



Australian Government

Department of Health



An Australian Government Initiative

Primary Health Network

Needs Assessment Reporting Template

Name of Primary Health Network

Western Sydney

Section 1 – Narrative

NEEDS ASSESSMENT PROCESS AND ISSUES

Introduction

WentWest as the Western Sydney PHN (WSPHN) undertook the 2017 Mental Health and Suicide Prevention Needs Assessment (hereafter referred to as The Needs Assessment) and engaged The Science of Knowing Pty Ltd¹ to assist with this process. Bill Campos, Head of Mental Health Services, and Mental Health Program Managers at WSPHN worked collaboratively with The Science of Knowing to complete the Needs Assessment. The Needs Assessment involved the collation and review of new and existing data, a health and service needs analysis, and an assessment process to identify key priority areas for action.

Methodology

Conceptual frameworks

This needs assessment was guided by two conceptual frameworks: a Stepped Care Model, which recognises the varying levels of need required by individuals and the corresponding level of intervention/support/services required; and the Ecological model of health, which recognises that individuals live within systems and that no single factor can explain or predict the health and wellbeing of individuals. These frameworks ensured that data collation, collection and analysis would identify mental health needs across the life span, for specific target groups, in particular areas (e.g. geographic hotspots), and for varying levels of acuity (e.g. mild to severe mental illness). The development of possible options (Section 4) in this Needs Assessment was informed by WSPHN's existing Activity Work Plan and Commissioning Framework. WSPHN is also currently engaged in the development/establishment of two key planning frameworks: The National Mental Health Service Planning Framework; and The Suicide Prevention Modelling Tool. The Suicide Prevention Modelling Tool is being developed by WSPHN in partnership with Western Sydney University and the Sax Institute. The tool will provide an understanding of the collective impact of a number of services and interactions, based on the type of services, to identify the most appropriate strategies in reducing suicide in the western Sydney region.

Data sources

The availability of data on mental health and suicide prevention has increased significantly since the initial needs assessment in 2016. This has allowed WSPHN to incorporate additional data sources, and more relevant and meaningful data (e.g. some data now available at SA3 and PHN levels). Both quantitative and qualitative data has been included to provide a deeper understanding of the region's mental health needs.

¹ The Science of Knowing Pty Ltd is a strategic research and evaluation consultancy, specialising in social research, and has personnel with expertise in a range of areas including mental health, suicide bereavement, health promotion, and psychology.

Data for this needs assessment was collected from a range of sources, including: Australian Bureau of Statistics (ABS), Public Health Information Development Unit (PHIDU), Australian Institute of Health and Welfare (AIHW), Medicare and Pharmaceutical Benefits Scheme statistics, NSW HealthStats website, and the Australian Atlas of Healthcare Variation. Where possible, data at the smallest granular level has been provided (i.e. SA3, PHN level). In instances where this data was unavailable, state or national level data is provided.

Findings from WSPHN stakeholder surveys, evaluations and consultations were incorporated into this report, including a Health Literacy Responsiveness Survey of regional mental health providers, a Primary Mental Health Care Provider Questionnaire, a General Practitioner Needs Survey, and a survey of Partners in Recovery (PIR) consortium members. Relevant data from the administration of the Health Literacy Questionnaire (HLQ)² to consumers across the western Sydney region and qualitative information from interviews with PIR patients have also been included. Particular attention was paid to ensuring that hard to reach populations (e.g. alcohol and other drug (AOD) users, refugees, people with low English proficiency) were provided an opportunity and supported to participate in consumer consultations.

Assessment – Synthesis and triangulation

A triangulation process was applied simultaneously to data collection and analysis to ensure that issues were consistent across multiple data sources, and that issues identified as priority areas were accurate and feasible. This process included cross-checking data across multiple sources, the application of eight prioritisation criteria, and an internal review process.

Prioritisation criteria and review

After data was collected and analysed, a list of emerging priority areas was created. A prioritisation process was applied to identify a shortlist of priority areas for WSPHN. This process included the application of eight criteria which were based on current literature and evidence. These criteria were:

1. **Scale of the issue** (a. Number of people affected; b. Prevalence of the issue; c. Incidence of the issue; d. Trends/changes over time)
2. **Benchmarking** against national/state data and other similar regions
3. **Impact of the issue** (a. Consequences of the issue; b. Consequences of inaction)
4. **Degree of health inequities**
5. **Linkages with known determinants of health**
6. **Alignment with priorities, targets and opinion** (a. Government; b. Community; c. Stakeholders; d. WSPHN mandate, strategic plan and current commissioning activities)
7. **Unmet need**
8. **Feasibility** (a. Resource feasibility; b. Impact feasibility; c. Evidence-base feasibility).

A review process was undertaken with key staff from WSPHN as well as members of the mental health commissioning advisory group (key regional stakeholders which meets every 2

² The Health Literacy Questionnaire is a validated survey instrument developed by Deakin University. It measures the health literacy strengths and weaknesses of communities and population groups.

months) to 'sense check' the identified priority areas, and to ensure that no key areas were missing. Endorsement of the priority areas was sought from WSPHN Mental Health Program Managers; Head of Mental Health Services; Director, Integrated Care and Commissioning; CEO, Walter Kmet.

