Australian Government
Department of Health

phn
An Australian Government Initiative

Northern Sydney Primary Health Network Needs Assessment 2019-2022

Contents

Section 1 – Executive Summary

1. Needs Assessment 2019-2022:

The **Northern Sydney PHN (NSPHN) Needs Assessment for 2019-2022** builds upon and compliments findings of the three previous Needs Assessments submitted to the Department of Health in 2016 and 2017, reflecting the iterative process of the commissioning and planning cycle of NSPHN.

NSPHN has taken great efforts over the past twelve months to develop a more informed and comprehensive understanding of public health issues within the region, which has included undertaking a regional Needs Assessment to identify ***psychosocial support needs*** of people with severe mental illness to inform service planning. NSPHN's Needs Assessment utilises the latest local and national qualitative and quantitative information to inform local activities relevant to identified need, combined with an **ongoing commitment from NSPHN to engage and consult with key stakeholders,** including community and clinical councils, other key advisory groups and the wider community of consumers, people with lived experience, clinicians and service providers to ensure NSPHN identifies key emerging public health themes across the region to inform ongoing service delivery.

NSPHN has undertaken significant activities since July 2015 to address local issues as identified in previous Needs Assessments. These activities have been bolstered by the commissioning of multiple primary care based services in the following areas:

Mental Health – vulnerable and hard to reach, youth, severe, CALD, Aboriginal mental health and suicide prevention.
Alcohol and Other Drugs - young people and adults requiring non-residential rehabilitation and a shared care approach to managing AOD misuse in primary care
After hours – improving access to social work, hospital discharge support, residential aged care
Aged Care – dementia care.
Aboriginal Health – Integrated Team Care
Behavioural Lifestyle Risk Factors (Smoking, Nutrition, Alcohol, Physical Exercise and Obesity) – targeted interventions for vulnerable population.

This document addresses the four Needs Assessment areas that are required to be considered for submission to the Department of Health this year:

1. General Population Health
2. Primary Mental Health Care (including suicide prevention)
3. Indigenous Health (including mental health and chronic disease)
4. Alcohol and Other Drugs Treatment needs

The health priorities, below, as identified in the previous NSPHN Needs Assessments, remain relevant and are a priority for the NSPHN region:

1. **Health of the Elderly**: Geographic hotspots of high population growth in the those aged 65+ years; complex needs of an ageing population will impose an increasing demand on healthcare services.
2. **Potentially Preventable Hospitalisations**: need to reduce potentially preventable hospitalisations through the delivery of services in primary care and community-based care settings.
3. **Mental Health**: High rates of intentional self-harm among young people; specific needs among vulnerable and hard to reach population groups.
4. **Alcohol and other drugs**: Geographic hotspot with higher rates of risky drinking; increasing rate of hospitalisations for methamphetamine use.

In addition to the above priorities, improving access to and navigation of services in the NSPHN region continues to be a key area of focus. Extensive stakeholder consultation has identified a range of barriers to accessing services in the region, particularly among vulnerable population groups.

The NSPHN initial Baseline Needs Assessment 2015-2016, NSPHN Needs Assessment Updates 2016-17 and 2017-18 remain pertinent and vital resources for the PHN, **the link to the previous Needs Assessments can be found below**:

https://sydneynorthhealthnetwork.org.au/about-us/commissioning/commissioningplanningperformance/

Mental health support needs are a focused area of investigation for this 2019-2022 NSPHN Needs Assessment and has been informed by:

- Findings and a gap analysis of previous NSPHN Needs Assessments
- Alignment to NSPHN strategic priorities
- NSPHN Clinical and Community Council direction
- Significant regional consultation
- National Mental Health priorities

In addition, the following focus areas presented in previous Needs Assessments have been updated with the latest available qualitative and quantitative information:

- Health of the elderly
- Youth Mental Health
- Socio-economic disadvantage
- Homelessness
- Culturally and Linguistically Diverse (CALD) population
- Lesbian, Gay, Bi-Sexual, Transgender and Intersex (LGBTI)
- Mental Health
- Alcohol and Other Drugs (AOD)
- Aboriginal and Torres Strait Islander people

Method:

The latest Needs Assessment incorporates:

- **Newly released quantitative data**
- **New qualitative information** gained from extensive stakeholder consultation
- **New and updated access to shared regional data** - as result of developed partnerships and relationships with the NGO and community sector
- **NSPHN Integrated Mental Health Atlas**

The resultant document provides further rich context to support and compliment the previous Needs Assessments, allowing the NSPHN to gain a deeper understanding and context of the complex public health issues that are persistent within our region.

2. Key Areas for the 2019-22 Needs Assessment

The following are a summary of key observations and new additions for 2019-2022 which add to the findings of the previous NSPHN Needs Assessments regarding the population, health status, and health services in the region.

Mental Health:

- Suicide death rates have remained at the same level for the previous ten years, with a high rate of suicide deaths among males within the NSPHN region.
- High rate of suicide and psychological distress among Aboriginal population.
- The SNPHN Mental Health Atlas highlights the limited availability of services for those with a lived experience of chronic and moderate to severe mental illness.
- The SNPHN Mental Health Atlas identifies a lower proportion of mental health services provided by NGOs in the region, coupled with funding insecurity.

Psychosocial Support Needs of People with Severe Mental Illness

- Impact of severe mental illness on social and emotional functioning, physical health and participation in the community necessitates need for non-clinical support.
- Stakeholder consultation highlighted need for access to flexible, integrated psychosocial services catering to the needs of people with severe mental illness, carers and family members.
- Need for services to support vulnerable population groups experiencing barriers to accessing the National Disability Insurance Scheme (NDIS).

Youth Mental Health:

- Nationally, approximately 14% of children aged 4-17 years were reported having a mental illness, with a higher prevalence among males. The survey was based on responses by parents or carers for children aged 4-17 years, with inclusion of self-reported responses for children aged 11 years and over.
- Higher prevalence of mental illness among children and young people living in socio-economically disadvantaged families or step, blended and single parent families.
- High rate of hospitalisations for intentional self-harm in those aged 15-24 years, with a higher rate among females, socio-economically disadvantaged and Aboriginal population.
- Disparity in service provision and access to services across the NSPHN region.
- Awareness of mental health and ability to navigate the health system among young people, parents, schools, clinicians, and the wider community is a significant need.

Aboriginal and Torres Strait Islander People:

- Significant under reporting of Aboriginal status by health care professionals, higher prevalence of chronic disease and low levels of breast screening among Aboriginal women.
- Low proportion of the Aboriginal population receiving MBS 715 health checks.
- High rate of suicide and psychological distress among Aboriginal people.
- Higher prevalence of smoking and obesity among Aboriginal people.

Alcohol and Other Drugs:

- Higher rates of risky drinking in the Northern Beaches LGA compared to the state and national rate.
- Increasing rate of hospitalisation for methamphetamine use within the NSPHN region.

Cancer Screening:

- Variation in breast and cervical cancer screening rates within NSPHN region.
- Low bowel cancer screening rates across the region

Childhood Immunisation:

- Childhood immunisation rates in children aged one, two and five years lower than the national aspirational target, with regional variation in childhood immunisations.

Health of older people:

- Geographic hotspots of high population growth in those aged 65+ years.
- The complex needs of an ageing population will impose an increasing demand on healthcare services within the NSPHN region.
- Financial barriers to older people in the NSPHN region accessing services.
- Growing CALD population in the region facing additional language and cultural barriers to accessing aged care services.
- Low proportion of those aged 75+ years receiving annual health check.
- Higher rate of hospitalisations for fall-related injuries within NSPHN region compared to NSW.

Culturally and Linguistically Diverse (CALD) Populations:

- Latest Census data highlights a growing CALD population within the NSPHN region, concentrated in specific geographic areas.
- Lower cancer screening rates and specific health literacy needs. Humanitarian entrant population in the region with significant and complex health issues.
- CALD groups present for a range of mental health and health needs, with a higher risk of suicidal behaviours among humanitarian entrants.

Socio-economic disadvantage:

- Pockets of disadvantage within the region, concentrated in Ryde, Hornsby and Northern Beaches LGAs.
- Higher rates of intentional self-harm in socio-economically disadvantaged population.
- Lower life expectancy and higher prevalence of smoking among those experiencing socio-economic disadvantage.

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Population:

- An estimated 23,000 LGBTI people (2-3% of the total population) live within the NSPHN region.
- Elevated risk of anxiety, depression, self-harm and suicide compared to non-LGBTI population.
- Suicidal ideation higher among young LGBTI people, partly due to higher rates of violence and harassment.

3. Consultation process:

The NSPHN has undertaken extensive stakeholder consultation and engagement during the development of the Needs Assessment – providing a rich source of additional qualitative input to inform service planning in the region. The consultations were well represented from a broad cross-section of the local community and service sector, including the following:

- General Practice
- The NSPHN Board
- NSPHN Community Council
- NSPHN Clinical Council
- NSPHN Mental Health and AOD Advisory Committee
- Northern Sydney Local Health District
- Allied Health – public and private
- Non-Government Organisations (local, state, national)
- People with lived experience, consumers, and carers
- Local schools, Local Government Councils and Family and Community Services (FACS)

The 2019-2022 Needs Assessment is also informed by the extensive consultation and engagement undertaken during commissioning co-design sessions in 2016 and 2018 for Mental Health, AOD and Aboriginal Health. Consultations from the latest Needs Assessment builds upon information gained from the commissioning co-design sessions, represented from more than **300 stakeholders**.

Data Analysis:

Quantitative and qualitative data was primarily sourced from the following areas:

- Australian Aboriginal and Torres Strait Islander Health Survey 2012-13
- Australian Bureaus of Statistics (ABS)- Census of Population and Housing, 2011 & Census of Population and Housing, 2016; Causes of deaths data, 2017
- Australian Institute of Health and Welfare (AIHW): GEN data
- AIHW analysis of National Hospital Morbidity Database 2015-16, 2014-15 and 2013-14
- AIHW analysis of the Medicare Benefits Schedule 2010-11 to 2015-16
- MBS claims data 2012-17
- National Drug Strategy Household Survey 2016
- NSW Cancer Institute- NSW Cancer Incidence and Mortality Data Set 2014
- NSW Cancer Institute- Reporting for Better Cancer Outcomes Performance Report 2016: Northern Sydney Local Health District
- NSW Department of Planning and Environment- Population Projections, 2016
- NSW Health Centre for Epidemiology and Evidence: NSW combined patient epidemiology data 2001-2017; NSW Population Health Survey
- Pat Cat data October 2018
- Public Health Information Development Unit (PHIDU) 2017-2018: Social Health Atlases of Australia
- PHIDU's analysis of the National Health Survey 2014-15
- Sydney North Primary Health Network (SNPHN) Integrated Mental Health Atlas 2017

- Stakeholder Consultation-Clinical Council, Community Council
- Stakeholder Consultation- Mental Health, AOD and Aboriginal Health co-design sessions
- Stakeholder Consultation- Local Councils
- Stakeholder consultation conducted by Relationships Australia NSW with the Gaimaragal Group
- The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing
- National Survey of Mental Health and Wellbeing 2007
- Literature review

This data has been used to assess key issues and their potential impact on the Northern Sydney population, and to present the analysis in a readily accessible format that NSPHN can continue to update and build upon as an iterative process for future needs assessments.

Future Considerations:

The composition of the region's CALD population is a complex one, with specific needs pertaining to generational issues, health literacy, methods of accessing health care, gender, culture, language and other factors related to the social determinants of health which are also individual to the many CALD sub-groups across the region.

Conclusion:

The latest NSPHN Needs Assessment further qualifies that there are significant health issues within the region, which will be further compounded by substantial growth in both the aged and CALD populations. The Northern Sydney PHN maintains a changing demographic which continues to face several challenges across age groups, with pockets of socio-economic disadvantage across the region.

Population cohorts, geographic hot spots and specific health issues exist and impact the public health profile of the region. There are issues relating to the impact of the social determinants of health, such as access to primary care, stress and addiction which can impact health outcomes and with an ageing demographic, significant challenges ensue for our older population.

The NSPHN Needs Assessment identifies a range of barriers to accessing services in the NSPHN region, with a need to improve system navigation and access to services for the most vulnerable populations. Extensive stakeholder consultation identifies affordability, awareness, health literacy, eligibility criteria and transport as common barriers to accessing services in the NSPHN region.

Analysis highlights cohorts of young people within the region with mental health issues who are impacted by the socio-economic determinants of health. Extensive consultation with a range of stakeholders identified numerous barriers for young people with mental health issues accessing services within the NSPHN region, including, a lack of awareness of local health services and uncertainty on where to seek help, with additional barriers for young people from CALD backgrounds. Consultation also identified a need for a community driven response to improve health literacy and raise awareness of youth mental health within the region.

Extensive consultation has identified many people diagnosed with severe mental illness experience additional impacts on their social and emotional functioning, physical health and participation in the community, with a need for psychosocial support services that are practical, flexible and meet the needs of vulnerable populations. Consultation highlighted the need for integration between clinical and non-clinical services to facilitate recovery among people experiencing severe mental illness.

Analysis also highlights underreporting of Aboriginal status by health service providers. There is also a significant proportion of the NSPHN population who are physically inactive. Hotspots with higher prevalence of obesity; cohorts with higher smoking rates; and low consumption of the recommended daily intake of fruit and vegetables across the population has both immediate and long-term impacts on health and wellbeing. New additions to PHN knowledge of our health profile also indicates that there are discrete cohorts who do not access available preventative and screening measures in the areas of childhood immunisation and cancer screening.

NSPHN has also developed a ***Commissioning Evaluation Framework***, which is based on the Quadruple Aim, as a method for evaluating the impact of commissioned services, which will go some way to address elements of needs as identified in this needs assessment and will in the future be an additional source of data to inform subsequent Needs Assessment and planning.

There is evidence and great scope to continue to work towards an improved health status for our community and enhance health service provision to a significant number of our residents. There is strong evidence that within our PHN region there are significant disparities in health outcomes and access to primary health care that require ongoing and proactive efforts to address. The Northern Sydney PHN will continue to build relationships with stakeholders, identify barriers in addressing local health services and serve the community to its fullest capacity by continually assessing and monitoring the complexities of the region's public health profile.

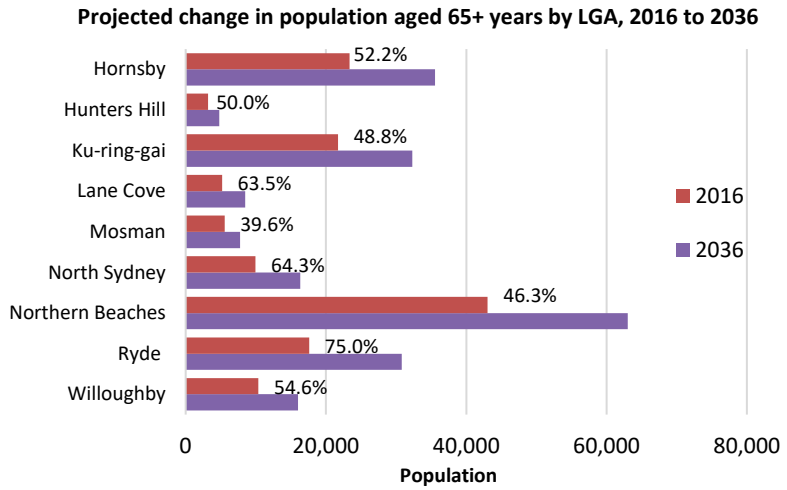
Section 2 – Outcomes of the health needs analysis

General Population Health

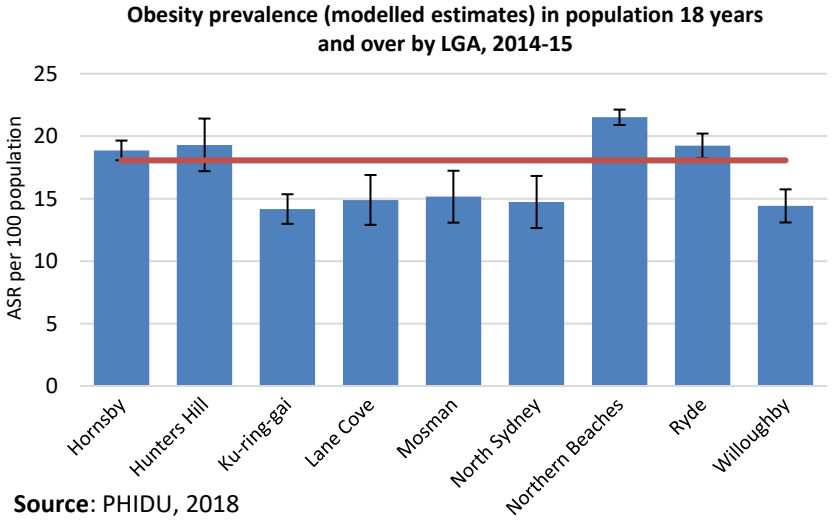
Summary:

NSPHN's Needs Assessment utilises the latest qualitative and quantitative data to highlight significant health issues within the region, which will be compounded further by substantial growth in both the aged and CALD populations. The following update identifies a higher prevalence of obesity concentrated in geographic areas within the region, lower life expectancy in socio-economically disadvantaged groups, regional variation in childhood immunisation and a need to reduce potentially preventable hospitalisations.

