mental health reported in this needs assessment need to be identified in regional plans, service plans and in client health care plans with strategies to address factors including: • Strengthening the capacity of sporting organisations to address mental health	Number of services participating in mental health training Priorities related to risk factors in regional and service plans	Review of commissioned services plans in relation to addressing factors associated with mental illness	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Family functioning • Support for education and employment • Stigma associated with help seeking			
Access	Reduce waiting times and cost barriers for psychologists and social workers across communities	Reduced waiting times to access psychologists across PHN	Waiting times for psychologists	PHN
Capacity of General Practice	The capacity of general practice to play a central role in mental health care needs to be strengthened through: • Supporting multi-disciplinary teams including psychologists and mental health nurses to work in general practice improve patient access and outcomes • Education and training of GPs particularly in	Increase in number of practices with mental health clinicians Increase in number of GPs trained in relation to evidence based mental health care guidelines Increase in number of GPs trained in relation to use of mental health plans	Number of practices with mental health clinicians Number of GPs trained in relation to evidence based mental health care guidelines Number of GPs trained in relation to mental health plans	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	relation to evidence based mental health care guidelines • Support for GPs in developing and monitoring mental health care plans • Access to allied health staff in local communities to support clinical care and case management			
Service Quality	Provide greater access to experienced psychologists across communities	Increase in number of psychologists per planning area Increase in access to psychologists for patients Reduction in waiting times to see psychologists	Workforce data Service access data	PHNs
2. Support region-specific, cross sectoral approaches to early intervention for children and young people with, or at risk of mental illness (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group				

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Access to psychologists for young people	Provide greater access to experienced psychologists accredited to provide services for children and young people across communities	Increase in number of accredited psychologists per planning area Increase in access to psychologists for children and young people Reduction in waiting times to see psychologists for children and young people	Workforce data Service access data	PHNs
Capacity of General Practice	The capacity of general practice to play a central role in mental health care of children and young people needs to be strengthened through: • Supporting multi-disciplinary teams including psychologists and mental health nurses to work in general practice	Increase in number of practices with mental health clinicians Increase in number of GPs trained in relation to evidence based mental health care guidelines Increase in number of GPs trained in relation to use of mental health plans	Number of practices with mental health clinicians Number of GPs trained in relation to evidence based mental health care guidelines Number of GPs trained in relation to mental health plans	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Education and training of GPs particularly in relation to relevant evidence based mental health care guidelines			
3. Address service gaps in the provision of psychological therapies for people in **rural and remote areas and other under-serviced and/or hard to reach populations**, making optimal use of the available service infrastructure and workforce				
Aboriginal People	In order to provide holistic care and to support early intervention for Aboriginal people of Western NSW PHN region, the factors associated with mental health reported in this needs assessment need to be identified in regional plans, service plans and in client health care plans with strengthening of strategies focusing on including: • Trauma (including intergenerational trauma)	Number of services that address Aboriginal specific factors Priorities related to risk factors in regional and service plans	Review of commissioned services plans in relation to addressing factors associated with mental illness	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Cultural safety in health and social services			
	All mental health services commissioned by WNSW PHN should demonstrate that they are culturally safe and have embedded cultural safety strategies to support access and care for Aboriginal and Torres Strait Islander peoples	Increased access for Aboriginal people to mental health services Increase in number of services with cultural safety frameworks	Review of commissioned services in relation to cultural safety	PHN
	In line with the RACGP standards for general practices, WNSW PHN should build the capacity of general practices to provide respectful and culturally appropriate care	Increased access for Aboriginal people to mental health services Increase in number of practices with cultural safety frameworks	Number of Aboriginal people with mental health care plans Number of practices with cultural safety frameworks	PHN
Stigma	Strategies to support national campaigns addressing stigma at a local level should be explored by WNSW PHN	Inclusion of stigma strategies in regional plans		PHN and LHD