Priority areas

In addition to the eight priority areas stipulated in the WSPHN schedule – Mental Health, with the Department of Health, further research and consultation with stakeholders and the community has identified thirteen specific priority areas for Western Sydney. They are categorised as follows:

Priority target groups

1. Maternal and perinatal mental health
2. Children and young people
3. Dementia and aged care
4. Aboriginal and Torres Strait Islander peoples
5. Culturally and linguistically diverse (CALD) community (refugees and migrants)
6. People who identify as lesbian, gay, bisexual, transgender, intersex, or queer (LGBTIQ)
7. People experiencing homelessness
8. People experiencing mild to moderate mental illness
9. People experiencing comorbidities (i.e. mental illness and other health conditions)
10. People experiencing severe and complex mental illness

Sectoral/system level priorities

11. Suicide prevention
12. Variations in care -Stepped Care principles.
13. Organisational health literacy responsiveness.

Future consultation activities

WSPHN are currently undertaking a region wide consumer consultation process, which will enable specific feedback on the health and wellbeing needs of consumers to be captured, including their healthcare stories and pathways, their challenges in accessing healthcare, and potential strategies for improving these experiences. This consultation commenced with the distribution of the HLQ, and will also include face-to-face, online and phone interviews with people experiencing mental illness. Interviews are scheduled to commence in mid-November 2017. The consultation activities are also aiming to capture experiences from the LGBTIQ, culturally and linguistically diverse, and Aboriginal and Torres Strait Islander communities. Both consumers and carers are being encouraged to participate in these consultation activities.

ADDITIONAL DATA NEEDS AND GAPS

WSPHN has identified that a comprehensive workforce needs analysis is required to better understand the current and future mental health workforce needs in the region, including supply, distribution, types of services being delivered, characteristics (e.g. full time/part time,

qualifications, etc.), and levels of integration and coordination with other professionals. This data gap will be partially filled by information provided through the National Mental Health Service Planning Framework, which is due to be implemented in the region in late 2017/early 2018.

ADDITIONAL COMMENTS OR FEEDBACK

During the consultation process it was identified that consumer feedback is an important element of assisting providers to refine their service delivery as well as evaluate the impact of the commissioned activities. WSPHN will begin the process of implementing a consistent and structured feedback process for consumers via the utilisation of the YES survey (Your experience of Service), which is also utilised by the NSW Ministry of Health and many other health districts in Australia.

SECTION 2 – OUTCOMES OF THE HEALTH NEEDS ANALYSIS

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Health literacy	<p>Preliminary data analysis of an ongoing region-wide Health Literacy Questionnaire indicates that survey respondents who reported having a chronic mental health condition have a poor ability to navigate the healthcare system, (i.e. they are unable to advocate on their own behalf, or find someone to help them address their health needs, and have limited understanding of what is available and their entitlements) and low social support for health (i.e. no social network, or relationships lack emotional and/or tangible support).</p> <p>This group, based on preliminary data, are predominantly Australian-born, with a relatively even distribution of males and females. They are more likely to have low education attainment (i.e. less than year 12), be unemployed and looking for work, and have low income. These respondents also included a higher proportion of people who identify as LGBTIQ, and Aboriginal and Torres Strait Islander people than the wider sample of respondents.</p> <p>Preliminary data also shows a high level of co-morbidity amongst people experiencing a chronic mental illness, with respondents reporting an average of 2.2 health conditions (in addition to their mental health condition). The most common conditions included arthritis, asthma or a lung condition, chronic back pain, and alcohol or</p>	<p>The Science of Knowing. 2017. <i>Preliminary Results from the Health Literacy Questionnaire: Western Sydney Mental Health Consumers</i>, report prepared for WSPHN. October 2017.</p> <p>Dodson, S, Beauchamp, A, Batterham, RW, and Osborne, RH. 2017. <i>Ophelia Toolkit: A step-by-step guide for identifying and responding to health literacy needs within local communities</i>.</p> <p>The Science of Knowing. 2017. <i>Preliminary Results from the Health Literacy Questionnaire: Western Sydney Mental Health Consumers</i>, report prepared for WSPHN. October 2017.</p> <p>The Science of Knowing. 2017. <i>Preliminary Results from the Health Literacy Questionnaire: Western Sydney Mental Health Consumers</i>, report prepared for WSPHN. October 2017.</p>