NSPHN's previous Needs Assessments identified pockets of high socio-economic disadvantage in the region and highlighted population cohorts with complex needs and varying levels of access to primary care services. Where possible, this latest Needs Assessment profile provides an update to relevant data for vulnerable and hard to reach populations and reflects national performance indicators on which the PHN will be measured, presenting the latest available data for cancer screening, childhood immunisation and potentially preventable hospitalisations.



Source: NSW Department of Planning and Enviroment, 2016



Source: PHIDU, 2018

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Demography		
Ageing population	In the NSPHN region, 15.7% of the population is aged 65+ years. The NSPHN 65+ years population is projected to increase by 55.2% between 2016-2036, with an estimated increase of 220,000 residents aged 65+ years by 2036.	**Quantitative evidence:** • 15.7% of the population aged 65+ years in the NSPHN region compared to 15.9% for NSW[1]. • Between 2016-2036, Ryde (75%), North Sydney (64.3%) and Lane Cove (63.5%) LGAs have a higher projected increase in the population aged 65 years and over compared to NSPHN (55.2%)[2]. The projected increase in Ryde also exceeds the projected increase for NSW (67.1%).
Ageing population	Healthcare for older people will remain an increasing priority for the NSPHN region, with a rise in chronic disease and comorbidity, the complex needs of an ageing population will impose an increasing demand on healthcare services. Successful navigation and access to the health and aged care system is critical for the NSPHN 65+ years population. Older people in the region can face financial barriers to accessing services, previous Needs Assessments highlighted asset rich but income poor cohorts of older people in the region. Navigating the complex aged care system is also a barrier, with a growing CALD population in the region facing additional language and cultural barriers to accessing aged care services.	The Needs Assessments utilises a range of data sources and stakeholder consultation to highlight the health needs of an ageing NSPHN population. Please refer to the relevant description of evidence for specific ageing population health and service needs throughout the document.

[1] Australia Bureau of Statistics (ABS) 2018, *Regional Population by Age and Sex, Australia*, cat no 3235, viewed October 2018.

[2] NSW: Department of Planning & Environment 2016. *2016 New South Wales State and Local Government Area population and household projections*. NSW Planning Department of Planning & Environment, Sydney, viewed October 2017

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Health outcomes		
Premature mortality	Higher rate of premature mortality (under 75 years) among males compared to females in the NSPHN region.	**Quantitative evidence:** • Premature mortality rates among males in the NSPHN region 184 per 100,000 (95% CI: 178-190) compared to 121 per 100,000 (95% CI: 116-126) among NSPHN females. • Rates of premature mortality are lower compared to NSW.
Premature mortality	Cancer is the main cause of premature mortality in the NSPHN region, followed by circulatory system diseases.	**Quantitative evidence:** • Approximately 50% of premature deaths in the NSPHN region attributed to cancer, with almost 20% of all premature deaths attributed to lung, colorectal and breast cancers (2011-15)[3].
Disability	3.7% of the NSPHN population have severe or profound disability, measured within the Census using the 'core activity need for assistance' variable developed by the Australian Bureau of Statistics (ABS). The proportion of those with profound or severe disability has remained at the same level within the region, compared to the 2006 and 2011 Census.	**Quantitative evidence:** • 3.7% of the population have a need for assistance with core activities, lower compared to NSW (5.4%). More than 32,000 people in the region have profound or severe disability[4]. **Severe disability** is defined as a person sometimes needing help with a core activity task (communication, mobility or self-care). **Profound disability** is defined as a person always needing help with a core activity task.

[3] Public Health Information Development Unit (PHIDU) 2018. *Social Health Atlas of Australia: Data by Primary Health Network (PHN)/Local Government Area (LGA), October 2018 release*. PHIDU, Adelaide, viewed October 2018

[4] Census of Population and Housing 2016

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Lifestyle Risk factors- Physical inactivity, hotspots with higher prevalence of obesity and low proportion of the NSPHN population consuming the recommended intake of fruits and vegetables.		
Smoking	An estimated 65,800 people aged 18 years and over are current smokers within the NSPHN region.	**Quantitative evidence:** • Smoking prevalence is lower in the NPSHN region (9.5 per 100; 95% CI: 8.7-10.2) compared to NSW (16 per 100; 95% CI:15.9-16.3)[5] (2014-15), however, it remains the leading cause of death and disease in Australia[6]. • Higher smoking prevalence in Aboriginal, socio-economically disadvantaged and LGBTI populations. Please refer to pages 19-24 for further detail.
Nutrition	Low proportion of children and adults consuming the recommended intake of fruits and vegetables	**Quantitative evidence:** • Within the NSPHN region, 7.8% (95% CI: 5.6-9.9) of adults and 6.2% (95% CI: 3.2-9.2) of children had the daily recommended intake of vegetables compared to 6.6% (95% CI: 6-7.3) of adults and 7.4% (95% CI: 6.1-8.8) of children in NSW (2017). • 49.5% (95% CI: 45.3-53.6) of adults and 74.8% (95% CI: 68.9-80.8) of children consumed the daily recommended intake of fruits compared to 46.4% of adults (95% CI:45-47.8) and 66.8% (95% CI: 64.5-69) of children in NSW[7] (2017).

[5] Public Health Information Development Unit (PHIDU) 2018. Social Health Atlas of Australia: Data by Primary Health Network (PHN)/Local Government Area (LGA), October 2018 release. PHIDU, Adelaide, viewed October 2018

[6] Cancer Council 2018, *Smoking and tobacco control*, viewed October 2018

[7] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed October 2018

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Physical activity	A significant proportion of adults in the NSPHN region are not undertaking adequate physical activity	**Quantitative evidence:** • In 2017, 32.8% of the NSPHN population 16 years and over did not undertake adequate physical activity, lower compared to NSW (41.6%; 95% CI: 40.2-43). • Whilst the proportion in NSPHN has decreased over the past 7 years from 41.1% in 2010 to 32.8% in 2017, a significant proportion continue to be below the threshold for adequate physical activity. • Adequate physical activity for persons aged 18 to 64 years is defined as undertaking moderate intensity exercise for a total of at least 150 minutes per week over 5 separate occasions[8]. • Please refer to page 20-22 for specific needs within Aboriginal and CALD groups.
Obesity	High prevalence of obesity in Northern Beaches LGAs. High prevalence of obesity identified at a lower geographic level (SA2) within Hornsby and Ryde LGAs. Limited data available to determine cohorts with high need, to allow provision of targeted local interventions.	**Quantitative evidence:** • Rates of obesity higher in Northern Beaches LGA (21.5 per 100; 95% CI: 20.9-22.1) compared to NSPHN (18.1 per 100; 95% CI: 17.7-18.4) (2014-15).[9] • Asquith-Mount Colah/Berowra-Brooklyn-Cowan (23.6 per 100; 95% CI: 22.2-25.1) and North Ryde-East Ryde/Ryde-Putney (21.7 per 100; 95% CI: 20.3-23.1) have higher rates compared to NSPHN (2014-15).

[8] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed October 2018

[9] Public Health Information Development Unit (PHIDU) 2017. *Social Health Atlas of Australia: Data by Primary Health Network (PHN), June 2017 release*. PHIDU, Adelaide, viewed September 2017

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Cancer Screening - Variation in breast and cervical cancer screening rates within NSPHN region and low bowel cancer screening rates across the region.		
Breast cancer	Higher incidence of breast cancer in NSPHN female population compared to NSW.	**Quantitative evidence:** • Breast cancer incidence 152 per 100,000 for NSPHN female population compared to 130 per 100,000 for NSW (2014)[10].
Breast cancer screening	Regional variation in breast cancer screening rates.	**Quantitative evidence:** • Breast cancer screening rates lower in Mosman (43.8 per 100; 95% CI: 42.2-45.4) and North Sydney (50.7 per 100; 95% CI: 49.6-51.8) compared to NSPHN (53.5 per 100; 95% CI: 53.2-53.8) and NSW (53 per 100; 95% CI: 52.9-53.1)[11].
Bowel cancer screening	Lower screening rates of bowel cancer in Ryde and Willoughby.	**Quantitative evidence:** • Bowel cancer screening rates for Mosman (37 per 100; 95% CI: 35.1-38.8) and North Sydney (37.2 per 100; 95% CI: 35.8-38.5) lower compared to NSPHN. • Bowel cancer screening rates for NSPHN population aged 50-74 years 39.5 per 100 (95% CI: 39.1-39.8) higher than NSW (37.8 per 100; 95% CI: 37.7-37.9). • Bowel cancer screening rate among women aged 50-74 years 40.9 per 100 (95% CI: 40.4-41.4) compared to 37.9 per 100 (95% CI: 37.4-38.5) among men from the same age group.[12] **Qualitative evidence:** • Consultation has highlighted that higher rates of colonoscopy could potentially impact bowel cancer screening rates within the region. Currently screening rates are based solely on results under the National Bowel Cancer Screening Program. Further access to regional data required to understand the impact of colonoscopy on screening rates.

[10] Cancer Institute NSW 2018, *Cancer statistics NSW*, Cancer Institute NSW, viewed October 2018.

[11] Cancer Institute NSW 2017, *Reporting for Better Cancer Outcomes Performance Report 2017: Northern Sydney PHN*, Cancer Institute NSW, Sydney.

[12] Cancer Institute NSW 2017, *Reporting for Better Cancer Outcomes Performance Report 2017: Northern Sydney PHN*, Cancer Institute NSW, Sydney

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Cervical cancer screening	Lower rates of cervical cancer screening in Ryde LGA.	**Quantitative evidence:** • Cervical cancer screening rates for NSPHN women aged 20-69 years (63.1 per 100; 95%CI: 63-63.3) highest in NSW (56.3 per 100; 95% CI: 56.3-56.4). • Screening participation rates in Ryde (54.7 per 100; 95%CI: 54.2-55.2) lower than both NSW and NSPHN.[13]
Childhood Immunisation – Childhood immunisation rates in children aged one, two and five years lower than the national aspirational target, with regional variation in rates.		
Childhood Immunisation	NSPHN childhood immunisation rates lower than the national aspirational target of 95%, with rates remaining at the same level for the previous eight years. Latest data at an LGA level available for 2016. NSPHN continues to work closely with the National Centre for Immunisation research and surveillance (NCIRS) to update the immunisation register and with the Public Health Unit to increase immunisation rates in the region by supporting general practice to implement targeted initiatives.	**Quantitative evidence:** • Immunisation rates for NSPHN children aged one year 92.7%, compared to 93.3% for NSW (2016). • Immunisation rates for NSPHN children aged two years 89.8% compared to 90.8% for NSW (2016). • Immunisation rates for NSPHN children aged five years 91.2% compared to 93.5% for NSW (2016)[14].

[13] Cancer Institute NSW 2017, *Reporting for Better Cancer Outcomes Performance Report 2017: Northern Sydney LHD*, Cancer Institute NSW, Sydney

[14] Public Health Information Development Unit (PHIDU) 2018. *Social Health Atlas of Australia: Data by Primary Health Network (PHN)/Local Government Area (LGA), October 2018 release*. PHIDU, Adelaide, viewed October 2018

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Childhood Immunisation	Regional variation in childhood immunisation, with lower immunisation rates in Lane Cove, Mosman, Ryde and North Sydney.	**Quantitative evidence:** • Lower immunisation rates for children aged one year in Lane Cove (91.4%). • Lower immunisation rates for children aged two years in Mosman (88.6%), Ryde (88.6%) and North Sydney (88.2%). • Lower immunisation rates for children aged five years in North Sydney (87.1%)[15].
Potentially Preventable Hospitalisations (PPH) – Lower rate of PPHs in the NSPHN region compared to NSW, increasing in the previous five years.		
Potentially Preventable Hospitalisations (PPH)	Rate of PPHs lower for the NSPHN region compared to NSW, increasing in the previous five years, with a higher rate in Northern Beaches LGA. NSPHN is in the process of finalising a data sharing agreement with the Local Health District to access relevant data to further inform service planning, including generating general practice-level informative data and to identify NSPHN's impact on local hospital avoidance rates.	**Quantitative evidence:** • In 2016-17, the rate of PPHs for NSPHN 1,714 per 100,000 (95% CI: 1,688-1,740) compared to 2,248 per 100,000 (95% CI: 2,238-2,259) for NSW. Cellulitis, urinary tract infections and dental conditions accounted for 36.7% of potentially preventable hospitalisations.[16] • The rate of PPH increased from 1,503 per 100,000 (95% CI: 1,478-1,529) in 2011-12 to 1,714 per 100,000 in 2016-17. Changes in the rate of PPH is driven by a range of factors including prevalence of disease, coding standards for hospitalisations and access to primary healthcare. Whilst, increase in hospitalisations between 2013-14 and 2014-15 were partly driven by changes in coding standards for vaccine preventable hospitalisations, further investigation is needed to ascertain the underlying reasons for increases in PPH within NSPHN. • Whilst lower than NSW, Northern Beaches LGA had a higher rate of PPH (1,826 per 100,000; 95% CI: 1,809-1,843) compared to other LGAs in NSPHN; remaining at the same level for the previous ten years.

[15] Public Health Information Development Unit (PHIDU) 2018. *Social Health Atlas of Australia: Data by Primary Health Network (PHN)/Local Government Area (LGA), October 2018 release*. PHIDU, Adelaide, viewed October 2018

[16] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed October 2018

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Potentially Preventable Hospitalisations (PPH)	Higher rate of PPH among people in the most socio-economically disadvantaged 20% of the population.	**Quantitative evidence:** • In the most disadvantaged 20% of the population, the PPH rate for NSW 2,743 per 100,000 (95% CI: 2,717-2,769) compared to 1,738 per 100,000 (95% CI: 1,718-1,758) for people in the least disadvantaged 20% (2016-17)[17]. Potential need within Ryde, Hornsby and Northern Beaches LGAs which have pockets of disadvantage.
Vulnerable population groups		
Aboriginal and Torres Strait Islander People		
Underreporting of Aboriginal and Torres Strait Islander status	Underreporting of Aboriginal status by service providers leading to lack of Aboriginal-specific programs. Widely reported throughout the region that health professionals do not ask patients regarding their Aboriginal identity. There are significant regional issues relating to a hidden population and the Stolen Generation, with cohorts of the population who do not always self-identify their ethnicity – which impacts on ability to access available health care provision. The **Integrated Team Care** NSPHN commissioned service supports the local Indigenous population who have chronic disease and works closely with general practice to enhance culturally appropriate services to improve patient outcomes, and also to support identification of Aboriginal status.	**Qualitative evidence:** Stakeholder consultation identified under reporting of Aboriginal status by health care professionals in the region, highlighting the question is not always asked, and when it is, there is a need to ask respectively and in a culturally appropriate manner. Underreporting of Aboriginal status leads to lack of identified health and community services for Aboriginal residents in the region, with one Aboriginal-specific GP clinic in the region operating one day per week.