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	and other services across the service system			
Stepped Care Model	Pathways to care, outlining roles of different services should be developed, implemented and evaluated to support the stepped care model.	Pathways to care agreed across services	Service access data Patient experience data	PHN and LHD
4. Commission primary mental health care services for people with **severe mental illness** being managed in primary care, including clinical care coordination for people with severe **and complex mental illness** through the phased implementation of primary mental health care packages and the use of mental health nurses				
Priority groups	WNSW should ensure that mental health services commissioned by the PHN demonstrate the appropriate targeting of people experiencing chronic and episodic moderate to severe mental illness and other complexities and report on activity and outcomes in relation to these priorities	Reduced mental health hospitalisations Improvements in coordination of care Improved patient experience for mental health patients in LHD services	Mental health hospitalisations Patient experience for mental health patients in LHD services GP experience data	PHN and LHD

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
		Improved GP experiences related to mental health care provided to patients		
Access	Develop and implement strategies to address the gap in services for people experiencing chronic and episodic moderate to severe mental illness including those with other health and social problems	Reduced mental health hospitalisations Improvements in coordination of care	Mental health hospitalisations Patient experience for mental health patients in LHD services	PHN and LHD
	Access to specialist mental health clinical advice for GPs should be seen as a priority.	System established for GPs to access clinical advice Improved GP experience	Service utilisation data GP experience data	PHN and LHD
	Reduce waiting times and cost barriers for psychiatry across communities and age groups	Strategy agreed for access to psychiatrists Reduced waiting times	Service utilisation data Service access data	PHN and LHD
	Apply assertive and proactive case management and follow-up as part of services	Reduced hospitalisations	Mental health hospitalisation data	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	Investigate why the rates of hospitalisation for mental disorders are declining in the two LHDs compared to the rest of NSW and the associated impact on outcomes for people experiencing mental illness.	Investigation completed with recommendations	Service access data	PHN and LHD
	Ensure criteria for access to specialist mental health services are transparent and communicated across the health system and community	Service access data publicly available Improvements in patient experience	Patient experience data	LHD and PHN
	Strategies to support knowledge and understanding of mental health, mental illness, mental health services, their roles and referral pathways should be	Strategy included in regional plans		PHN and LHD

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	supported by across services			
Service Quality	The capacity of community support services needs to provide high quality services needs to be strengthened focusing on integration with clinical services and clinical governance	Improved access to mental health care Improved patient experience data	Service access data Patient experience data	PHN and LHD
Support for Carers	Support for carers and family members should be a key element of services across communities	Carer strategy included in regional plans	Patient experience of care	PHN and LHD
5. Encourage and promote a regional approach to **suicide prevention** including community based activities and liaising with Local Hospital Networks (LHNs) and other providers to help ensure appropriate follow-up and support arrangements are in place at a regional level for individuals after a suicide attempt and for other people at high risk of suicide				
Planning	In developing regional plans recognition should be given to: • Aboriginal and Torres Strait Islander people • Young people aged 12 – 25 years	Priorities included in the regional plans	Plans ratified by Boards of LHDs and PHN	PHN and LHD

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Males aged 25 - 45 years • People who are socially or geographically isolated			
Commissioning	WNSW PHN should ensure that suicide prevention services commissioned by WNSW PHN demonstrate the appropriate targeting of these priority groups and report on activity and outcomes in relation to these priorities	Number of commissioned services reflecting priorities	Audit of commissioned services	PHN
Mental health prevention and promotion	Mental health prevention and promotion, and suicide prevention should reflect evidence based frameworks with an emphasis on strategies which are broader than education and training	Compliance with evidence based frameworks	Assessment of plans against frameworks	PHN
	Evidence based mental health promotion and	Number of agencies implementing evidence	Service reporting data	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	prevention, and suicide prevention strategies should be implemented across sectors including: • Youth specific services • Sporting clubs • Education and training sectors • community and sporting groups • Workplaces • General health system	based mental health promotion and prevention, and suicide prevention strategies		
Access	Improve timely access to specialist mental health services for those at risk of suicide	Improvement in patient experience after presentation for suicide	Patient experience data	PHN
Capacity	Improve the capacity of GPs to manage patients at risk of suicide	Number of GPs trained in managing suicidal patients	Practice support data	PHN
Follow-up care	Follow-up support for those who have attempted suicide following presentation to ED or	Improvements in number of GPs who report patient discharge after suicide attempt	GP experience data Patient experience data	LHD and PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	admission to hospital should be a key component of any suicide prevention service delivery	Improvements in patient experience		
	The capacity of communities to implement evidence-based post-vention strategies needs strengthening	Number of agencies implementing post vention strategies	Service reporting data	PHN
6. Enhance and better integrate **Aboriginal and Torres Strait Islander mental health** services at a local level facilitating a joined up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services				
Access for Aboriginal people	Improve access, and the capacity and quality of services for Aboriginal people should be a priority in all regional planning.	Number of services with cultural safety frameworks	GP Practice and commissioned service data	PHN
AMS Service Capacity	The capacity of Aboriginal Health Services to play a central role in mental health services and suicide prevention needs to be supported through:	Reduction in mental disorders Increase in number of AMS with mental health clinicians working in practices	Proportion of Aboriginal people who are identified with mental disorders Number of AMS with Mental health clinicians	PHN and Bila Muuji