Outcomes of the health needs analysis		
	<p>drug addiction. These findings were supported by previous regional research, which found that people with mental health conditions also experienced chronic conditions such as 'arthritis, osteoporosis, cardiovascular conditions, cancer, diabetes and other conditions'. In addition, this research found that only 67% of the sample who reported having a mental illness rate their health positively, compared to 82% of the total sample.</p>	<p>Brooke, M, 2016. <i>Consumers and after hours health care in Western Sydney: Summary of Research Insights</i>. Report prepared for WSPHN. March 2016.</p>
Maternal mental health	<p>Worldwide about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression.</p> <p>In 2015, there were 14,640 births in the region. As such, based on available statistics, there are potentially approximately 1,900 women experiencing a postnatal mental health issue in the western Sydney region. Data is unavailable on the number of pregnant mothers in the region, so this estimation does not account for mental health issues in pregnancy.</p> <p>Blacktown had the highest number of births in the region (at 5,590), and the largest number of mothers under the age of 19 (70% of all mothers under 19 years across the region).</p> <p>Rates of domestic assaults in the western Sydney region are higher than NSW rates for the period 2015-16 (414.89 per 100,000 and 385.38 per 100,000 respectively).</p>	<p>World Health Organisation. 2017. <i>Maternal Mental Health</i>. [ONLINE] Available at: http://www.who.int/mental_health/maternal-child/maternal_mental_health/en/. Accessed 30 October 2017.</p> <p>Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Mothers giving birth: by Local Government Area, NSW 2015. Available at: www.healthstats.nsw.gov.au Accessed October 2017.</p> <p>NSW Bureau of Crime and Statistics, 2014. Accessed via the Family and Community Services (FACS) website at: https://www.facs.nsw.gov.au/facs-statistics/facs-districts/western-sydney Accessed November 2017.</p>
Children and young people	<p>Rates of children developmentally vulnerable on one or more domain and two or more domains is slightly higher in western Sydney than the NSW average, particularly in the Auburn and Parramatta LGAs. Rates</p>	<p>Public Health Information Development Unit. <i>Social Health Atlas of Australia: Data by Primary Health Network</i>. December 2016. Accessed March 2017.</p>

Outcomes of the health needs analysis

also appear to be increasing, particularly in Holroyd and Parramatta LGAs.

Percent of children developmentally vulnerable on one or more domain in Western Sydney PHN, 2012 to 2015

	2015	2012
NSW	20.2%	
WSPHN Region	22.7%	
Auburn LGA	27.3%	27.1%
Blacktown LGA	22.8%	23.8%
Holroyd LGA	23.4%	19.7%
Parramatta LGA	25.7%	22.0%
The Hills Shire LGA	17.3%	14.4%

Headspace data for the region's sites (Castle Hill, Mount Druitt and Parramatta) show that, for the July-Sept 2017 quarter:

- Parramatta has the highest proportion of CALD clients at 38.2% (compared to the regional average at 25.1%) and of LGBTIQ clients at 25.6% (compared to the regional average at 21.4%). Mount Druitt has the highest proportion of Aboriginal and Torres Strait Islander clients at 14.2% (compared to the regional average at 5.8%). The proportions of these vulnerable populations are all higher than national rates.
- Most clients are presenting with 'mild to moderate general symptoms' (46.4%, compared to national average of 39.5%); followed by 'sub-threshold diagnosis' (21%), which is equivalent to the national averages.
- Service effectiveness, as measured by average K-10 scores at start and end of services, appears to be relatively minimal, reducing from

Headspace. 2017. *Headspace centres: Western Sydney PHN: Financial Year 2017/18 (Quarter one – 1 Jul to 30 Sep 2017)*.

Outcomes of the health needs analysis																	
	<p>an average of 28.8 to 26.0, which indicates High distress. However, these results are slightly better than national rates, which show a reduction from an average of 28.7 (start) to 26.6 (end).</p> <ul style="list-style-type: none"> - The total occasions of service for the sites was 8,376 for the 2016/17 year, up from 4,754 in 2015/16. This increase is, at least in part, likely due to the Castle Hill site being opened in July 2016. - 13% of clients reported waiting too long for an appointment, with more than 20 percent of clients waiting more than three weeks for an appointment. Castle Hill had the highest proportion waiting more than 3 weeks (22%). However, these rates are comparable to national averages (23%). 																
Dementia	<p>Rates for dementia as a principal diagnosis or as a comorbidity: hospitalisations for 65-74 year olds shows a declining trend (2001-02 to 2014-15). However, hospital separations do not reflect the burden of dementia in the community, but account for additional burden placed on hospital resources when persons with severe dementia are admitted, posing difficulties in treatment and overall management.</p> <p><i>Hospitalisations for Dementia, 2014-15, age standardised, per 100,000 people (SA3s listed in descending order of hospitalisation rates)</i></p> <table> <tr> <th></th><th>Hospitalisations</th><th>Bed days</th></tr> <tr> <td>Australia</td><td>50</td><td>820</td></tr> <tr> <td>Western Sydney</td><td>36</td><td>352</td></tr> <tr> <td>Carlingford</td><td>46</td><td>609</td></tr> <tr> <td>Parramatta</td><td>43</td><td>408</td></tr> </table> <p>Regional stakeholder consultation has highlighted an increasing need for mental health services in residential aged care facilities (RACFs). Service providers stated that, "if more funding was available, they would</p>		Hospitalisations	Bed days	Australia	50	820	Western Sydney	36	352	Carlingford	46	609	Parramatta	43	408	<p>HealthStats website - NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed March 2017</p> <p>AIHW (2015), Analysis of the National Hospital Morbidity Database.</p> <p>Brooke, M, 2016. <i>Consumers and after hours health care in Western Sydney: Summary of Research Insights</i>. Report prepared for WSPHN. March 2016.</p>
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Outcomes of the health needs analysis		
	<p>refer more residents for mental health care...The mental health needs of residents are a growing problem in the combination of high care needs with dementia. Several commented that they now need of specialists in this area as their usual geriatricians are not as good in managing care demands."</p> <p>Dementia in CALD communities</p> <p>"Further research with carers and family members of people with dementia is required to better understand the impact of cultural and linguistic background on: stigmatisation and knowledge of dementia; personhood and maintenance of wellbeing for people living with dementia; the health and wellbeing of carers; decision-making processes and planning for the future; and the impact of national aged care reforms".</p>	<p>Source: Dr Olivia Hamilton and Amy Lawton of WESTIR Ltd. Dementia Care for Culturally and Linguistically Diverse (CALD) communities in Blacktown Local Government Area. 2015</p>
Comorbidities	<p>Preliminary regional data from the Health Literacy research undertaken as part of WSPHN's Consumer Needs Analysis shows a high level of co-morbidity, with respondents reporting a chronic mental health condition also reporting an average of 2.2 health conditions (in addition to their mental illness). The most common conditions included arthritis, asthma or a lung condition, chronic back pain, and alcohol or drug addiction.</p> <p>These findings were supported by previous regional research, which found that people with mental health conditions also experienced chronic conditions such as 'arthritis, osteoporosis, cardiovascular conditions, cancer, diabetes and other conditions'. In addition, this research found that 67% of the sample who reported having a mental illness rate their health positively, compared to 82% of the total sample.</p>	<p>The Science of Knowing. 2017. <i>Preliminary Results from the Health Literacy Questionnaire: Western Sydney Mental Health Consumers</i>, report prepared for WSPHN. October 2017.</p> <p>Brooke, M, 2016. <i>Consumers and after hours health care in Western Sydney: Summary of Research Insights</i>. Report prepared for WSPHN. March 2016.</p>