[17] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed October 2018

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Cancer screening rates for Aboriginal and Torres Strait Islander women	Low breast screening rates among Aboriginal women in NSPHN region.	**Quantitative evidence:** • Breast cancer screening rates among Aboriginal women in the NSPHN region 27.7 per 100 (95%CI: 21.6-33.8) compared to 52.5 per 100 (52.2-52.8) for all women aged 50-69 years (2014-15).[18]
Aboriginal and Torres Strait Islander lifestyle behaviours	High smoking prevalence.	**Quantitative evidence:** • In NSW, 28.5% (95% CI: 21.2-35.8) of Aboriginal people report smoking daily or occasionally; higher compared to non-Aboriginal people (14.7%; 95% CI:13.6-15.7) (2017) [19].

Aboriginal and Torres Strait Islander lifestyle behaviours	High prevalence of overweight and obesity	**Quantitative evidence:**
		• In 2012–13, compared to non-Indigenous adults, Indigenous adults were:
		  ○ 1.2 times as likely to be overweight or obese and
		  ○ 1.6 times as likely to be obese.[20]

Aboriginal and Torres Strait Islander lifestyle behaviours	Insufficient physical activity	**Quantitative evidence:** • In 2012–13, a larger proportion of Indigenous adults (64%) were not sufficiently active for health compared to non-Indigenous adults (56%) [21]. • Being sufficiently active for health for an adult in a non-remote area is defined as undertaking 150 minutes of physical activity over five or more sessions per week[22].

[18] Cancer Institute NSW 2016, *Reporting for Better Cancer Outcomes Performance Report 2016: Northern Sydney LHD*, Cancer Institute NSW, Sydney.
[19] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed October 2018
[20] Australian Institute of Health and Welfare (AIHW) 2018, *Australia's Health 2018*, Cat. no: AUS 221, AIHW, Canberra.
[21] Australian Institute of Health and Welfare (AIHW) 2018, *Australia's Health 2018*, Cat. no: AUS 221, AIHW, Canberra.
[22] Australian Institute of Health and Welfare (AIHW) 2018, *Australia's Health 2018*, Cat. no: AUS 221, AIHW, Canberra.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Chronic disease in Aboriginal and Torres Strait Islander population	High prevalence of chronic disease.	**Quantitative evidence:** • Nationally, chronic diseases contribute to 64% of the disease burden among Aboriginal people and 70% of the gap in health outcomes between Aboriginal and non-Aboriginal people. [23] • Nationally, cardiovascular diseases and cancer contribute to 21.9% of the total disease burden among Aboriginal people. [24]
Culturally and linguistically diverse (CALD)		
CALD population	Growing CALD population within the NSPHN region with specific geographies that have a higher proportion of CALD groups.	**Quantitative evidence:** • According to the 2016 Census, NSPHN has a larger proportion of people from culturally and linguistically diverse backgrounds (25.7%) compared to NSW (21.1%), increasing from 22.1% in 2011. • Chinese, Indian and South Korean are the largest CALD groups within the NSPHN. Similar to the national trend, the proportion of people born in China and India has increased compared to the 2011 Census. • Within NSPHN, Ryde has the highest proportion of its population from a CALD background (42%), increasing from 36.5% in 2011, with 47.7% of the total population in Ryde speaking a language other than English. • Mandarin, Cantonese and Korean are the most commonly spoken languages in the NSPHN region.

[23] Australian Institute of Health and Welfare (AIHW) 2016, *Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011*, AIHW, Canberra.

[24] Australian Institute of Health and Welfare (AIHW) 2016, *Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011*, AIHW, Canberra.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Health needs	There is a subsequent need to develop culturally appropriate interventions to cater for the diverse health needs of the growing CALD population within the region. Limited availability of national and local data to understand the complexities of the multiple CALD groups within the region, who have differing health needs and experiences of accessing and utilising primary care.	**Qualitative evidence:** • Complex health needs of CALD groups can be attributed to the distinct needs of each CALD group[25]with variation in needs between successive generations of migrants adding further to the complexity in care provision[26]. • There are specific barriers to accessing health services which subsequently impact the health status of CALD groups. Please refer to page 52 for further detail. • Further investigation needed to understand health issues prevalent within different / specific CALD groups to identify issues that can be managed within primary care in a culturally appropriate manner.
Risk factors	Higher rate of smoking, physical inactivity and diabetes among Chinese Australians.	**Quantitative evidence:** According to Jin et al (2017), findings from the 45 and Up Study highlight that Chinese Australians have 22% higher rates of smoking, 48% higher rate of physical inactivity and 25% higher rate of diabetes compared to non-Chinese Australians[27]. Limited data available to identify the prevalence of these risk factors in the local Chinese population which is the largest CALD group within the Northern Sydney region, accounting for 5.8% of the total population.

[25] The Royal Australian College of General Practitioners (RACGP) 2011, *The RACGP Curriculum for Australian General Practice 2011- Multicultural health*, RACGP, Victoria.

[26] NSW Ministry of Health 2012, *Policy and Implementation Plan for Healthy Culturally Diverse Communities 2012-16*, NSW Ministry of Health, Canberra.

[27] Jin K, Neubeck L, Gullick J, Koo F, Ding D 2017, *Marked differences in cardiovascular risk profiles in middle-aged and older Chinese residents: Evidence from a large Australian cohort*, International Journal of Cardiology, vol 227, pp 347-354.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Cancer screening in CALD population	Low breast cancer screening rates among CALD women. Lower rates among CALD women in Mosman and Pittwater LGAs.	**Quantitative evidence:** • In NSPHN, breast cancer screening rates among CALD women: 50.9 per 100 (95% CI: 50.3-51.5) compared to 52.5 per 100 (52.2-52.8) for all women aged 50-69 years (2014-15). • Screening rates among CALD women in Pittwater (38.5%) and Mosman (37.4%) is lower compared to NSPHN (50.9%) and NSW (46.1%).[28]
At risk and hard to reach CALD populations	Higher rates of domestic violence reported in families from CALD backgrounds. Further investigation needed to determine which CALD groups are most likely to be impacted, with a need to deliver culturally appropriate services to the relevant CALD populations.	**Qualitative evidence:** Consultations with service providers highlighted domestic violence in families from CALD backgrounds, not specific to new migrants and humanitarian entrants. This issue is exacerbated by social isolation, poverty, poor awareness of services and limited health literacy.
Refugee population	Refugee population within the region with significant and complex health issues.	**Qualitative evidence:** Northern Sydney currently has a Tibetan refugee population, with the number of Syrian humanitarian entrants expected to increase, however, further work required to understand true population number and health needs.
Socio-economic disadvantage		
Socio-economic disadvantage	Pockets of socio-economic disadvantage.	**Quantitative evidence:** Pockets of disadvantage within the region, concentrated in Ryde, Hornsby and Northern Beaches LGAs.[29]

[28] Cancer Institute NSW 2016, *Reporting for Better Cancer Outcomes Performance Report 2016: Northern Sydney LHD*, Cancer Institute NSW, Sydney.

[29] Australian Bureau of Statistics (ABS) 2018, *Census of Population and Housing*: *Socio-economic indexes for areas (SEIFA)*, *Australia, 2016*, cat 2033.0.55.001, viewed October 2016

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Socio-economic disadvantage Smoking	Higher prevalence of smoking among people in the most disadvantaged quintile.	**Quantitative evidence:** In NSW, current smoking prevalence is higher among people in the most disadvantaged quintile (19.5%; 95% CI: 16.9-22.1) compared to those in the least disadvantaged quintile (10.8%; 95% CI: 8.7-12.8) (2017) [30]. Current smoking is defined as the proportion of the population reporting smoking daily or occasionally.
Life expectancy	Lower life expectancy among people in the most disadvantaged quintile.	**Quantitative evidence:** For NSW, life expectancy among people in the most disadvantaged quintile (87.4 years) is 4.1 years lower compared to those in the least disadvantaged quintile (83.3 years)[31] (2016).
Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) population		
LGBTI population	NSPHN LGBTI population with specific lifestyle behaviours and health issues.	**Quantitative evidence:** An estimated 23,000 LGBTI people (2-3% of the total population) live within the NSPHN region.[32]

LGBTI lifestyle behaviours	High smoking prevalence among LGBTI population.	**Quantitative evidence:**
		• Nationally, whilst there has been a decrease in daily smoking rates among homosexual/bisexual Australians from 27.7% in 2010 to 18.7% in 2016; there continues to be a higher prevalence among homosexual/bisexual Australians compared to heterosexual Australians (12.1%)[33]. Smoking prevalence escalates to:
		  ○ 44% among transgender men
		  ○ 35% among transgender women[34]
		  ○ 47.7% among lesbian, bisexual and queer women aged 16-24 years[35]

[30] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed October 2018

[31] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed October 2018

[32] Aids Council of NSW (ACON), Estimating the prevalence and distribution of LGBTI adults in NSW, ACON, Sydney.

[33] Australian Institute of Health and Welfare (AIHW) 2017, *National Drug Strategy Household Survey 2016: Detailed findings*, cat no. PHE 184, AIHW, Canberra

[34] Berger I, Mooney-Somers, J 2015, *Smoking cessation programs for LGBTI people: A systematic review of content and effect*, Centre for values, ethics and the lay in Medicine, University of Sydney, Sydney.

[35] Mooney-Somers, J, Deacon, RM, Richters, J & Parkhill, N 2015, *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH)Survey 2006, 2008, 2010, 2012, 2014,* ACON & VELiM, University of Sydney, Sydney.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
LGBTI sexual health	Screening behaviours poorer among homosexual women.	**Quantitative evidence:** 20% of 1,100 women surveyed through Sydney Women and Sexual Health (SWASH) study never had a pap smear and 40% never underwent STI screening despite being sexually active.[36]
LGBTI sexual health	Higher risk of HIV and Hepatitis C due to high risk sexual practices as well as drug usage patterns.[37]	**Quantitative evidence:** • Nationally, the self-reported HIV prevalence among gay and bisexual men participating in the Gay Community Periodic Surveys was 7.3% in 2016.[38] • Male-to-male sex continues to be the major HIV risk exposure in Australia[39], with 74% (232) of newly diagnosed HIV infections in NSW among men who have sex with men. [40] • Despite the high rate of newly diagnosed infections, HIV education and prevention initiatives by Aids Council of NSW (ACON) have contributed to greater knowledge about HIV testing and awareness among gay and homosexual men.[41] Expanded PrEP Implementation in Communities in NSW (EPIC-NSW) trial is available in the region through Clinic 16 providing access to Pre-Exposure Prophylaxis (PrEP) for high-risk individuals to reduce the risk of HIV transmission.[42]

[36] Mooney-Somers, J, Deacon, RM, Richters, J, Parkhill, N (2015) *Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH)Survey 2006, 2008, 2010, 2012, 2014.* Sydney: ACON & VELiM, University of Sydney

[37] De Wit, J, Mao, L, Adam, P, Treloar C 2014, *HIV/AIDS, hepatitis, and sexually transmissible infections in Australia: Annual report of trends in behaviour 2014*, Centre for Social Research in Health, UNSW, Sydney.

[38] The Kirby Institute 2017, HIV, viral hepatitis and sexually transmissible infections in Australia – Annual Surveillance Report 2017, The Kirby Institute, UNSW, Sydney.

[39] The Kirby Institute 2018, *HIV in Australia- Annual Surveillance Report 2018*, The Kirby Institute, UNSW, Sydney.

[40] NSW Government: Department of Health 2017, *NSW HIV Strategy 2016-2020: Quarter 4 & Annual 2017 Data Report*, Department of Health

[41] ACON 2015, Annual Report 2014/15, ACON, Sydney.

[42] HIV/AIDS and Related Programs (HARP) Unit Northern Sydney LHD (NSLHD) Clinic 16 2016, *Expanded PrEP Implementation in Communities in NSW (EPIC-NSW),* NSLHD, Sydney.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
People experiencing homelessness		
Homelessness	A cohort in the NSPHN region homeless or at risk of being homeless, with significant and complex health issues.	**Quantitative evidence:** The 2016 Census estimated 2,130 people to be homeless in the NSPHN region with the largest numbers in Neutral Bay/Kirribilli and Macquarie Park/Marsfield (Statistical Area Level 2)[43]. Northern Sydney District Homeless Project [44]snapshot of contacts made to organisations in the region seeking a service found: • 56.2% of clients recorded as homeless compared to 41.2% being at risk. • Single men and women most likely to contact services, followed by families with children. Majority of 'families with children' consisted of single mothers. • 3.3% of clients identified as Aboriginal and 17.2% as CALD.
Homelessness	Access to secure and affordable housing.	**Quantitative evidence:** • A snapshot of homelessness in the region [45] identified the most common presenting issue as financial stress (54%), with mental health (38%) and domestic violence (38%) also featuring predominately. • 28.8% of low-income families experience financial stress from mortgage or rent (NSW: 29.3%) with higher rates in Ryde (37.2%), Willoughby (34.1%) and North Sydney (33%) (2016).[46]

[43] Australian Bureau of Statistics (ABS) 2018, *Census of population and housing: estimating homelessness, 2016*, cat no 2049, viewed October 2018

[44] Northern Sydney District Homelessness Project 2016

[45] Northern Sydney District Homelessness Project 2016

[46] Public Health Information Development Unit (PHIDU) 2018. *Social Health Atlas of Australia: Data by Primary Health Network (PHN)/Local Government Area (LGA), October 2018 release*. PHIDU, Adelaide, viewed October 2018.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Homelessness	Risk of poorer outcomes	**Qualitative evidence:** • Although there is a lack of national data pertaining to the prevalence rate of smoking amongst homeless persons, a 1995-1996 Melbourne based study reported that 77% of the 238 homeless people surveyed were current smokers.[47] • A high rate of smoking amongst this group is problematic because homeless persons may adapt their smoking behaviours to save money (i.e. sharing cigarettes and smoking from used cigarette butts or filters), potentially exposing themselves to greater health risks[48].
Older people		
Health of older people	Higher rate of fall-related injury hospitalisations within NSPHN region compared to NSW, with a higher rate among females compared to males.	**Quantitative evidence:** • Whilst the prevalence of falls among people aged 65 years and over within NSPHN (22.1%; 95% CI: 14.9-29.3) is comparable to NSW (22.7%, 95% CI: 20.4-25), the rate of fall-related injury hospitalisations (3,563 per 100,000; 95% CI: 3,471-3,657) is higher in the NSPHN region compared to NSW (3,126 per 100,000; 95% CI: 3,095-3,157). Disaggregating the rates further by gender, rates are higher for both NSPHN males and females compared to NSW males and females respectively. • The rate of hospitalisations among NSPHN females (4,016 per 100,000; 95% CI: 3,884-4,150) is higher compared to NSPHN males (2,974 per 100,000; 95% CI: 2,846-3,107), indicating a greater burden among females (2016-17) [49].

[47] Kermode M, Crofts N, Miller P, Speed B & Streeton J. *Health Indicators and risks among people experiencing homelessness in Melbourne 1995-1996*. Australia and New Zealand Public Health. 22:464-70).

[48] Australian Institute of Health and Welfare (AIHW) 2018, *Alcohol, tobacco & other drugs in Australia Web report.* AIHW, Canberra.