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Multi-disciplinary teams including mental health clinicians in AMS • Education and training of GPs working in AMS in relation to evidence based guidelines for early intervention for mental health problems	Increase in number of AMS GPs trained in evidence based guidelines for early intervention	Number of AMS GPs trained in evidence based guidelines for early intervention	
7. System redesign and service improvement – reorientation of effort, energy and resources to different steps in a stepped care approach				
A focus on prevention	Reorient services to keep people out of acute settings rather than the current system which channels people to the acute setting due to a lack of services	Increased access to psychological services Improved patient experience Improved access to specialist mental health services	Service access data Patient experience data	PHN
Service Quality	Improve patient and service provider	Improved patient experience	Patient experience data	PHN and LHD

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	experience of the mental health line and other triaging systems for mental health care	Improved GP experience	GP experience data	
	The experience of GPs with specialist mental health services should be routinely monitored and reported as an indicator of satisfaction.	Improved GP experience	GP experience data	PHN and LHD
	Data on the proportion of GPs who always receive comprehensive discharge summaries within seven days about their patients who have presented or been admitted to specialist mental health services should be collected and reported by LHD specialist mental health services	Improved GP experience in relation to access to discharge summaries	GP experience data	PHN and LHD
	All services should be required to demonstrate	Increased number of services with:	Number of services with: • Service improvement plans	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	an approach to quality through the development, implementation, monitoring and evaluation of: • Service improvement plans • Clinical governance frameworks • Case review policies and procedures • Clinical supervision	• Service improvement plans • Clinical governance frameworks • Case review policies and procedures • Clinical supervision	• Clinical governance frameworks • Case review policies and procedures • Clinical supervision	
	Organisations that provide support services to people with mental illness should demonstrate their capacity to access clinical care for clients when symptoms are escalating. This could occur through partnerships, consortia or in-house access to clinicians and requires mechanisms for	Increased number of services with: • Clinical governance frameworks • Case review policies and procedures	Number of services with: • Clinical governance frameworks • Case review policies and procedures	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	escalating clients experiencing a worsening of symptoms			
	Commissioning of services by WNSW should reflect the need for an approach to quality, requiring services to demonstrate this commitment as an element of key performance indicators	Increased number of commissioned services with: • Clinical governance frameworks • Case review policies and procedures	Number of services with: • Clinical governance frameworks • Case review policies and procedures	PHN
	In ensuring an approach to quality, commissioning of services should consider the service model, and discipline and experience of staff	Commissioning specifications of services will include requirement for services in line with models of care and access to experienced staff	Review of mental health service specifications	PHN
	The capacity of services to develop and implement an approach to quality should be strengthened with the aim of developing a	Increased number of commissioned services with: • Clinical governance frameworks	Number of services with: • Clinical governance frameworks • Case review policies and procedures	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	consistent approach with tailoring to service types	• Case review policies and procedures		
	Services should ensure a commitment to measurement and reporting of activity and outcomes in line with the quadruple aims of health care (patient experience, clinician experience, population health outcomes and efficiency)	Increased number of commissioned services with: • Outcome reporting frameworks	Number of services with: • Outcome reporting frameworks	PHN
	The development of outcomes which are consistent across like services and evidence-based, tailored to services, measured efficiently and able to be used for service improvement and client care should be resourced and implemented	Agreement on content of outcome performance frameworks by services		PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Research	Research into the acceptability and effectiveness of telehealth services for primary mental health care should be supported.	Research project completed	Equitable access for people with mental illness	PHN and LHD
Patient and Provider experience	Strategies are implemented to ensure patient and service provider experience is routinely measured and monitored and reported across the service system	Improved patient experience Improved GP experience	Patient experience data GP experience data	PHN and LHD
	There should be transparency in reporting outcomes, activity and experience with Mental Health line with these reported to services, and the community.	Reportable outcomes agreed	Reportable outcomes communicated across communities	LHD and PHN
Governance	A committee with representatives from LHD mental health services, GPs, AMS, consumers and	Committee and terms of reference established	Quarterly reporting to CEs	PHN and LHD