Outcomes of the health needs analysis		
Mental and substance use disorder	<p>Mental and substance use disorders co-exist, the relationship between them is one of mutual influence, with both conditions serving to maintain or exacerbate the other. Such comorbidity leads to poor treatment outcomes and severe illness course.</p> <p>GP data from Western Sydney PHN indicates that around 15% of all drinkers attending WSPHN primary care practices have an associated mental health condition and 60% of all drug users have a mental health condition. (Source: PAT patient data base WSPHN).</p>	Western Sydney PHN held a specific conference addresses co-morbidity and the needs of the treatment population. A set of identified actions have been collated from this event to promote service need (see section on service need AOD needs assessment).
People with severe and persistent mental illness	<p>It is estimated that 3.3% of adults experience a severe mental illness each year, of whom one-third (1.1% of adults) experience a persistent mental illness that requires ongoing services to address residual disability. It is estimated that 0.4% of the adult population experience severe and persistent mental illness that have complex needs (SPMICN) requiring multi-agency support. Assuming an even distribution of people with SPMICN across Australia, this equates to approximately 3,659 people in the western Sydney region. This is approximately 1,500 more people than estimated in the PIR Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16.</p> <p>The Mental Health Nurse Incentive Program (MHNIP) provides mental health nurses to assist in the provision of clinical care for people with severe mental disorders. The number of people in the region accessing MHNIP services has remained relatively consistent over time, however in 2014/15, a higher level of utilisation is evident in Blacktown, Baulkham Hills, and Parramatta. The MHNIP has been limited by workforce availability in the region, and as a result the commissioned</p>	<p>Whiteford H., et al., Estimating the number of adults with severe and persistent mental illness who have complex, multi-agency needs. <i>Australian & New Zealand Journal of Psychiatry</i>. 2017; 51; 8; 799–809.</p> <p>Public Health Information Development Unit. Social Health Atlas of Australia: Supplementary Release of 2016 Census Data by Primary Health Network. September 2017. Accessed October 2017.</p> <p>MHNIP Patients and Services by SA3, 2014/15. Department of Health (2015c), MHNIP Tables.</p> <p>Australian Government Department of Health and Ageing. Partners in Recovery (PIR): Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs initiative. 2015.</p>