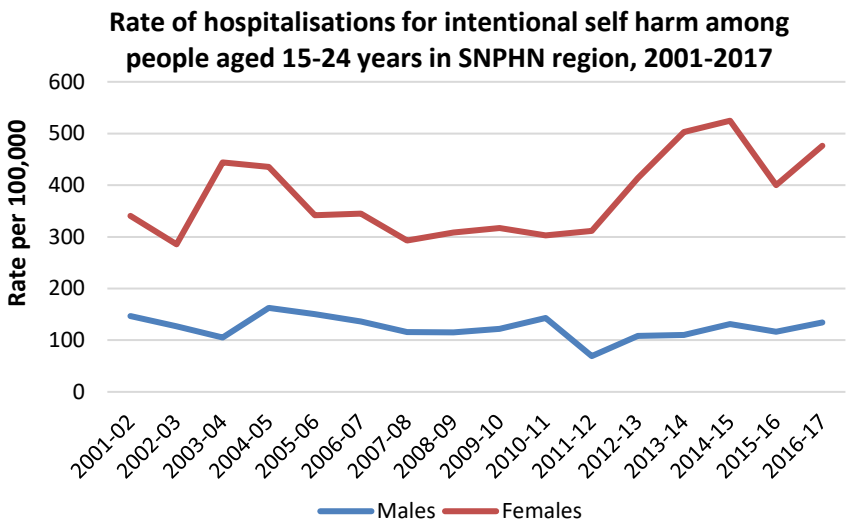
[49] Centre for Epidemiology and Evidence 2017, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed October 2017

Primary Mental Health Care (including Suicide Prevention)

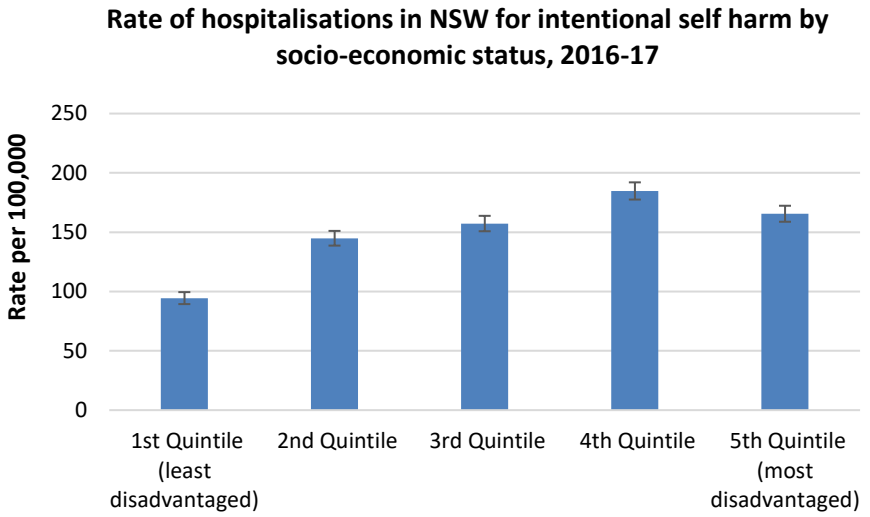
Summary

The NSPHN Needs Assessment utilises available qualitative and quantitative data to highlight the impact of mental illness across the NSPHN population with a focus on vulnerable and hard to reach groups. The 2019-2022 Needs Assessment identifies support needs of people diagnosed with severe mental illness who experience corresponding psychosocial disability. In line with the requirement to commission local psychosocial support services through the National Psychosocial Support Measure, NSPHN has consulted with local stakeholders including GPs, Northern Sydney Local Health District, community-based service providers, consumers, carers and local councils to identify service needs and cohorts unlikely to be able to access support services through NDIS.

Previous Needs Assessments have identified higher rates of distress among Aboriginal and Torres Strait people, higher rates of intentional self-harm among young people, impacts of social determinants on youth experiences of mental health, varying levels of access to mental health services and specific needs among other vulnerable and hard to reach cohorts. The following analysis builds upon previous findings to identify mental health needs within the NSPHN region, with relevant data updated where possible.



Source: Centre for Epidemiology and Evidence, 2018



Source: Centre for Epidemiology and Evidence, 2018

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Prevalence and Suicide Prevention		
Prevalence of mental illness across the spectrum of severity	Stratification of the population into different 'needs groups', ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions is important in understanding the different service responsibilities within the **stepped care approach**[50]**.**	**Quantitative evidence:** • Applying national estimates[51] to the NSPHN population, an estimated 39.9% of the total population have a mental health need pertaining to current or prior illness. This translates to approximately: ○ 23.1% (214,117) of NSPHN population with previous illness, risk of relapse or at early stage of developing illness. ○ 9.1% (84,349) with mild mental illness. ○ 4.6% (42,638) with moderately severe mental illness. ○ 3.1% (28,734) with severe mental illness
Prevalence of mental illness	Depression and anxiety account for the largest proportion of diagnosed mental health conditions.	**Quantitative evidence:** • 9.6% (95% CI: 7.1-12.2) of people aged 16 years and over report high or very high psychological distress in the NSPHN, lower compared to NSW (15.1%; 95% CI: 14.1-16.2)[52] (2017). • Anxiety and depression are one of the most commonly managed mental health conditions in general practice**,** accounting for 48.7% of mental health related encounters in general practice [53], consultation with local GPs estimates that the prevalence is higher. • Pat Cat data from 136 NSPHN GP practices estimates the prevalence of mental health conditions at 10.9 per 100, with depression and anxiety accounting for the largest proportion of mental health conditions. The data is limited to cohorts visiting a GP practice.

[50] Australian Government- Department of Health 2017, PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance- Stepped Care;

[51] Australian Government- Department of Health 2017, PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance- Stepped Care; Australian Bureau of Statistics (ABS) 2018, *Population by Age and Sex, Region of Australia*, ABS cat. no. 3235, viewed October 2018.

[52] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 8th October 2018

[53] Australian Institute of Health and Welfare (AIHW) 2017, *Mental health services in Australia- Mental health-related care in general practice*, AIHW, Canberra

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Suicide prevention	Suicide death rates have remained at the same level for the previous ten years.	**Quantitative evidence:** • 59 deaths due to suicide in the NSPHN region in 2016 averaging one death from suicide every six days. • Suicide death rate within the NSPHN region 6.4 per 100,000 (95% CI: 4.9-8.2), lower than the NSW rate of 10.3 per 100,000 (95% CI: 9.6-11) [54]. • Suicide death rates have remained at the same level in NSPHN in the past 10 years - 6 per 100,000 in 2006 (95% CI: 4.5-8) to 6.4 per 100,000 (95% CI: 4.9-8.2) in 2016. • Suicide rates are influenced by coronial processes, methodologies in defining and determining cases of 'intentional self-harm' in hospital records and procedures for coding deaths data. Limited availability of local data to identify burden across age groups.
Suicide prevention	High rate of death by suicide amongst males.	**Quantitative evidence:** • In 2016, rate of deaths from suicide among NSW males (15.9 per 100,000; 95% CI: 14.6-17.2) was 3.2 times higher than the rate for NSW females (4.9 per 100,000; 95% CI: 4.2-5.6). • Males aged 35-44 years had the highest rate and number of suicide deaths in NSW: 23.9 per 100,000 (95% CI: 19.9-28.6) compared to 15.9 per 100,0000 among males of all ages.[55]

[54] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 8th October 2018

[55] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 8th October 2018

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Psychosocial support needs for people with mental illness – Comorbid physical health conditions, risk of social isolation, difficulty in accessing secure housing and lower rates of labour force participation among people with mental illness highlights need for support beyond clinical services.		
Supporting psychosocial needs of people with severe mental illness	Many people diagnosed with severe mental illness experience additional impacts on their social and emotional functioning, physical health and participation in the community. Individuals with reduced psychosocial functional capacity who do not meet the threshold for 'permanent disability' will not be appropriately supported through the NDIS and will require support through the National Psychosocial Support (NPS) measure. For people to meet the threshold to access NDIS support they must: • have an impairment or condition that is likely to be permanent (i.e. it is likely to be lifelong) and • have an impairment that substantially reduces their ability to participate effectively in activities, or perform tasks or actions unless they have: ○ assistance from other people or ○ assistive technology or equipment (other than common items such as glasses) or ○ you can't participate effectively even with assistance or aides and equipment and • have an impairment that affects their capacity for social and economic participation and • are likely to require lifetime support under NDIS	**Quantitative evidence:** • Approximately 2.5% of the total population with severe/not complex mental illness may require psychosocial support. This equates to approximately 23,000 people within the NSPHN region[56]. • Vulnerable and hard to reach population groups experiencing barriers to accessing NDIS services are the potential target cohorts for the NPS measure. Please refer to page 60 for further detail on cohorts experiencing barriers to accessing NDIS services.

[56] Australian Government-Department of Health n.d., Specialised community mental health support services and the National Mental Health Service Planning Framework, accessed October 2018; National Mental Health Services Planning Framework Planning Support Tool AUSV2.1 2018 build 4.0.6.1 May2018; Australian Bureau of Statistics (ABS) 2018, *Population by Age and Sex, Region of Australia*, ABS cat. no. 3235, viewed October 2018

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Impact of mental illness	Morbidity associated with mental illness.	**Quantitative evidence:** Mental illness and substance use disorders accounted for 23.6% of the total non-fatal burden of disease, emphasising the impact of mental health and substance use disorders on quality of life. Years of life lost due to disability (YLD) owing to a health condition was used as a marker to measure the non-fatal burden[57].
Physical wellbeing of people with mental illness	Co-morbid physical health conditions impacting health outcomes of people with mental illness.	**Quantitative evidence:** • 11.7% of people aged 16-85 years with a mental illness also reported a co-morbid physical health condition[58]. • Underdiagnosis of physical health conditions among people with mental illness and lower rates of treatment for physical health conditions impacts quality of life. Co-morbid physical health conditions are a contributor to lower life expectancy[59] among people experiencing severe mental illness with cardiovascular disease being a common cause of premature mortality[60].
Social Isolation	Risk of social isolation among people with mental illness.	**Qualitative evidence:** • Mental illness can impact the ability to maintain relationships with friends, family and acquaintances, making individuals susceptible to risk of social isolation with a greater risk among those who have been hospitalised[61]. • According to the 2010 National Survey of Psychotic Illness, social isolation, lack of employment and financial problems were highlighted as key challenges among people living with psychotic illness[62].

[57] AIHW 2016, Australian *Burden of Disease Study: Impact and causes of illness and death in Australia 2011*, AIHW, Canberra.
[58] ABS 2008, *2007 National Survey of Mental Health and Wellbeing: Summary of Results,* ABS, Canberra.
[59] Department of Health 2017, The Fifth National Mental Health and Suicide Prevention Plan, Department of Health, Canberra.
[60] De Hert et al 2011, *Physical illness in patients with severe mental disorder. I. Prevalence, impact of medications and disparities in health care*, World Psychiatry, vol. 10, pp. 52-77.
[61] Rickwood D 2006, *Pathways of Recovery: Preventing further episodes of Mental Illness (Monograph)*, Commonwealth of Australia, Canberra.
[62] Morgan et al 2011, People living with psychotic illness 2010: Report on the second Australian national survey, National Mental Strategy, Commonwealth of Australia.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Accessing and maintaining secure housing	Challenges in accessing secure housing	**Qualitative evidence:** Severity of symptoms, financial disadvantage and stigmatisation predispose individuals with mental illness to homelessness with outcomes exacerbated for those with severe mental illness[63]and co-morbid alcohol and other drug issues[64]. **Quantitative evidence:** Nationally, 48% of clients presenting to specialist homelessness services with mental illness had previously experienced an episode of homelessness in the last 12 months, highlighting the need to prevent repeated cycles of homelessness[65].
Maintaining employment	Lower rates of labour force participation	**Quantitative evidence:** Nationally, 32% of people with a self-reported mental illness did not participate in the labour force compared to 17% of people without a mental illness[66].
Carer/family support	Greater risk of adverse outcomes for people with severe mental illness necessitates the need for psychosocial support.	**Qualitative evidence:** Outcomes related to co-morbidities with physical health conditions, social isolation, housing and employment can potentially be worse off among people with severe mental illness. The repercussions are not limited to persons with mental illness but also creates economic and social burden for carers and families who are the primary source of ongoing support and recovery for persons with severe mental illness[67].

[63] Costello L, Thomson M, Jones K 2013, Mental Health and Homelessness Final Report, NSW Mental Health Commission.

[64] Rickwood D 2006, *Pathways of Recovery: Preventing further episodes of Mental Illness (Monograph)*, Commonwealth of Australia, Canberra.

[65] AIHW 2018, Mental health services in Australia, AIHW, Canberra.

[66] Department of Health and Ageing 2013, *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993-2011*, Commonwealth of Australia, Canberra.

[67] Department of Health 2017, The Fifth National Mental Health and Suicide Prevention Plan, Department of Health, Canberra.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Vulnerable Population Groups		
Young People		
Prevalence	Higher prevalence of mental illness among males and adolescents.	**Quantitative evidence:** • According to the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing, nationally, approximately 13.9% of children aged 4-17 years were reported as having a mental illness in the previous 12 months. The survey was based on responses by parents or carers for children aged 4-17 years with inclusion of self-reported responses for children aged 11 years and over when available. Applying the national estimates to the NSPHN population, approximately 21,000 children were estimated to have a mental illness in the previous 12 months. • Higher prevalence (16.3%) among males compared to females (11.5%). • 14.4% of children aged 12-17 years report having a mental illness in the past 12 months compared to 13.6% of children 4-11 years. [68]
Prevalence of severe mental illness among young people	2.1% of children aged 4-17 years have a severe mental disorder[69].	**Quantitative evidence:** Applying the national estimates to the NSPHN population, approximately 3,000 children were estimated to have severe mental illness.
Prevalence based on social-determinants of health	Higher prevalence of mental illness among children living in step, blended and single parent families.	**Quantitative evidence:** 18.3% of children in step families, 20.2% in blended families and 22.4% in single parent families report having a mental illness in the past 12 months compared to 10.4% of children in original families.[70] Potential need within Northern Beaches LGA which has a higher proportion of step, blended and single parent families compared to NSPHN.[71]

[68] Lawrence D et al 2015, The Mental Health of Children and Adolescents- Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra.
[69] Lawrence D et al 2015, The Mental Health of Children and Adolescents- Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra
[70] Lawrence D et al 2015, The Mental Health of Children and Adolescents- Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra.
[71] ABS 2017, Census of Population and Housing: 2016

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Prevalence based on social-determinants of health	Higher prevalence of mental illness among children living in socio-economically disadvantaged families.	**Quantitative evidence:** 20.7% of children living in families in the most disadvantaged quintile report having a mental illness in the past 12 months, higher compared to children living in families in the least disadvantaged quintile (10.9%)[72]. Potential need in Ryde LGA which is ranked as the most socio-economically disadvantaged LGA within NSPHN[73].
Self-harm in young people	High rate of intentional self-harm in those aged 15-24 years, with a higher rate of hospitalisations in females and socio-economically disadvantaged youth and higher rate of deaths in males.	**Quantitative evidence:** • Higher rate of hospitalisations due to intentional self-harm among those aged 15-24 years within NSPHN region - 302 per 100,000 (95% CI: 270-338) compared to 102 per 100,000 (95% CI: 96-110) for all ages (2016-17). • The rate of hospitalisations among females aged 15-24 within NSPHN has increased from 345 per 100,000 in 2006-07 (95% CI: 296-401) to 476 per 100,000 in 2016-17 (95% CI: 418-540) and is higher compared to NSPHN males (134 per 100,000; 95% CI: 105-169)[74]. • Higher rate of hospitalisations among people aged 15-24 years in the most disadvantaged quintile (389 per 100,000; 95% CI: 362-417) compared to those in the least disadvantaged quintile (259 per 100,000; 95% CI: 236-283) in NSW. [75] • For NSW, age-specific death rate for intentional self-harm in those aged 15-24 years is 10.5 per 100,000. Rate among males – 15.9 per 100,000 compared to 4.9 per 100,000 for females[76].

[72] Lawrence D et al 2015, The Mental Health of Children and Adolescents- Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra.

[73] ABS 2016, Census of Population and Housing: Socio-economic Indexes for Areas (SEIFA)

[74] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 9th October 2018.

[75] Centre for Epidemiology and Evidence 2017, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 7th September 2017.

[76] Australian Bureau of Statistics (ABS) 2018, *Causes of Death, NSW, 2017* cat no. 3303, viewed 9th October 2018.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Aboriginal and Torres Strait Islander people		
Aboriginal and Torres Strait Islander people	Impacts of the Stolen Generations, poor access to preventative health care and higher rates of social disadvantage impact rates of psychological distress amongst the Aboriginal and Torres Strait Islander community.	**Qualitative evidence:** Stakeholder consultations highlighted that mental health issues related to the stolen generation faced by the Aboriginal population in the NSPHN region. Poor access to preventative health care and higher rates of social disadvantage impact rates of psychological distress amongst the Aboriginal and Torres Strait Islander community.
Aboriginal and Torres Strait Islander people	Higher rate of hospitalisations for mental health disorders among Aboriginal people compared to non-Aboriginal people.	**Quantitative evidence:** For NSPHN, higher rate of hospitalisations for mental health disorders among Aboriginal people 3,648 per 100,000 (95% CI: 2,935-4,471) compared to 2,126 per 100,000 (95% CI: 2,097-2,157) for non-Aboriginal people in NSPHN (2016-17). [77]
Suicide in Aboriginal and Torres Strait Islander people	Higher rates of suicide among Aboriginal people compared to non-Aboriginal people.	**Quantitative evidence:** • Rates among Aboriginal people across NSW – 16.3 per 100,000 (95% CI: 13.4-19.6) compared to 9.9 per 100,000 for non- Aboriginal people (95% CI: 9.6-10.2) (2012-16) [78]. • 23.3% (95% CI: 16.7-29.9) of Aboriginal people in NSW reported high/very high psychological distress compared to 14.9% (95% CI: 13.8-15.9) of non-Aboriginal people[79] (2017).