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	carers should oversee the implementation of the recommendations of this needs assessment. This committee should report on progress quarterly to the CEs of the respective organisations.			
Service Stability	The stability of the mental health support service system and the associated pathways to care should be a priority to support the central role of GPs in mental health care	Improved GP experience	GP experience data	PHN and LHD
Planning and Commissioning	Decisions on commissioning of services should reflect the principles outlined in the needs assessment report for addressing mental health, and suicide prevention	Number of commissioned services compliant with principles	Review of commissioned services	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	The population health needs of communities should guide the planning and delivery of services across the mental health and drug and alcohol services	Number of commissioned services compliant with population health approach	Review of commissioned services	PHN
	Early intervention is a priority for improving mental health and drug and alcohol outcomes and is applicable across: • All stages of life • All mental illness and drug and alcohol categories • All population and priority groups	Reduction in proportion of population with mental disorders	NSW Health Survey data	PHN
	In partnership with WNSW PHN, the development of regional plans for mental health, drug and alcohol and for suicide prevention	Agreement by Chief Executives for regional plan development	Regional Plans ratified by Boards of respective organisations	PHN and LHDs

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	should involve and be supported by: • Chief Executives of Western and Far West Local Health Districts, their Directors of Mental Health and their cluster managers • Service Managers of other clinical and support services • Private providers including medical specialists, GPs and allied health			
	As part of the regional planning process all participating providers and organisations should demonstrate willingness to reform service models to meet community needs	Agreement by Chief Executives for regional plan development	Regional Plans ratified by Boards of respective organisations	PHN and LHDs

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Models of Care	The WNSW PHN stepped care framework, which reflects evidence and national and state mental health policies should continue to form the basis of service models and should inform regional plan	Agreement on stepped care model across mental health services	Service access	PHN
	The hub and spoke model, which supports integrated care between main referral sites (hubs) and those in outlying communities (spokes) should form the basis of service delivery for mental health care	Agreement on hub and spoke model across mental health services	Service access	PHN
	From the perspective of WNSW PHN, consideration should be given to applying the hub and spoke model in service planning and commissioning with alignment against LHD	Agreement on hub and spoke model across mental health services	Service access	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	clusters, where this fits with program objectives			
	The WNSW PHN should continue to invest in placed-based planning as complementary to the stepped care approach in the context of the hub and spoke models	Services commissioned in context of placed based planning	Service access per head of population	PHN
Cross Border Challenges	The opportunity for co-commissioning has the potential to improve access in these areas.	Improved access to services Increase in numbers of services which are co-commissioned	Numbers of services which are co-commissioned	PHN
8. Workforce				
Capacity	A focus on building the capacity of mental health, and suicide prevention service staff to increase the impact of their services at a population level	Reduced prevalence of mental health disorders	NSW Health Survey Data	PHN and LHDs

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	should be a key feature of regional plans			
Professional development	Services should be required to demonstrate that professional development and supervision is accessible to staff, particularly for psychologists	Commissioned service specification include access to professional development and supervision	Review of commissioned services	PHN
Recruitment and retention	Recruitment and retention strategies for allied health staff in services should be implemented in line with a hub and spoke model	Recruitment and retention data for all relevant professionals	Workforce data	PHN