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	<p>Mental health nurse are now delivering services under the PMHC (primary mental health care) services as a contracted provider.</p> <p>Across 2015-16, the University of Sydney partnered with Western Sydney Partners in Recovery (WSPiR) to undertake a consumer consultation process, culminating in a publicly released booklet that details people's recovery journeys. This process involved two men and eleven women who were all receiving help from WSPiR, and uncovered shared ideas about recovery from the perspective of those who are still 'recovering', rather than 'recovered'. This consultation uncovered several themes, such as: the important role of mental health support workers; the importance of having a range of services (GP, counsellor, psychologist, culturally appropriate services, homeless services), as there is no one-size-fits-all approach; the value of work and volunteering, including in the peer workforce; physical health; and social support.</p> <p>The annual Partners in Recovery consumer survey reported overwhelmingly positive client outcomes such as: The PIR program has made my life better (95%); The PIR program has given me hope (70%); I feel that I was being listened to by staff in the program (87%) in deciding what services I was referred to (69%).</p> <p>However, a need has been identified for additional transitional support for people experiencing severe mental illness (which PIR does not provide), when experiencing an acute mental health episode, resulting in presentation to a hospital ED. Acute mental health services are orientated towards scheduling, admitting and medicating people to try and stabilise their illness in an acute episode. Once this was achieved,</p>	<p>Wayland, S. et al., (2017). <i>What recovery means to us: understanding real-life recovery</i>. Blacktown: Western Sydney Partners in Recovery.</p> <p>WSPHN Partners in Recovery Consumer Survey, 2016.</p> <p>Brooke, M, 2016. Consumers and after-hours health care in Western Sydney: Summary of Research Insights. Report prepared for WSPHN. March 2016.</p>
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Outcomes of the health needs analysis																				
	<p>by their clinical definition, people no longer qualified for support and were typically discharged, usually without any follow up links or support - thus the phrase "not sick enough". This severity-dependent care approach guides the way Mental Health Crisis Teams work in making initial contact with people in acute situations but withdrawing completely once stabilisation and discharge occurs. Consumer advocates describe, and research literature confirms, this post-discharge period as a high-risk point for suicide, often because of the absence of any support networks in place.</p> <p>WSPHN as a lead agency for the PIR program has also identified 2 key needs in the region for people with severe and complex mental illness, which are access to Psychiatrists and continuity and follow up of care.</p>	<p>Chung DT et al. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. Journal of the American Medical Association Psychiatry, Vol 74(1), pp. 694-702.</p>																		
Psychological distress – place based need	<p>For the 2014/2015 period, the estimated population aged 18 years and over within the Western Sydney region with high or very high psychological distress was consistent with the national rate. However, the rates in some areas of the region were substantially higher, in particular Mount Druitt SA3, with sizeable populations also in the SA3s of Merrylands-Guildford, Blacktown, and Parramatta, and higher rates in the Auburn SA3.</p> <p><i>High or very high psychological distress, persons aged 18 years and over, modelled estimates, 2014-15, rates per 100,000 people</i></p> <table> <tr> <th></th><th>Rate</th><th>No.</th></tr> <tr> <td>Australia</td><td>11.7</td><td></td></tr> <tr> <td>NSW</td><td>11.0</td><td></td></tr> <tr> <td>Western Sydney PHN</td><td>11.7</td><td>80,177</td></tr> <tr> <td>Mount Druitt</td><td>16.0</td><td>13,032</td></tr> <tr> <td>Blacktown</td><td>13.4</td><td>13,785</td></tr> </table>		Rate	No.	Australia	11.7		NSW	11.0		Western Sydney PHN	11.7	80,177	Mount Druitt	16.0	13,032	Blacktown	13.4	13,785	<p>Public Health Information Development Unit. Social Health Atlas of Australia: Data by Primary Health Network. 2016.</p>
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	<table><tr><td>Merrylands-Guildford</td><td>13.0</td><td>14,703</td></tr><tr><td>Auburn</td><td>12.9</td><td>8,496</td></tr><tr><td>Parramatta</td><td>11.6</td><td>12,697</td></tr><tr><td>Blacktown-North</td><td>10.7</td><td>6,894</td></tr><tr><td>Carlingford</td><td>9.0</td><td>4,660</td></tr><tr><td>Rouse Hill - McGraths Hill</td><td>8.5</td><td>1,887</td></tr><tr><td>Baulkham Hills</td><td>7.6</td><td>8,610</td></tr><tr><td>Dural - Wisemans Ferry</td><td>6.6</td><td>1,364</td></tr></table>	Merrylands-Guildford	13.0	14,703	Auburn	12.9	8,496	Parramatta	11.6	12,697	Blacktown-North	10.7	6,894	Carlingford	9.0	4,660	Rouse Hill - McGraths Hill	8.5	1,887	Baulkham Hills	7.6	8,610	Dural - Wisemans Ferry	6.6	1,364	
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Psychological distress – vulnerable groups	<p>Regional data shows that rates of high or very high psychological distress are higher among particular cohorts. For example, the age bracket 16-24 years scored higher across all three categories of moderate, high and very high levels of psychological distress, rates are higher among the Aboriginal and Torres Strait Islander population, and people in lower SES areas.</p> <p>High or very high psychological distress, persons aged 16 years and over, NSW, 2015 (percentage):</p> <table><tr><td>Western Sydney PHN</td><td>9.1%</td></tr><tr><td>People aged 16-24 years</td><td>16.8%</td></tr><tr><td>Aboriginal and Torres Strait Islander people</td><td>21.7%</td></tr></table> <p>Since the headspace Youth Early Psychosis Program commenced full service operations in 2014-15 (headspace Mt Druitt, Parramatta & Penrith), the service has received 1,080 unique referrals, including 446 from July 2016-May 2017. In April 2017, of the 299 young people currently registered with the program, 57 were assessed as Ultra High Risk; 208 First Episode Psychosis; and 34 were new cases in assessment.</p>	Western Sydney PHN	9.1%	People aged 16-24 years	16.8%	Aboriginal and Torres Strait Islander people	21.7%	<p>HealthStats Website: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed March 2017.</p> <p>Turner, M, Pradhan, P, Abadines, G (2017). <i>Suicide, Youth, Peer Connections & Hope; headspace Youth Early Psychosis Program</i>. Presentation at the WentWest Connections Conference, May 2017.</p>																		
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Outcomes of the health needs analysis

Mental health and suicide in low SES groups

Data shows that in 2011/12 in New South Wales, 43% of people with mental and behavioural problems fell into the lowest two quintiles of socio-economic disadvantage.