[77] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 9th October 2018.
[78] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 9th October 2018.
[79] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 9th October 2018.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Self-harm in young Aboriginal and Torres Strait Islander people	Higher rate of hospitalisations due to intentional self-harm among Aboriginal people aged 15-24 years compared to non-Aboriginal people.	**Quantitative evidence**: • Rates of hospitalisations in NSW for intentional self-harm among 15-24 years old Aboriginal people 904 per 100,000 (95% CI: 820-994) compared to 356 per 100,000 (95%CI: 343-369) for non-Aboriginal people (2016-17) [80]. • The rates of intentional self-harm among Aboriginal people aged 15-24 years has increased from 470 per 100,000 (95% CI: 407-541) in 2011-12 to 904 per 100,000 (95% CI: 820-994) in 2016-17[81].
Culturally and linguistically diverse (CALD)		
Prevalence of mental illness in CALD population	Complex presentations in CALD groups within the NSPHN region.	**Qualitative evidence:** Stakeholder consultation highlighted the complexities of mental health need and service provision for CALD groups in the NSPHN region. CALD groups presenting for a range of mental health and health need e.g. trauma, migration, career change, physical health, social isolation, separated families.
Suicide prevention in CALD population	Higher risk of suicidal behaviours among humanitarian entrants.	**Qualitative evidence:** Overrepresentations are related to lower service utilisation, greater stigma related to mental health, limited knowledge about available services as well as language and cultural barriers. [82]

[80] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 9th October 2018.

[81] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 9th October 2018.

[82] Mental Health in Multicultural Australia (MHiMA) 2014, *Framework for Mental Health in Multicultural Australia- Towards culturally inclusive service delivery*, MHiMA, Queensland.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Socio-economic disadvantage		
Self-harm in socio-economic disadvantaged population	Higher rates of intentional self-harm in socio-economically disadvantaged population.	**Quantitative evidence:** • For NSW, rates of intentional self-harm in the least disadvantaged quintile were 94.3 per 100,000 (95% CI: 89.4-99.5) compared to 166 per 100,000 (95% CI: 159-172) for those in the most disadvantaged quintile (2016-17).[83]
Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) population		
Prevalence of mental illness in LGBTI population	Elevated risk of anxiety, depression, self-harm and suicide compared to non-LGBTI population. This risk is further elevated in LGBTI people from CALD backgrounds. Suicidal ideation higher among young LGBTI people, partly due to higher rates of violence and harassment[84].	**Quantitative evidence:** • Australian studies have found that LGBTI people are: ○ 2.9 times more likely to experience post-traumatic stress disorder ○ 2.4 times more likely to experience social phobia. ○ 1.7 times more likely to experience major depression ○ 4.1 times more likely to attempt suicide. [85]
People experiencing homelessness		
Homelessness	High prevalence of mental health issues in homeless population.	**Quantitative evidence:** • A snapshot of homelessness in the region identified 38% of contacts seeking a homeless service related to mental health issues[86], with 32.8% of people in NSW accessing specialist homelessness services reporting a current mental health issue[87].

[83] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 9th October 2018.

[84] beyondblue 2010, Clinical practice guidelines: Depression in adolescents and young adults, beyondblue, Melbourne.

[85] Ritter A, Matthew-Simmons F, Carragher N 2012, *Monograph 23: Prevalence of and Interventions for Mental Health and Alcohol and other drug problems amongst the Gay, Lesbian, Bisexual and Transgender Community: A review of the Literature*, Drug Policy Modelling Program Monograph Series, National Drug and Alcohol Research Centre, Sydney

[86] Northern Sydney District Homelessness Project, 2016

[87] AIHW 2018, *Mental health services in Australia*, AIHW, Canberra; AIHW 2018, *Specialist homelessness services annual report 2016-17*, AIHW, Canberra.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Older People		
Mental health of older people	Mental health issues among older people in residential care facilities. Nationally, males aged 85+ years have higher rates of suicide compared to other age-groups[88].	**Quantitative evidence:** • According to the Mental Commission of NSW (2017), approximately 50% of older people living in residential aged care facilities report mild, moderate or severe symptoms of depression.[89]
Other vulnerable population groups		
Prevalence of perinatal depression	20% of Australian mothers experience perinatal depression.	**Quantitative evidence:** Nationally, young mothers (under 25 years), mothers who smoke and mothers from low-income households are at greater risk of experiencing perinatal depression[90].
Prevalence of perinatal depression	Stigma associated with perinatal depression.	**Qualitative evidence:** Stakeholder consultation highlighted that stigma attached to perinatal depression for women in the NSPHN region, with women being underdiagnosed and falling through gaps in service provision.
People with intellectual disability	Approximately 3% of Australians are diagnosed with intellectual disability[91].	**Quantitative evidence:** Comorbidity with mental disorders especially psychiatric and mood disorders is very common. However, diagnosis of these disorders is often difficult especially among people with speech difficulties[92]. Nationally, 57% of people with intellectual disability also have psychiatric disability[93].

[88] AIHW 2015, *Australia's welfare 2015*. Cat.no. AUS 189, AIHW, Canberra

[89] Mental Health Commission of NSW 2017, *Living Well in Later Life: The Case for Change*, Mental Health Commission of NSW, Sydney.

[90] Australian Institute of Health and Welfare (AIHW) 2012, *Experience of perinatal depression: data from the 2010 Australian National Infant Feeding Survey*, cat no. PHE 161, AIHW, Canberra.

[91] ABS 2014, *Intellectual Disability, Australia, 2012*, ABS cat no. 4433.0.55.003

[92] Simpson J 2012, *Healthier Lives- Fact sheets on health and people with intellectual disability for families, advocates, disability workers and other professionals*, NSW Council for Intellectual Disability.

[93] Australia Institute of Health and Welfare (AIHW) 2008, *Disability in Australia: intellectual disability*, Bulletin 67, AIHW, Canberra.

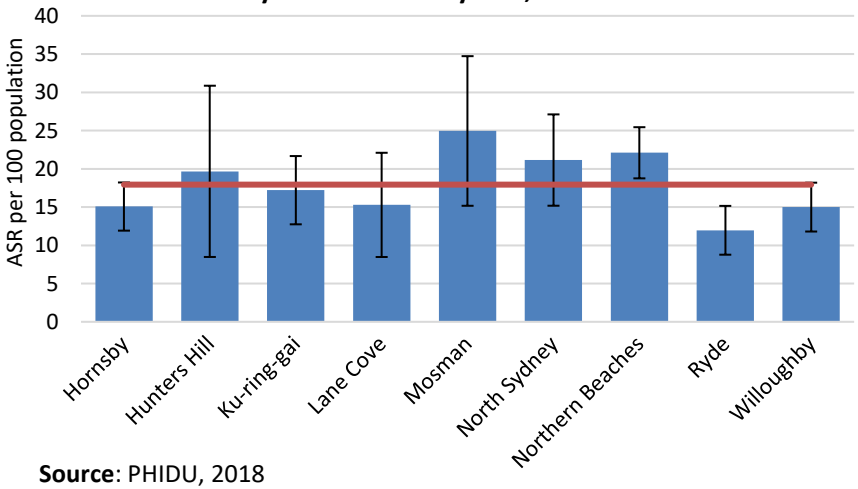
Alcohol and Other Drug Treatment Needs

Summary

NSPHN's Alcohol and Other Drugs (AOD) Needs Assessment builds upon previous AOD Needs Assessments to identify vulnerable cohorts and geographic hotspots of need within the NSPHN region, with higher rates of risky drinking, illicit drug use and alcohol attributable hospitalisations. Similar to the trend for NSW, the analysis identifies a continuing increase in hospitalisations for methamphetamine use within the region, with stakeholder consultation highlighting an increase in Emergency Department presentations in young males for steroid abuse.

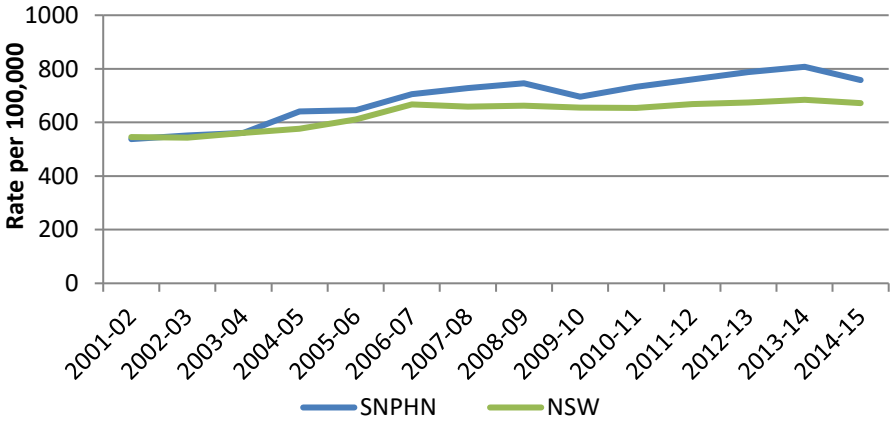
NSPHN's previous AOD Needs Assessments remain valid and highlighted risky alcohol consumption, binge drinking in young people, hidden drinking in CALD groups, increasing use of ice and polysubstance abuse in young people and cohorts experiencing barriers to accessing AOD services. The following Needs Assessment builds upon previous findings to identify AOD needs across population cohorts utilising the latest qualitative and quantitative data.

Risky drinking (modelled estimates) in population 15 years and over by LGA, 2014-15



Source: PHIDU, 2018

Alcohol attributable hospitalisations in the SNPHN region and in NSW, 2001-02 to 2014-15



Source: Centre for Epidemiology and Evidence, 2016

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Prevalence and mortality		
Alcohol consumption	Higher rate of risky drinking in Northern Beaches LGA.	**Quantitative evidence:** • According to the Australia Health Survey (2014-15), higher rate of people aged 15 years and over consuming more than two standard drinks per day in Northern Beaches LGA (22.1 per 100; 95% CI:18.8-25.4) compared to Australia (16.7 per 100; 95% CI: 16.5-17) and NSW (16.7 per 100; 95% CI: 16.3-17.2)[94].
Alcohol consumption	Higher rate of alcohol attributable hospitalisations compared to NSW. Females in the NSPHN region have the highest rate of alcohol attributable hospitalisations in NSW.	**Quantitative evidence:** • NSPHN's rate of alcohol attributable hospitalisations 759 per 100,000 (95% CI: 741-776) compared to 672 per 100,000 (95% CI: 685-732) for NSW (2014-15). • Rate of hospitalisations among females -709 per 100,000 (95% CI: 685-732), highest in NSW (2014-15) [95]. • Limited availability of local data to identify underlying causes of alcohol attributable hospitalisation including the impact of better access to private healthcare and prevalence of alcohol consumption on rates of hospitalisations.

[94] Public Health Information Development Unit (PHIDU) 2017. *Social Health Atlas of Australia: Data by Primary Health Network (PHN), June 2017 Release*. PHIDU, Adelaide, viewed October 2016

[95] Centre for Epidemiology and Evidence 2016, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed October 2016

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Alcohol consumption	Manly LGA has the highest rate of alcohol attributable hospitalisations in the region. NSPHN continues to work with the Northern Sydney Local Health District (NSLHD) to access data that identifies areas and cohorts with higher rates of alcohol related hospitalisations.	**Quantitative evidence:** • Manly (1,134 per 100,000) LGA has the highest rates of alcohol attributable hospitalisations in the region, 60.5% (95% CI: 50.5-70.7) higher compared to NSW (2013-15). • Manly has a standardised separation ratio of 120.7 (CI: 109.2- 133.4) for alcohol attributable injury hospitalisations, 21% higher compared to NSW[96]. • The rate of liquor offences in North Sydney (422 per 100,000) is 2.91 times higher than the rate for NSW (145 per 100,000). • Alcohol related crimes are influenced by a range of factors including policing; regulations around liquor licences and, recording, reporting and classification of offences[97]. Limited availability of local data to draw inferences about the impact of prevalence of alcohol consumption on alcohol related crime.
Alcohol consumption	Cultural acceptance of alcohol.	**Qualitative evidence:** Stakeholder consultation highlighted the cultural acceptance of alcohol can create challenges in identifying a need to seeking help, highlighting people are able to be high functioning and often not seeking help until entering the criminal justice system or other crises.

[96] Centre for Epidemiology and Evidence 2016, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed October 2016

[97] Goh D, Holmes J 2017. *New South Wales Recorded Crime Statistics 2016*, NSW Bureau of Crime Statistics and Research, Department of Justice, Sydney.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
AOD misuse- population prevalence	The National Drug and Alcohol Clinical Care and Prevention (DA-CCP) tool estimates the prevalence of alcohol and other drugs misuse disorder to provide an understanding of the health needs of the population which can inform subsequent planning of AOD services[98].	**Quantitative evidence:** Applying the national estimates from the DA-CCP tool to the NSPHN regional population, it can be estimated that approximately 120,000 people residing within NSPHN report alcohol and other drug misuse in the past 12 months. This can be further stratified into: • 80,800 with alcohol misuse • 6,000 with amphetamine misuse • 4,300 with benzodiazepine misuse • 21,000 with cannabis misuse • 7,300 with opioids misuse
AOD mortality	Drug related deaths within the NSPHN region	**Quantitative evidence:** • Between 2012-16, 256 drug related deaths within the NSPHN region with the highest rates in North Sydney-Mosman SA3[99]. • Further analysis required to understand the underlying causes and confounders of drug related deaths and identify cohorts that are at greater risk of drug related mortality.
Illicit drug use	Significant increase in hospitalisations due to methamphetamine usage in NSPHN region. Latest data available is from 2016-17. NSPHN is working with the Local Health District to access latest regional data to further identify need and inform service planning.	**Quantitative evidence:** • The rate of persons hospitalised for methamphetamine related poisoning/use disorder in NSPHN has increased significantly from 6 per 100,000 (95% CI: 4.3-8.2) in 2009-10 to 41.2 per 100,000 (95% CI: 36.5-46.3) in 2016-17. • The rate is lower compared to NSW (92.8 per 100,000; 95% CI: 90.3-95.4).

[98] Ritter et al 2014, New Horizons: The review of alcohol and other drug treatment services in Australia, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, Sydney.

[99] Penington Institute 2018, NSW SA3 all drug related deaths 2011-15, Penington Institute, Melbourne, viewed November 2017.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Vulnerable Population Groups		
Young people		
Illicit drug use among young people	Overrepresentation of people aged 16-34 years in methamphetamine related hospital admissions and ED presentations.	**Quantitative evidence:** • Nationally, in 2016, higher proportion of young people aged 20-29 yrs. reported using illicit drugs in the last 12 months (28.2%) compared to other age groups (range: 6.9-18.1).[100] • In 2016-17, hospitalisations for people aged 16-34 years in NSW accounted for 52% of all methamphetamine related hospitalisations and 58% of all methamphetamine related ED presentations.[101]
Steroid use among young men	Increasing steroid use among young men. NSPHN is currently awaiting the Local Health District data to quantify information.	**Quantitative evidence:** In 2016, 30.6% of young people aged 15-19 years in NSW highlighted that they were extremely concerned or very concerned about their body image[102]. **Qualitative evidence:** Stakeholder consultations highlighted growing perception of 'self-image' among young men is contributing to increasing prevalence of steroid use with combined steroid and methamphetamine usage imposing a burden on ED presentations. Consultation identified social media, advertising projecting 'ideal' body types and peer pressure as potential drivers.