High or very high psychological distress, persons aged 16 years and over, NSW, 2003 to 2015 (percentage), by SES quintile

	Percentage
Quintile 1: Least disadvantaged	8.8
Quintile 2	10.5
Quintile 3	13.0
Quintile 4	14.9
Quintile 5: Most disadvantaged	12.5

Service utilisation by people in low SES areas

Analysis of data relating to Mental Health MBS Items shows that when compared to national rates, overall, the western Sydney region has lower utilisation rates for psychiatrists and clinical psychologists, and higher utilisation rates for GPs and other allied health providers.

Within the region, there are differences in the rates of service utilisation that are suggestive of the socio-economic variances between SA3s. For example, Auburn (a lower SES area) has the lowest rates of access for psychiatrists, GPs, and clinical psychologists. Conversely, Dural – Wisemans Ferry has the highest rates of access to psychiatrists, and Rouse Hill – McGraths Hill have the highest access to GPs and clinical psychologists. Both of these two SA3s rank in the highest SES quintile.

Estimated number of people with mental and behavioural problems (direct estimates), Social Health Atlas of Australia, Data by Population Health Area, Published August 2017.

HealthStats Website: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. Accessed March 2017.

Department of Health (2015b), MBS Mental Health by SA3 – Patient.

Public Health Information Development Unit. *Social Health Atlas of Australia: Data by Primary Health Network*. December 2016. Accessed March 2017.

Public Health Information Development Unit. *Monitoring inequality in Australia: New South Wales. Data by Quintile of Socioeconomic Disadvantage. September 2017 Release*. Accessed October 2017.

Outcomes of the health needs analysis														
	<p>From 2010 to 2014, 44% of suicide deaths in NSW were people from the lowest two socio-economic quintiles (36% among the top two quintiles).</p> <p><i>Deaths from suicide and self-inflicted injuries, NSW, 0 to 74 years, 2010 to 2014, by SES quintile</i></p> <table><thead><tr><th></th><th>Rate per 100,000</th></tr></thead><tbody><tr><td>Quintile 1: Least disadvantaged</td><td>7.4</td></tr><tr><td>Quintile 2</td><td>8.7</td></tr><tr><td>Quintile 3</td><td>9.5</td></tr><tr><td>Quintile 4</td><td>11.3</td></tr><tr><td>Quintile 5: Most disadvantaged</td><td>9.7</td></tr></tbody></table> <p>45% of mental health admissions to public hospitals are by people from the lowest two SES quintiles; and 35% of mental health admissions to all hospitals are by people from the lowest 2 quintiles.</p>		Rate per 100,000	Quintile 1: Least disadvantaged	7.4	Quintile 2	8.7	Quintile 3	9.5	Quintile 4	11.3	Quintile 5: Most disadvantaged	9.7	<p>Public Health Information Development Unit. Monitoring inequality in Australia: New South Wales. Data by Quintile of Socioeconomic Disadvantage. September 2017 Release. Accessed October 2017.</p>
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Veteran Population	<p>Veteran health has been identified as an emerging need in the WSPHN region by stakeholders including health professionals and service organisations.</p> <p>The transition of care of defence workers from the Australian Defence Force to the Department of Veteran Affairs have been identified as a barrier to service access and delivery. Several Veterans experience problems accessing a regular GP due to regular relocation and deployment.</p>	<p>The total number of veterans reported by the Department of Veteran Affairs residing in the WSPHN region is 5,215 with almost a third of these residing in the Blacktown LGA.</p> <p>Health and wellbeing issues pertaining to Veterans include high prevalence of mental conditions including PTSD and anxiety disorders and those experiencing homelessness.</p> <p><i>Source: Department of Veteran Affairs, 2015, Social Health Strategy for the Veteran and Ex-Service Community. Available at http://www.dva.gov.au/sites/default/files/files/publications/health/social_health_strategy.pdf (Accessed 09 November 2016) A. C. McFarlane, S.</i></p>												

Outcomes of the health needs analysis		
	There are variances in health service utilisation across the Veteran population.	<p>A follow up study of Gulf War Veterans found that this group utilised more DVA health services compared to similar military groups, which could indicate higher health needs.</p> <p>Source: <i>Gulf War Veterans Follow up Health Study 2015</i>, https://www.dva.gov.au/health-and.../health-studies/gulf-war-veterans-health-study</p>
Mental health among the homeless population	<p>Research consistently finds that high numbers of people who experience homelessness also experience mental illness. This group experience the dual stigma of homelessness and mental illness, and face lack of access to mental health services (both community and clinical), as they are both economically and socially excluded.</p> <p>Further, Aboriginal and Torres Strait Islander peoples are overrepresented in the homeless population. In 2014-15, 23% of people supported by specialist homelessness services identified as Aboriginal or Torres Strait Islander, including more than 1 in 4 children aged 0-10.</p> <p>Overall, the rate of homelessness in the region is comparable to the state average, however this is due to quite low levels of homelessness in the more affluent areas of the region offsetting the extremely high rates in low SES areas. For example, the rate of homelessness in the SA3 with the highest rate (Auburn) is nearly seven times higher than the SA3s with the lowest rate (Baulkham Hills and Rouse Hill – McGraths Hill).</p>	<p>Homelessness Australia. States of being: Exploring the links between homelessness, mental illness and psychological distress. An evidence based policy paper. ACT: Homelessness Australia; 2011.</p> <p>Homelessness Australia. <i>Homelessness and Aboriginal and Torres Strait Islanders Fact Sheet</i>. ACT: Homelessness Australia; 2016.</p> <p>2049.0 Census of Population and Housing: Estimating homelessness, 2011. 2012. <i>Table 2 HOMELESS OPERATIONAL GROUPS AND OTHER MARGINAL HOUSING, New South Wales—by Statistical Area Level 3—2011</i>.</p> <p>20490DO001_2011 Census of Population and Housing: Estimating homelessness, 2011. 2012. <i>HOMELESS PERSONS, Selected characteristics—2001, 2006 and 2011</i>.</p> <p>Data note: All homeless persons data includes Persons who are in improvised dwellings, tents or sleeping out, Persons in supported accommodation for the homeless, Persons staying temporarily with</p>

Outcomes of the health needs analysis																																									
	<p>People experiencing homelessness, 2011, by SA3 (SA3s listed in descending order of rates per 100,000)</p> <table> <tr> <th>Region</th><th>Number</th><th>Rate per 100,000 (not age standardised)</th></tr> <tr> <td>NSW</td><td>28,190</td><td>408</td></tr> <tr> <td>Western Sydney</td><td>3,752</td><td>406</td></tr> <tr> <td>Auburn</td><td>629</td><td>796</td></tr> <tr> <td>Mount Druitt</td><td>688</td><td>638</td></tr> <tr> <td>Merrylands - Guildford</td><td>829</td><td>583</td></tr> <tr> <td>Parramatta</td><td>611</td><td>467</td></tr> <tr> <td>Blacktown</td><td>573</td><td>441</td></tr> <tr> <td>Blacktown - North</td><td>152</td><td>197</td></tr> <tr> <td>Dural - Wisemans Ferry</td><td>41</td><td>156</td></tr> <tr> <td>Carlingford</td><td>68</td><td>109</td></tr> <tr> <td>Baulkham Hills</td><td>134</td><td>96</td></tr> <tr> <td>Rouse Hill - McGraths Hill</td><td>27</td><td>96</td></tr> </table>	Region	Number	Rate per 100,000 (not age standardised)	NSW	28,190	408	Western Sydney	3,752	406	Auburn	629	796	Mount Druitt	688	638	Merrylands - Guildford	829	583	Parramatta	611	467	Blacktown	573	441	Blacktown - North	152	197	Dural - Wisemans Ferry	41	156	Carlingford	68	109	Baulkham Hills	134	96	Rouse Hill - McGraths Hill	27	96	<p>other households, Persons staying in boarding houses, Persons in other temporary lodging, Persons living in 'severely' crowded dwellings. Although youth are over-represented in the homeless population, homeless estimates for youth are likely to have been underestimated in the Census due to a usual address being reported for some homeless youth.</p> <p>For some youth (sometimes referred to as 12-18 years or 12-24 years) who are homeless and 'couch surfing', a usual residence may still be reported in the Census. Their homelessness is masked because their characteristics look no different to other youth who are not homeless but are simply visiting on Census night. A usual address may be reported for 'couch surfers' either because the young person doesn't want to disclose to the people they are staying with that they are unable to go home, or the person who fills out the Census form on behalf of the young person staying with them assumes that the youth will return to their home. Homeless youth will be underestimated within the group: 'Persons staying temporarily with other households'.</p>
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Mental health in LGBTIQ people	<p>Research has demonstrated that certain vulnerable groups – including lesbian, gay, bisexual, transsexual, intersex and/or queer people (LGBTIQ), carers, the homeless population and offenders – are at higher risk of mental illness than the general population.</p> <p>A disproportionate number of LGBTIQ Australians of all age groups experience poorer mental health outcomes, including depression and anxiety, and have higher risk of suicidal behaviours than the general population.</p> <p>Preliminary data analysis of an ongoing region-wide Health Literacy Survey indicates that survey respondents who have reported having a</p>	<p>Ritter et al 2012, Hillier et al 2008, Carman et al 2012, Leonard et al 2012, Couch et al 2007.</p> <p>Rosenstreich, G. (2013). LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance. Sydney.</p>																																							