[100] Australian Institute of Health and Welfare (AIHW) 2017, *National Drug Strategy Household Survey 2016: Detailed findings*, cat no. PHE 184, AIHW, Canberra.

[101] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, NSW Ministry of Health, Sydney, viewed October 2018.

[102] NSW Government: Department of Health 2017, *NSW Youth Health Framework 2017-2024*, NSW Ministry of Health.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Aboriginal and Torres Strait Islander people		
Alcohol consumption in Aboriginal and Torres Strait Islander population	Higher rate of alcohol related hospitalisations	**Quantitative evidence:** • Higher rate of hospitalisations for alcohol among Aboriginal people (1,390 per 100,000; 95% CI: 1,329-1,453) compared to non-Aboriginal people (639 per 100,000; 95% CI: 634-645) [103]. • The prevalence of daily or weekly alcohol consumption among Aboriginal people across NSW is similar to estimates among non-Aboriginal people. However, among Aboriginal people, a greater proportion of those who drink engage in risky drinking posing long-term risk to health (41.3%; 95% CI: 33.5-49.1) in comparison to the non-Aboriginal population (30.7%; 95% CI:29.4-32.1)[104], potentially contributing to the higher rate of hospitalisations (2017). • Limited availability of data to evaluate the impact of drinking patterns on the rate of alcohol related harm and hospitalisation.
Illicit drug use in Aboriginal and Torres Strait Islander population	Higher usage of illicit substances among Aboriginal population, particularly among Aboriginal males.	**Quantitative evidence:** • Nationally, 25.6% of Aboriginal people reported using illicit drugs in the last 12 months compared to 15.7% of non-Aboriginal people. [105] • Cannabis is the most commonly used illicit drug with 16.7% of Aboriginal people reporting cannabis use in the past 12 months compared to 10.7% of non-Aboriginal people. • Nationally, 28% of Aboriginal males reported using illicit substances compared to 17% of Aboriginal females. [106] • Higher rate of accidental drug related deaths among Aboriginal people (20.7 per 100,000) compared to non-Aboriginal people (6.4 per 100,000)[107] (2016).

[103] Centre for Epidemiology and Evidence 2016, Health Statistics New South Wales, NSW Ministry of Health, Sydney, viewed September 2016.
[104] Centre for Epidemiology and Evidence 2017, Health Statistics New South Wales, NSW Ministry of Health, Sydney, viewed October 2017.
[105] Australian Institute of Health and Welfare (AIHW) 2017, National Drug Strategy Household Survey 2016: Detailed findings, cat no. PHE 184, AIHW, Canberra
[106] Australian Institute of Health and Welfare (AIHW) 2011, *Substance use among Aboriginal and Torres Strait Islander People*, cat no. IHW 40, AIHW, Canberra.
[107] Penington Institute 2018, Australia's Annual Overdose Report 2018, Penington Institute, Melbourne.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Socio-economic disadvantage		
Alcohol related mortality in socio-economically disadvantaged population	Higher rate of alcohol attributable deaths among those who are socio-economically disadvantaged.	**Quantitative evidence:** In NSW, there is a lower proportion of people consuming alcohol at levels posing long-term risk in the most disadvantaged quintile (22.6%; 95% CI: 20-25.2) compared to those in the least disadvantaged quintile (28.6%, 95% CI: 25.9-31.3). However, the rate of alcohol attributable deaths is higher among people in the most disadvantaged quintile (17.9 per 100,000; 95% CI: 16.5-19.5) compared to those in the least disadvantaged quintile (10.9 per 100,000; 95% CI: 9.8-12.1) [108].
Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI)		
Alcohol consumption in LGBTI population	LGBTI people more likely to engage in risky drinking behaviours.	**Quantitative evidence:** • Across Australia, 28.4% of LGBTI people reported engaging in risky drinking behaviours compared to 17.1% for the non-LGBTI population[109]. • Whilst the prevalence of risky drinking among LGBTI people did not show significant changes between 2010-2016, the proportion of those who engaged in risky drinking reduced significantly among the non-LGBTI population.

[108] Centre for Epidemiology and Evidence 2017, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 13th September 2017

[109] Australian Institute of Health and Welfare (AIHW) 2017, *National Drug Strategy Household Survey 2016: Detailed findings*, cat no. PHE 184, AIHW, Canberra.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence

Illicit drug use in LGBTI population	Higher prevalence of illicit substance abuse among LGBTI population compared to non-LGBTI population.	**Quantitative evidence:**
		• LGBTI population:
		  ○ 4.1 times more likely to use ecstasy
		  ○ 5.1 times more likely to use methamphetamine
		  ○ 2.7 times more likely to use cocaine
		  ○ 2.8 times more likely to use pharmaceuticals for non-medical purpose[110]
		• Methamphetamine usage has remained at the same level among LGBTI people between 2010-2016, contrary to prevalence among non-LGBTI people which reduced significantly in 2016 compared to 2013.[111]

People experiencing homelessness		
AOD use among people experiencing homelessness	Alcohol dependence and its associated impact on maintaining tenancies.	**Quantitative evidence:** Nationally, 9% of specialist homelessness centre clients have been identified as having problematic drug and/or alcohol misuse[112]. **Qualitative evidence:** Research indicates that alcohol dependence is common amongst populations that are experiencing chronic homelessness[113]. In particular, a strong association has been established between recent or current problematic drug use and the maintenance of ongoing tenancy[114]. Other adverse associations include higher levels of chronic illness, increased duration of hospital stays and higher mortality rates[115].

[110] Australian Institute of Health and Welfare (AIHW) 2017, *National Drug Strategy Household Survey 2016: Detailed findings*, cat no. PHE 184, AIHW, Canberra.
[111] Australian Institute of Health and Welfare (AIHW) 2017, *National Drug Strategy Household Survey 2016: Detailed findings*, cat no. PHE 184, AIHW, Canberra.
[112] Australian Institute of Health and Welfare (AIHW) 2018, Specialist Homelessness Services Annual Report 2016-2017 Cat. no: WEB 217 AIHWM, Canberra.
[113] Ezard N, Cecilio ME, Clifford B, Baldry E, Burns L, Day CA, Shanahan M & Dolan K. 2018. A managed alcohol program in Sydney, Australia: Acceptability, cost-savings and non-beverage alcohol use. Drug and Alcohol Review, 37:184-194.
[114] Australian Institute of Health and Welfare (AIHW) 2018, Specialist Homelessness Services Annual Report 2016-2017 Cat. no: WEB 217 AIHWM, Canberra.
[115] Ezard N, Cecilio ME, Clifford B, Baldry E, Burns L, Day CA, Shanahan M & Dolan K. 2018. A managed alcohol program in Sydney, Australia: Acceptability, cost-savings and non-beverage alcohol use. Drug and Alcohol Review, 37:184-194.

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Older people		
Alcohol consumption among older people	Daily drinking in people aged 65 years and over.	**Quantitative evidence:** In NSW, the prevalence of daily drinking is higher among those aged 65-74 years (15.5%, 95% CI: 13.5-17.4) and 75+ years (17.1%, 95% CI: 14.9-19.4) compared to other age groups[116].

[116] Centre for Epidemiology and Evidence 2018, Health Statistics New South Wales, NSW Ministry of Health, Sydney, viewed October 2018.

Section 3 – Outcomes of the service needs analysis

General Population Health

Summary

NSPHN's Needs Assessment highlights efforts required to improve access to health services for Aboriginal people in the region, with the latest quantitative data highlighting a low proportion of Aboriginal people receiving health checks. The analysis also identifies a lower proportion of bulk-billing GPs in the region, highlighting a potential financial barrier to accessing services for socio-economically disadvantaged groups; and a significant growth in local CALD population requiring aged care services, who also face specific barriers to accessing services.

NSPHN's previous Needs Assessments highlighted a lack of Aboriginal and CALD specific services in the region, with specific barriers to accessing services for people experiencing homelessness and LGBTI population. Analysis also found a lack of high care services for older people to keep people healthier at home. The following analysis incorporates latest available data where possible to compliment previous findings.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Service access		
Access – availability	Financial barrier to accessing primary health services due to low number of bulk-billing GPs.	**Quantitative evidence:** • Lower proportion of bulk-billed GP attendances in NSPHN region – 76.2% of GP attendances bulk-billed within the NSPHN region compared to 85.7% nationally (2016-17). The rate of bulk billed GP attendances in NSPHN has remained at the same level for the past three years. • North Sydney- Mosman SA3 has lower proportion of bulk-billed GP attendances (57.8%) compared to NSPHN and Australia[117]. Lower rates of bulk billing medical services and practitioners charging higher gap fees providing a financial barrier to access.

[117] Australian Institute of Health and Welfare (AIHW) 2016, *Healthy communities: Medicare Benefits statistics 2010-11 to 2015-16.*, AIHW, Canberra.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
GP workforce	Hotspots considered as a District of Workforce shortage within the region.	**Quantitative evidence:** • The rate of FTE GPs per 100,000 in NSPHN (104 per 100,000) is similar to NSW (106 per 100,000) and Australia (107 per 100,000)[118]. • Areas around Dural-Wisemans Ferry, Asquith, Bayview-Elanora Heights and Terry Hills-Duffys Forest considered as a District of Workforce shortage for general practice. District of Workforce Shortage are regions of need with lower level of access to Medicare subsidised services compared to the national average[119].

Health and Wellbeing	Need for continued engagement and collaboration with the community to deliver targeted interventions.	**Qualitative evidence:**
		• Consultation with local councils, community groups and service providers identified opportunities to collaborate and build partnerships on new and existing programs addressing:
		  ○ lifestyle risk factors across vulnerable population groups including culturally appropriate interventions for Aboriginal and CALD populations
		  ○ social isolation across the population to promote emotional wellbeing and build community capacity to mutually support one another
		• Consultation also highlighted a need for family-based interventions that facilitated participation from both parents and children to target physical and mental wellbeing.

After hours Access – availability	Increasing proportion of people accessing after hours services over the past four years.	**Quantitative evidence:** • The proportion of the total population accessing GP services after hours in the NSPHN region has increased from 21.9% in 2012-13 to 36.9% in 2016-17, higher than both NSW (24.3%) and Australia (25.4%). • Whilst there is a high availability of after-hours providers within the NSPHN (124 per 100,000) compared to NSW (101 per 100,000) and Australia (107 per 100,000); there are hotspots within the region with lower availability of after-hours providers concentrated in Dural-Wisemans Ferry SA3[120].

[118] Health Workforce Data tool

[119] Australian Government: Department of Health 2018, Doctor Connect: Districts of Workforce Shortage (DWS), Department of Health, viewed October 2018.

[120] Australian Government: Department of Health 2017, *MBS data by PHN- MBS Item and Reporting Group 2012-13 to 2016-17*, Department of Health, Canberra, viewed October 2018; ABS 2012-2018.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Vulnerable Groups		
Aboriginal and Torres Strait Islander people		
Aboriginal and Torres Strait Islander People Access – availability	Low proportion of the Aboriginal population receiving MBS 715 health check. Improving access and navigation of services for Aboriginal people continues to be an area of focus for NSPHN, with significant efforts occurring in the past three years to address this.	**Quantitative evidence:** • In 2016-17, GP usage rate for the Aboriginal population in the NSPHN region 3.3% compared to 27.1% for NSW and 32.6% nationally. • There has been an increase in the proportion of Indigenous people accessing GPs for their annual health checks from 1.2% in 2012-13 to 3.3% in 2016-17, peaking at 5% in 2015-16. However, the proportion is still lower compared to NSW and Australia. [121]
Aboriginal and Torres Strait Islander People Access - availability	Limited access to culturally appropriate services.	**Qualitative evidence:** Stakeholder consultation highlighted the need to develop a more culturally aware and appropriate primary care workforce to promote access, highlighting the lack of access to cultural competence training and availability of culturally-aware information for staff. Consultations also highlighted need within mental health and AOD services.
Aboriginal and Torres Strait Islander People Access - availability	Need for flexibility in how and where sessions are delivered.	**Qualitative evidence:** Lack of flexibility in provision of health services to Aboriginal population in NSPHN region. Lack of services open to a client's family and a need to provide outreach services within the Aboriginal community. Consultations also highlighted need within mental health and AOD services.
Aboriginal and Torres Strait Islander People Access – availability	Need for holistic focus within health care, current focus on illness rather than wellness.	**Qualitative evidence:** Stakeholder consultation highlighted the need for a holistic approach in primary care services, focusing on the social, emotional, and cultural well-being of the whole community rather than solely on illness. Consultations also highlighted need within mental health and AOD services.

[121] Australian Government: Department of Health 2017, *MBS data by PHN- MBS Item and Reporting Group 2012-13 to 2016-17*, Department of Health, Canberra, viewed October 2018.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Culturally and linguistically diverse (CALD)		
CALD Access - availability	Limited providers with local CALD language skills.	**Qualitative evidence:** Stakeholder consultation identified the need for better access to interpreters for CALD clients in the NSPHN region. Consultation highlighted health service providers with relevant ethnic background and language-speaking are limited, with a need for sustainable key bilingual GPs and psychologists in the region.
CALD Access - availability	Financial barriers to access.	**Qualitative evidence:** Stakeholder consultation highlighted potential financial barriers for CALD groups accessing primary health services due to visa status.
CALD Access – availability	Need for ongoing and culturally appropriate health promotion.	**Qualitative evidence:** Stakeholder consultation highlighted a need for ongoing and culturally appropriate health promotion for sexual health, nutrition and oral health, highlighting a need to focus on women and older CALD groups.
Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI)		
LGBTI	Need for collaboration across different domains of health promotion to ensure inclusivity of the LGBTI population.	**Qualitative evidence:** ACON (2013) highlights a number of service needs for the LGBTI population: • Training of the health workforce to ensure inclusivity • Early intervention • Broader health promotion strategies that include LGBTI people[122]

[122] Aids Council of NSW (ACON) 2013, *Submission to: NSW Mental Health Commission Towards a draft Strategic Plan for Mental Health in NSW- the Life Course and the Journeys*, ACON.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
LGBTI Access - availability	Diverse needs of the LGBTI population under-represented in aged care planning.	**Qualitative evidence:** The National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy[123], released by the Australian Government in December 2012, is designed to ensure the aged care sector can deliver the appropriate care and inform the way the Government responds to the needs of older LGBTI people by: • Recognising the rights and needs of older LGBTI people. • Empowering older LGBTI people to access high-quality services. • Encouraging LGBTI individuals and communities to be involved in the development of aged care services.
People experiencing homelessness		
Homelessness Access - availability	Need to increase availability of services focusing on early intervention to prevent people 'at risk' becoming homeless.	**Qualitative feedback:** Stakeholder consultation highlighted the need to increase the availability of early intervention services, including counselling and case management, to stop people 'at risk' becoming homeless.
Homelessness Access - availability	Need for a continuum of care and flexibility in how and where services are provided.	**Qualitative feedback:** Need for a continuum of care from crisis to affordable housing, keeping people independent and involved in the community when housed, with coordination between housing, police, youth justice, health and councils. Need for flexibility in how and where services are provided to build relationship with the client for longevity to prevent homelessness.

[123] Department of Health and Ageing (DOHA) 2012, National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, DOHA, Canberra.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Older People		
Older people Ageing population	Reflected by General Practice data (Pat Cat), an ageing population within the NSPHN region will see an increase in co-morbidities and dementia, increasing the need for aged care services.	**Quantitative evidence:** • Nationally, 8.8% of people aged 65+ years at risk of developing dementia.[124] • Ryde (75%), North Sydney (64.3%) and Lane Cove (63.5%) LGAs have higher rate of increase in the 65+ years population compared to NSPHN.
Older people Access to primary care	Low rate of health assessments among people aged 75 years and over within the NSPHN region.	**Quantitative evidence:** • General practice data from 137 practices within the NSPHN region highlights that 26.3% of people aged 75 years and over received a health assessment from their GPs in the past 12 months. Further analysis needed to assess regional variation. • Rate of health assessments from a GP includes claims for MBS items 701,703,705 or 707 in the previous 12 months among people aged 75 years and over.
Older people Access to primary care	GP attendance at residential aged care facility comparable to Australia.	**Quantitative evidence:** • The number of GP attendances per person in residential aged care facilities in the NSPHN region (15.7) was similar to Australia (16.6)[125]. Limited availability of data to assess regional variation.

[124] Australian Institute of Health and Welfare (AIHW) 2016, *Australia's Health 2016*, cat no. AUS 199, AIHW, Canberra.

[125] Australian Institute of Health Welfare (AIHW) 2018, *Medicare Benefits Schedule statistics Reporting period 2010-11 to 2016-17*, AIHW, Canberra.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Aged Care services Access – availability	Undersupply of Level 1 and 2 Home Care Packages with a large waiting list for people accessing Level 3 and 4 Home care packages. The process to accessing Home Care Packages has now been centralised nationally. The ageing NSPHN population will increase the demand for aged care services across the region. This will have significant strain and impact upon the aged care, primary care, and hospital sectors, with an increase in preventable hospitalisations, residential aged care admissions and carer stress.	**Quantitative evidence** • Previous needs assessment highlighted an undersupply of Level 3 and 4 Home Care packages within NSPHN compared to NSW. There has been an increase in the number of Level 3 and 4 Home Care Packages between 2015-16 resulting in a higher rate of these packages per 1,000 people aged 65+years within NSPHN (8.3 per 1,000) compared to NSW (6.5 per 1,000). However, despite the increase, according to the Home Care Packages Program Data Report (2017), NSPHN has the highest number of people awaiting allocation to a Level 3 and 4 Home Care Package (1,398) in Australia [126] potentially impacting older people with high or complex level care needs requiring immediate assistance. • Whilst there has been an increase in the number of Home Care Packages, the rate of Level 1 and 2 Home Care packages per 1,000 people aged 65+ years is lower in NSPHN (12.8 per 1,000) compared to NSW (14.6 per 1,000). Level 1 and 2 Home Care Packages are aimed at supporting people with low level care needs to avoid premature admissions into residential care.[127] • Further analysis required to ascertain the varying care and service needs of the older population and its subsequent impact on the demand and utilisation of Home Care packages and Commonwealth Home Support Services (aimed at providing care for people with lower level care needs).

[126] Australian Government: Department of Health 2017, *Home Care Packages Program Data Report 27 February-30 June 2017*, Department of Health, Canberra.

[127] Australian Institute of Health and Welfare (AIHW) 2017, *GEN data: services and places in aged care*, AIHW, Canberra, viewed October 2017.

Primary Mental Health Care (including Suicide Prevention)

Summary

NSPHN's Mental Health Needs Assessment includes emerging themes from extensive consultation with a range of stakeholders highlighting need for practical, flexible and integrated psychosocial support services in the region for cohorts experiencing severe mental illness, with specific needs among young people, people from CALD backgrounds and people experiencing homelessness. The Needs Assessment also includes findings from the SNPHN Integrated Mental Health Atlas which highlights limited availability of services for people with moderate to severe mental illness and lower proportion of mental health services provided by NGOs in the region.

NSPHN's previous Needs Assessments have highlighted barriers to accessing services, including lack of awareness of local health services and uncertainty on where to seek help, with additional barriers for young people, Aboriginal and Torres Strait Islander people and those from CALD backgrounds. Analysis has also highlighted specific service needs of LGBTI people, people with intellectual disability and women experiencing perinatal depression. The following Needs Assessment builds upon findings from previous needs assessments and incorporates latest qualitative and quantitative data, with a focus on psychosocial support for cohorts within the region.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Service access		
Access to mental health care	Lower MBS mental health treatment rate compared to NSW and Australia.	**Quantitative evidence:** • In 2016-17, 8.4% of the NSPHN population accessed an MBS funded provider (psychiatrist, GP, allied health) compared to 9.7% for NSW and 9.8% for Australia. • Between 2011-12 to 2016-17, NSPHN's mental health treatment rates increased by 2% compared to 2.5% and 2.8% for NSW and Australia respectively. [128] • Treatment rate dependent on prevalence of mental illness and accessibility and availability of mental health services, both public and private.

[128] Department of Health: Primary Health Networks (PHN) 2017, *MBS Mental Health Data by PHN*, Department of Health, Canberra, viewed November 2017

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Mental Health Hospitalisations	Higher rate of hospitalisations for mental disorders, with rates increasing in the past 10 years and a greater burden among females.	**Quantitative evidence:** • The rate of hospitalisations for mental disorders has increased within NSPHN from 1,714 per 100,000 (95% CI: 1,685-1,742) in 2006-07 to 2,190 per 100,000 (95% CI: 2,159-2,221) in 2016-17; higher compared to NSW (1,894 per 100,000; 95% CI: 1,885-1,904). • Rate of hospitalisations for mental disorders is influenced by prevalence of mental disorders, access to and availability of mental health services and coding standards for classification of mental disorders. Limited availability of local data to identify the underlying precursors for increasing rates of hospitalisations for mental disorders within NSPHN and assess regional variation. • Higher rate among NSPHN females (2,462 per 100,000; 95% CI: 2,417-2,508) compared to NSW females (2,034 per 100,000; 95% CI: 2,020-2,048)[129].
	Anxiety and stress disorders account for largest proportion of mental health overnight hospitalisations. Schizophrenia and delusional disorders account for largest number of bed days.	• Anxiety and stress disorders account for 16.9% of all mental health overnight hospitalisations in the NSPHN region. Warringah, North Sydney-Mosman and Chatswood-Lane Cove SA3s have the highest rate of hospitalisations for anxiety and stress disorders. • Schizophrenia and delusional disorders account for 28.4% of all bed days in the NSPHN region. [130]

[129] Centre for Epidemiology and Evidence 2017, Health Statistics New South Wales, Sydney: NSW Ministry of Health, viewed 1st September 2017.

[130] Australian Institute of Health and Welfare (AIHW) 2017, *Hospitalisations for mental health conditions and intentional self-harm Reporting years 2013-14,2014-15 and 2015-16,* AIHW, Canberra.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Integrated Mental Health Atlas: The Integrated Mental Health Atlas provides a standardised, internationally validated tool highlighting gaps in mental health service provision for evidence informed local health planning. The following data highlights key patterns in mental health care provision from the SNPHN Integrated Mental Health Atlas 2017.		
General Mental Health	Limited alternatives to hospitalisations	**Quantitative evidence:** • Lower proportion of services provided by NGOs (43%) compared to South Western Sydney LHD (54%), coupled with funding insecurity. ***Day care services*** • Lower rates of day care service provision within SNPHN with absence of acute day care services and relatively low levels of non-acute day care services. • Acute day care services can provide a less restrictive alternative to admission to an acute ward admission for people in crisis. ***Residential care services*** • Absence of acute and sub-acute community Residential Care ***Other services*** • Absence of services associated with both employment and CALD population • Absence of social acute Outpatient Care, and • Relatively low levels of supported accommodation initiatives. ***Further investigation needed to determine:*** • Patterns of care provision of residential rehab, non-acute outpatient care and specialised services for specific groups. • Impact of the private sector on the availability and accessibility of mental health services.
Older people	Limited day services for older adults	• Limited availability of day care services for older adults in the SNPHN catchment. • Residential services for older adults provided only in a hospital setting. • Limited Accessibility or Information and Guidance services for older adults identified within the SNPHN region
Children and Young people	Limited availability of support services	Limited Accessibility or Information and Guidance services for children or adolescents identified within the SNPHN region which could potentially create barriers for vulnerable cohorts in navigating pathways to accessing services.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Psychosocial support needs of people with severe mental illness		
Access to services	Limited availability of services for those with chronic and moderate to severe mental illness.	**Qualitative evidence:** The type of services provided in NSPHN may cover the needs of the two extremes of the lived experience of mental illness - those with mental health problems needing low-level support and those in severe crisis requiring acute care in a hospital setting. However, there is a need for more community-based alternatives for people with chronic and moderate to severe mental illness[131]. Existing programs and services providing support to people in the region experiencing psychosocial disability include: • Housing and Accommodation Support Initiative (HASI) • Community Living Supports (CLS) • Pathways to Community Living Initiative (PCLI) • Personal Helpers and Mentors (PHaMs) • Day to Day Living Supports (D2DL) • Partners in Recovery (PIR) The NSW Health funded programs HASI, CLS and PCLI are intended for people with severe mental illness who are also consumers of the Local Health District Community Mental Health Teams or hospital services. The Commonwealth-funded programs PHaMs, D2DL and PIR are all transitioning into NDIS in 2019. Demand for all the services listed above outstrips supply, with many services operating long waiting lists.

[131] The SNPHN Integrated Mental Health Atlas 2017

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence

National Disability Insurance Scheme (NDIS)	Transition of care for consumers with severe and complex needs under NDIS.	**Qualitative evidence:**
		• Stakeholder consultation highlighted the likelihood of the NDIS application process acting as a barrier to accessing psychosocial support services for persons with a mental illness. Additional concerns were raised regarding the instability of funding streams for NGO mental health services and the impact that this and the casualisation of the workforce would have on the provision of quality care to consumers.[132]
		• Stakeholder consultation has highlighted barriers to accessing NDIS services for specific cohorts experiencing severe mental illness and corresponding psychosocial disability, including:
		  ○ younger people;
		  ○ people experiencing homelessness;
		  ○ people with co-morbid mental health and substance misuse issues;
		  ○ people from CALD backgrounds;
		  ○ people with a primary diagnosis of depression or anxiety and;
		  ○ people with a personality disorder disability.

[132] The SNPHN Integrated Mental Health Atlas 2017

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Psychosocial support services- Stakeholder consultation	Stakeholder engagement highlighted the need for: • Access to flexible, integrated services • Practical interventions catering to the needs of people with mental illness, carers and family members • Targeting vulnerable and hard to reach groups including young people, people from CALD backgrounds and people experiencing homelessness	**Qualitative evidence:** Thematic analysis from consultations with: • Carers • Consumers / people with lived experience • Case managers • General Practitioners • Mental Health Nurses • Allied Health professionals • Peer Support Workers • NGOs • Northern Sydney Local Health District • NSPHN Community Council • NSPHN Mental Health and AOD Advisory Committee
Psychosocial support Access- availability	Need for holistic care to foster wellbeing among persons with mental illness, carers and family.	**Qualitative evidence:** • Interventions targeting physical health needs[133], building social relationships, employment opportunities and support for accessing secure housing are key to improve the quality of life for people with severe mental illness, carers and families[134]. • Stakeholder consultation highlighted limited availability of support services for carers/family who are central to the recovery process.
Psychosocial support Access- flexibility	Need for flexible services	**Qualitative evidence:** • Stakeholder consultation highlighted the need for outreach and centre based services that are conducive to the target population. • Consultation also highlighted the need for after hours services, particularly for groups that are difficult to engage.

[133] Lawrence D, Kisley S 2010, *Inequalities in healthcare provision for people with severe mental illness*, Journal of Psychopharmacology, vol 24, issue 11, pp. 61-68.

[134] Department of Health 2017, *The Fifth National Mental Health and Suicide Prevention Plan*, Department of Health, Canberra.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence

Psychosocial support
 	
Service Integration
	Need for service integration	**Qualitative evidence:**
		• Stakeholder consultation highlighted the need to increase awareness of referral pathways to help navigate access to different services, particularly among vulnerable population groups such as CALD, young people and people experiencing homelessness. Psychosocial service needs specific to these vulnerable groups have been discussed further on pages 65-69.
		• Consultation also highlighted the need for:
		  ○ integrating clinical and non-clinical services within the stepped care continuum to prevent silos, and
		  ○ linking with pre-existing services providing psychosocial support to avoid service duplication.

Psychosocial support Workforce	Limited workforce capacity	**Qualitative evidence:** • Stakeholder consultation highlighted limited availability of workers (e.g. peer support workers) and service providers in providing wrap around holistic services to support the psychosocial needs of people with severe mental illness. • Stakeholder consultation also highlighted the need to leverage support from the community via adequate training to facilitate a community driven response. • Stakeholder consultations raised concerns about under skilled or insufficiently trained workers providing support services to people experiencing psychosocial disability.
Psychosocial support Community Response	Need for community driven response to support psychosocial needs of people with severe mental illness	**Qualitative evidence:** Stakeholder consultation highlighted the need for interventions that are led by people with lived experience and are focussed on engagement with the target population to plan and deliver services.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
People with severe mental illness and complex needs Access – availability	Financial barrier due to lack of bulk-billing private psychiatrists.	**Qualitative evidence:** Stakeholder consultation highlighted that whilst Northern Sydney has a relatively high supply of psychiatrists, many of them do not bulk bill and charge higher than average gap payments. People with severe mental illness and complex needs who are not clients of public mental health services have difficulty accessing affordable and appropriate psychiatric support.
People with severe mental illness and complex needs Access – availability	Limited early intervention treatments.	**Qualitative evidence:** Stakeholder consultation highlighted limited early intervention treatments for patients with severe mental illness and limited alternatives to hospitals. Stakeholders highlighted the management of suicide in public hospital can be very traumatising, leading to marked deterioration in a patient's mental illness.
Vulnerable Groups		
Children and Young people		
Access to mental health care for children and young people	Low rate of subsidised mental health treatment in those aged 12-24 years relative to need. Higher service usage in males under 12 years compared to females, but lower for males aged 12-24 years.	**Quantitative evidence:** • Approximately 7.3% of the NSPHN population aged under 25 years accessed MBS subsidised mental health services in 2016-17 compared to 7.9% and 8.1% for NSW and Australia respectively.[135] • Between 2011-12 to 2016-17, the proportion of people aged under 25 years accessing MBS subsidised mental health issues has increased by 2.5% in NSPHN compared to 2.7% and 3% for NSW and Australia respectively. • The ratio of males to females aged under 12 years accessing the services was 1.5:1 compared to 0.7:1 for those aged 12-24 years. [136] • Treatment rate dependent on prevalence of mental illness and accessibility and availability of mental health services, both public and private.

[135] Department of Health: Primary Health Networks (PHN) 2017, *MBS Mental Health Data by PHN*, Department of Health, Canberra, viewed November 2017--

[136] Department of Health: Primary Health Networks (PHN) 2017, *MBS Mental Health Data by PHN*, Department of Health, Canberra, viewed November 2017

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Mental health related hospitalisations in children and young people	Eating and obsessive-compulsive disorders account for the largest proportion of bed days in those aged 0-17 years in the NSPHN region.	**Quantitative evidence:** • Between 2013-14, those aged 0-17 years represented 12.7% (525) of mental health related separations in the NSPHN region. • Eating and obsessive-compulsive disorders account for 38.6% of total bed days (2,845), whilst accounting for only 18.9% of mental health related separations among those aged 0-17 years. • Majority of separations (72.7%) occurred in public hospitals.[137]

Service usage	Barriers to accessing services	**Quantitative evidence:**
		• The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing highlighted some common barriers among parents or carers of children with mental illness to accessing mental health services:
		  ○ Affordability- 37% of the respondents identified affordability of the service as a barrier preventing them from accessing mental health services. This was a more common issue among parents/carers of children aged 4-11 years compared to parents/carers of those aged 12-17 years, highlighting a need for pathways that facilitate access to services for families who are socio-economically disadvantaged.
		  ○ Uncertainty around 'where to seek help': 39.6% of parent/carers highlighted that they were unsure about where to seek help. [138]

[137] NSLHD Health Services Planning Unit 2016, Hospital Admissions Data 2013-14

[138] Lawrence D et al 2015, The Mental Health of Children and Adolescents- Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Youth Mental Health services review – focus of Needs Assessment 2017-18	**Key themes identified during extensive consultation:** • Disparity in primary health care-based youth mental health service provision and access across the region • New Models of Care for a whole of youth mental health system that is integrated should be considered • Awareness of mental health illness and ability to navigate the health system – in young people, consumers, parents, schools, clinicians, and the wider community is a significant need.	**Qualitative evidence:** Thematic analysis from consultations with: • Young people, including headspace Youth Advisory groups • Parents • Schools • NSW Department of Health • General Practice • Northern Sydney Local Health District • Family and Community Services • Headspace National Office • Orygen – Centre for Youth Mental Health Excellence • NSPHN Clinical and Community Councils and Mental Health and AOD Advisory Committee
Young people Psychosocial support	Need for psychosocial support to address gaps in service provision through NDIS	**Quantitative evidence:** For majority of children with a mental disorder, the disorder impacted their functioning in different domains of life including school/work, friend/social activities and family emphasising the need for support beyond clinical services[139]. **Qualitative evidence:** Stakeholder consultation have highlighted barriers for younger people in accessing NDIS services associated with challenges in qualifying the NDIS eligibility criteria, reiterating the need for targeted service delivery to address the gaps.

[139] Lawrence D et al 2015, The Mental Health of Children and Adolescents- Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Children and young people Access and awareness	Lack of awareness of local health services	**Qualitative evidence:** Stakeholder consultation identified young people are often unwilling to share concerns with parents/carers which is compounded by a lack of awareness of local mental health services. These barriers are further exacerbated within CALD and socio-economically disadvantaged groups. Consultation highlighted a need for technology based & cyber-safe access pathways that raise awareness of health services that are available and empower young people to seek help appropriately.
Children and young people Access and awareness	Additional barriers to access for young people and their families from CALD backgrounds.	**Qualitative evidence:** Stakeholder consultation identified the need for peer or community led services that allow young people and families in need to access culturally appropriate services that best cater their needs.
Children and young people Community response	Need for a community driven response to improve health literacy, raise awareness about mental health and cater to psychosocial needs of young people with mental illness.	**Qualitative evidence:** • Stakeholder consultation identified the need for educating and empowering parents, GPs, schools, councils, businesses, sports and recreational clubs to identify early signs of mental illness to facilitate early intervention. • Consultation also highlighted leveraging support from these networks for delivering flexible and practical interventions that actively engages young people to adequately address psychosocial needs of the cohort.
Children and young people Self-awareness	Need for educating and empowering to identify early signs of mental illness	**Qualitative evidence:** Stakeholder consultation identified that often mental illness is diagnosed at later stages resulting in acute psychosis requiring mitigation through pharmaceutical therapy. Consultation identified the need for increasing awareness among young people to allow them to identify early signs/symptoms of mental illness.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Children and young people Prevention and early intervention	Need to facilitate early intervention.	**Qualitative evidence:** Stakeholder consultation highlighted that mental health education in its current form commences in high school. Consultation identified the need for commencing mental health education in concluding years of primary school to provide an opportunity for early intervention and primary prevention.
Children and young people Access - availability	Limited availability of services for children aged under 12 years.	**Qualitative evidence:** Stakeholder consultation identified limited availability of services for children aged under 12 years in comparison to those aged 12+ years. Consultation highlighted less recognition of early indicators in those aged under 12 years, with limited availability of mental health services for children with mild to moderate mental health issues.
Children and young people Access	Complex health system a barrier to families accessing mental health services.	**Qualitative evidence:** Stakeholder consultation identified navigating a complex health system as a barrier to families, children and young people accessing services; highlighting services predominantly utilised by proactive and health literate families.
Children and young people Access - availability	Lack of services for young people with moderate to severe mental health issues.	**Qualitative evidence:** Stakeholder consultation identified a service gap for young people whose mental health issues are too severe or complex for Headspace, but level of acuity ineligible for the LHD Child and Youth Mental Health Services (CYMHS). NSPHN has commissioned services to meet this gap through youth severe funding, however, this remains an ongoing need.
Children and young people Access - availability	Limited group programs for families.	**Qualitative evidence:** Stakeholder consultation identified a lack of group programs available in the region for families, highlighting the limited availability of family intervention treatments, including integrated child and parent interventions.
Children and young people Access - availability	Lack of outreach services for young people.	**Qualitative evidence:** Stakeholder consultation identified the need to provide outreach or in-place, rather than centre-based support to young people. Young people may not engage in a clinical environment, requiring a safe and neutral environment. Consultation highlighted services need to be flexible in where services are delivered.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Children and young people Access - availability	Financial barrier to access.	**Qualitative evidence:** Stakeholder consultation highlighted financial barriers for socio-economically disadvantaged families and children in the region. Lower rates of bulk billing medical services and practitioners charging higher gap fees providing a financial barrier to access.
Aboriginal and Torres Strait Islander People		
Aboriginal and Torres Strait Islander People Access-availability	Limited access to culturally appropriate services.	**Qualitative evidence:** Stakeholder consultation conducted by Relationships Australia NSW and the Gaimaragal Group identified the need for a culturally competent, trauma informed workforce with 'cultural' accreditation, recognising champions in providing care for people from Aboriginal and Torres Strait Islander backgrounds[140].
Aboriginal and Torres Strait Islander people Access	Need to enhance integrated care.	**Qualitative evidence:** There is a need for holistic integrated approaches to care that are driven by focus on early intervention to better capacitate young Indigenous people and professionals for crisis management. [141]
Aboriginal and Torres Strait Islander people Access- awareness & Early intervention	Lack of awareness of health services available.	**Qualitative evidence:** Consultations have highlighted that lack of awareness of available health services within the region creates structural barriers for people trying to access health services especially among Indigenous youth who have moved into the region from other parts of the state and country. There is a need for an integrated platform that facilitates dialogue between Indigenous youth and allows seamless transition of care between health services, breaking down silos existing between services[142].

[140] Relationships Australia NSW and The Gaimaragal Group Pty Ltd 2017, *Indigenous Wellbeing in Northern Sydney Roundtable Report*, Relationships Australia (NSW) Limited, NSW.
[141] Relationships Australia NSW and The Gaimaragal Group Pty Ltd 2017, *Indigenous Wellbeing in Northern Sydney Roundtable Report*, Relationships Australia (NSW) Limited, NSW.
[142] Relationships Australia NSW and The Gaimaragal Group Pty Ltd 2017, *Indigenous Wellbeing in Northern Sydney Roundtable Report*, Relationships Australia (NSW) Limited, NSW.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Culturally and linguistically diverse (CALD)		
CALD Psychosocial support	Need for culturally appropriate psychosocial support services.	**Qualitative evidence:** Stakeholder consultation highlighted the need to address stigma related to mental illness to facilitate holistic, culturally appropriate services that adequately addresses the psychosocial needs of people experiencing mental illness.
CALD Access - availability	Provision of culturally appropriate services.	**Qualitative evidence:** Stakeholder consultation highlighted that understanding of complexities related to cultural background is not always addressed by service providers. Barriers relating to utilisation of psychological services for CALD population around stigma, including between generations within cultures.
Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) population		
LGBTI Access - availability	Service gap for LGBTI population.	**Qualitative evidence:** Stakeholder consultation highlighted a gap in service provision for LGBTI population with mental health issues, with a lack of culturally appropriate services, specific to the community.
People experiencing homelessness		
Psychosocial support for people experiencing homelessness	Need for support in accessing secure housing	**Qualitative evidence:** Stakeholder consultation have highlighted barriers to accessing NDIS services for people experiencing homelessness. Adequate support provided to accessing secure housing can prevent repeated episodes of homelessness that might be common among people with mental illness[143]; facilitating pathway to recovery.

[143] AIHW 2018, Specialist homelessness services annual report 2016-17, AIHW, Canberra.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Older People		
Health of Older People Access – availability	Low uptake of mental health services in those aged 65+ years.	**Quantitative evidence:** • In 2016-17, approximately 5.6% of people aged 65+ years in NSPHN accessed MBS subsidised mental health services compared to 6.1% and 5.9% for NSW and Australia respectively. [144] • Between 2011-12 to 2016-17, the proportion of people aged 65+ years accessing MBS subsidised mental health services in NSPHN has increased by 1.4% in NSPHN compared to 1.7% for NSW and Australia. • Treatment rate dependent on prevalence of mental illness and accessibility of mental health services, both public and private.
Mental health related hospitalisations in Older People	Mood disorders account for largest proportion of mental health related hospitalisations in those aged 65+ years.	**Quantitative evidence:** Major affective disorders account for 36.6% of separations and 41.8% of total bed days among people aged 65+ years.[145]
Health of Older People Access - availability	Barriers to access.	**Qualitative evidence:** Stakeholder consultation identified challenges to those aged 65+ years accessing mental health services when living in a residential aged care facility and those aged 65+ years with comorbidities. Barriers to access intensified for those who lack support from families.
Health of Older People Integration/Early intervention	Need for holistic services that address the concurrent physical and mental health needs of older people.	**Qualitative evidence:** Overprescribing of psychotropic medications[146] compounded with social isolation and biological factors associated with ageing[147] presents challenges in addressing co-morbid physical and mental health conditions. This highlights a need for integrated services that address both physical and mental health needs of older people to facilitate early intervention. [148]

[144] Department of Health: Primary Health Networks (PHN) 2017, *MBS Mental Health Data by PHN*, Department of Health, Canberra, viewed November 2017

[145] NSLHD Health Services Planning Unit 2016, Hospital Admissions Data 2013-14

[146] Mental Health Commission of NSW 2017, *Living Well in Later Life: The Case for Change*, Mental Health Commission of NSW, Sydney.

[147] AIHW 2017, *Australia's Health and Welfare 2017*, Australia's welfare series no. 13, AUS 216, AIHW, Canberra.

[148] Department of Health 2017, *The Fifth National Mental Health and Suicide Prevention Plan*, Department of Health, Canberra.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Other vulnerable groups		
People with Intellectual Disability Access – availability	Limited services available for people with intellectual disability. [149].	**Qualitative evidence:** Stakeholder consultation highlighted the limited options available for clients with intellectual disability and a lack of awareness from GPs around suitable services.
People with Intellectual Disability Access – availability	Limited skills and workforce capability in diagnosing mood or psychiatric disorders often delays treatment.	**Qualitative evidence:** Families, disability professionals often struggle to identify signs of mood disorders and there are limited number of psychiatrists specialising in treatment of mental health issues in people affected by intellectual disability. This often leaves diagnosis at the hands of GPs who often find it difficult to make differential diagnosis.[150]
Women experiencing perinatal depression Access – availability	Low uptake of psychological services.	**Qualitative evidence:** Stigma associated with diagnosis acts a barrier to accessing support services, exacerbated in women from Aboriginal and CALD backgrounds. Women often self-diagnose and classify symptoms of distress as 'normal part of motherhood' restricting them from accessing services[151]. Majority of women seek assistance from GPs for perinatal depression. However, limitations in dealing with mental conditions often creates a barrier for both women and health professionals[152].
Women experiencing perinatal depression Access - availability	Financial barriers to access.	**Qualitative evidence:** Stakeholder consultation highlighted the importance of engaging mothers with perinatal depression at the antenatal stage (if required) as clients will present postnatal at higher acuity. However, financial barrier as not all antenatal care is subsidised, with patients unable to determine what services are available privately and publicly.

[149] ABS 2014, *Intellectual Disability, Australia, 2012*, ABS cat no. 4433.0.55.003

[150] Simpson J 2012, *Healthier Lives- Fact sheets on health and people with intellectual disability for families, advocates, disability workers and other professionals*, NSW Council for Intellectual Disability.

[151] Austin MP, Highet N, the Guidelines Expert Advisory Committee 2011, *Clinical practice guidelines for depression and related disorders- anxiety, bipolar disorder and puerperal psychosis-in the perinatal period. A guideline for primary care health professionals*, beyondblue, Melbourne.

[152] Australian Institute of Health and Welfare (AIHW) 2012, *Experience of perinatal depression: data form the 2010 Australian National Infant Feeding Survey*, cat no. PHE 161, AIHW, Canberra.

Alcohol and Other Drug Treatment Needs

Summary

NSPHN's Alcohol and Other Drug (AOD) Needs Assessment highlights geographic variation in drug and alcohol related hospitalisations within the region and builds upon findings from previous Needs Assessments, highlighting gaps in service provision in relation to residential rehabilitation beds and day/outpatient programs within the region.

Previous Needs Assessments highlighted need for early identification, screening and support to accessing services which remains pertinent. Consultations also highlighted undersupply of detox beds relative to need, no Aboriginal-specific drug and alcohol services and Residential Aged Care Facilities poorly equipped to meet the needs of older people. The following update for alcohol and other drugs utilises the latest qualitative and quantitative data where possible to compliment findings from previous Needs Assessments.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Service access		
AOD combined morbidity	Drug and alcohol related hospitalisations.	**Quantitative evidence:** • Rates of hospitalisations in NSPHN: 18 per 10,000 compared to 20 per 100,000 nationally (62.9% in public hospitals). The rate has remained at the same level for the past three years. • Within NSPHN, Warringah SA3 had the highest rate of mental health related overnight hospitalisations for drug and alcohol use (26 per 10,000), higher than both NSPHN and national rates. • Drug and alcohol hospitalisations accounted for 20.5% of all mental health related overnight hospitalisations in NSPHN. • Rate of bed-days for NSPHN: 180 per 10,000 compared to 145 per 10,000 nationally. Majority of the bed-days in private hospitals (62.7%).[153]

[153] Australian Institute of Health and Welfare (AIHW) 2017, *Hospitalisations for mental health conditions and intentional self-harm Reporting years 2013-14,2014-15 and 2015-16,* AIHW, Canberra.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Alcohol	Alcohol a leading contributor to self-harm and overdose related ambulance attendances in NSW.	**Quantitative evidence:** • Alcohol intoxication (NSW) involved in[154]: ○ 18% of suicide attempts cases ○ 28% of accidental overdose cases ○ 20% of suicide attempts involving overdose
Access	Lack of bulk billing GPs provides financial barriers to accessing AOD services	**Qualitative evidence:** Stakeholder consultations identified a financial barrier to AOD clients accessing AOD services due to the lack of bulk billing GPs. Majority of AOD services supplied through private healthcare. People in this cohort who are not clients of public AOD services have difficulty accessing affordable and appropriate support.
Access	Limited recognition of appropriate screening and referral pathways amongst primary health care providers.	**Qualitative evidence:** Stakeholder consultation identified confusion for clients around AOD services available and access pathways. Complex health care system, navigation challenging for clients and service providers.
Access	Limited early intervention programs for AOD.	**Qualitative evidence:** Limited early intervention programs for AOD, service gap around female clients presenting at the emergency department.
Access – availability	Lack of day/out-patient programs.	**Qualitative evidence:** Stakeholder consultations identified a need for bulk-billing day/out-patient programs in the region. Northern Sydney Local Health District has recently established outpatient clinics. There is a small day program provided for adults in the community as an interim measure until community residential rehabilitation services are re-established.

[154] Lloyd B, Gao C X, Heilbronn C, Lubman DI 2015, *Self-harm and mental-health related ambulance attendances in Australia: 2013 Data*, Turning Point, Victoria.

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Access – availability	Undersupply of residential rehabilitation beds.	**Qualitative evidence:** Stakeholder consultation identified the demand for residential rehabilitation beds placement outstrips supply and people seeking residential rehabilitation either face long wait times or travel out of area to access support. This acts as a barrier to people obtaining support for AOD misuse disorders. The sole provider of community based residential rehabilitation in the NSPHN region has lost its premises with the closure of Manly hospital. The 10-bed residential facility is not expected to be re-established until sometime in 2019.
Access – availability	Services have limited capacity to provide AOD support outside of business hours.	**Qualitative evidence:** Stakeholder consultation identified most non-residential AOD services in the region only provide service during business hours. This makes access to specialist support difficult for people who attend work or education and for the families of people receiving AOD treatment.
Access – availability Service coordination	Poor coordination between detox and availability of residential rehabilitation.	**Qualitative evidence:** Stakeholder consultation identified people seeking to access residential rehabilitation are often required to go through detox first. This creates delays in accessing treatment and can serve to diminish peoples' willingness to pursue rehabilitation.
Access – availability Service coordination	Lack of services skilled in addressing co-occurring AOD and mental health issues.	**Qualitative evidence:** Stakeholder consultation identified clients with complex presentations (esp. with trauma) and multiple needs can experience barriers to service/insufficient service. Whilst the AOD services in the region receiving state funding are required to service people with co-occurring AOD and mental health issues, stakeholder reports highlighted the need for the wider service sector to respond better to people with co-morbid conditions. Many services address one issue to the exclusion of the other.
Integration	Limited coordination and integration between services.	**Qualitative evidence:** Stakeholder consultation highlighted the need for coordination and integration between services as silos currently exist between services, with a need for collaboration across multiple services.

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