Outcomes of the health needs analysis		
	<p>chronic mental health condition have a low ability to navigate the healthcare system, (i.e. they are unable to advocate on their own behalf, or find someone to help them address their health needs, and have limited understanding of what is available and their entitlements) and low social support for health (i.e. no social network, or relationships lack emotional and/or tangible support). These survey respondents included a higher proportion of LGBTIQ people than the general survey sample.</p>	<p>The Science of Knowing. 2017. <i>Preliminary Results from the Health Literacy Questionnaire: Western Sydney Mental Health Consumers</i>, report prepared for WSPHN. October 2017.</p>
Mental health in CALD communities	<p>Research has shown that people from culturally diverse backgrounds face numerous barriers to accessing timely and appropriate mental health care.</p> <p>2016 Census data indicates that 360,069 people in the western Sydney PHN (WSPHN) region were born overseas in predominantly non-English speaking (NES) countries. This makes up nearly 40% of the western Sydney population. Nearly 70% of the WSPHN population born in predominantly NES speaking countries have been residents of Australia for less than 5 years. Some parts of the WSPHN region have substantially higher proportions of people from NES backgrounds, namely Auburn with nearly 58% (residents in Australia for less than 5 years approximately 60%), and Parramatta at 48.3% (residents in Australia for less than 5 years approximately 68%).</p> <p>Among the multiple barriers to accessing mental health services, language is a primary factor. In the region, there is a high proportion of people with poor English proficiency, which is considerably higher in some SA3 areas, particularly in Auburn, which has nearly five times the NSW rate.</p>	<p>Department of Health and Ageing Report – Review of the Multicultural Mental Health Australia (MMHA) Project, November 2009.</p> <p>Social Health Atlas of Australia, Data by Population Health Area, Published August 2017.</p>

Outcomes of the health needs analysis																
	<p>People born overseas reporting poor proficiency in English – People born overseas who speak English not well or not at all (2011)</p> <table><tr><td>NSW</td><td>3.4%</td></tr><tr><td>Western Sydney PHN</td><td>43,860 (5.9%)</td></tr><tr><td>Auburn (C)</td><td>11,377 (16.7%)</td></tr><tr><td>Blacktown (C)</td><td>10,331 (3.7%)</td></tr><tr><td>Parramatta (C)</td><td>11,776 (7.6%)</td></tr><tr><td>Holroyd (C)</td><td>5,936 (6.5%)</td></tr><tr><td>The Hills Shire (A)</td><td>4,440 (2.8%)</td></tr></table>	NSW	3.4%	Western Sydney PHN	43,860 (5.9%)	Auburn (C)	11,377 (16.7%)	Blacktown (C)	10,331 (3.7%)	Parramatta (C)	11,776 (7.6%)	Holroyd (C)	5,936 (6.5%)	The Hills Shire (A)	4,440 (2.8%)	Public Health Information Development Unit. Social Health Atlas of Australia: Data by Primary Health Network. December 2016. Accessed March 2017.
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Mental health – refugee and migrant community	<p>Mental health among the refugee and migrant community is a particular challenge for the region, with available data showing more than 2,000 settlers to the region being granted humanitarian visas from October 2015 to September 2017. The vast majority of people on humanitarian visas are settled in the Blacktown and Parramatta LGAs.</p> <p>Consumer consultation among newly arrived refugees resulted in the identification of a number of barriers to service utilisation, which included language difficulties, difficulty in accessing interpreters, finding aspects of treatment strange or distrusting government services, unfamiliarity with the health system, transportation problems, long waiting times to get medical care, and a preference for their own cultural services.</p> <p>Permanent settlers from October 2015 to September 2017*</p> <table><tr><td></td><td>WSPHN</td></tr><tr><td>Humanitarian visas</td><td>2,013</td></tr><tr><td>Family visas</td><td>9,955</td></tr><tr><td>Skilled migration visas</td><td>21,025</td></tr></table>		WSPHN	Humanitarian visas	2,013	Family visas	9,955	Skilled migration visas	21,025	<p>Australian Government, Department of Social Services. Local Government Area of Permanent Settlers (All Streams) with a Date of Settlement* between 01 October 2015 to 04 October 2016. Accessed 23 October 2017.</p> <p>Renzaho, AMN and Dhingra, N, 2016. Addressing the Needs of Syrian and Iraqi Refugees in the Nepean Blue Mountains region: a formative assessment of health and community services needs. Penrith: Wentworth Healthcare Limited.</p> <p>Australian Government, Department of Social Services. Local Government Area of Permanent Settlers (All Streams) with a Date of Settlement* between 01 October 2015 to 04 October 2016. Accessed 23 October 2017.</p>						
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Outcomes of the health needs analysis																				
	<p>Humanitarian settlers, October 2015 to 30 September 2017, by LGA</p> <table> <tr> <th></th><th>Number</th><th>Percentage of total humanitarian settlers in the region</th></tr> <tr> <td>Parramatta (C)</td><td>592</td><td>29%</td></tr> <tr> <td>Blacktown (C)</td><td>646</td><td>32%</td></tr> <tr> <td>Auburn (C)</td><td>313</td><td>16%</td></tr> <tr> <td>Holroyd (C)</td><td>371</td><td>18%</td></tr> <tr> <td>The Hills Shire (A)</td><td>91</td><td>5%</td></tr> </table> <p><i>*note that the available data does not include the months of November and December 2016.</i></p>		Number	Percentage of total humanitarian settlers in the region	Parramatta (C)	592	29%	Blacktown (C)	646	32%	Auburn (C)	313	16%	Holroyd (C)	371	18%	The Hills Shire (A)	91	5%	<p>Australian Government, Department of Social Services. Local Government Area of Permanent Settlers (All Streams) with a Date of Settlement* between 1 January 2017 and 30 September 2017. Accessed 23 October 2017.</p>
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Suicide prevention - Aboriginal and Torres Strait Islander people	<p>In New South Wales in 2016, Aboriginal and Torres Strait Islander people made up approximately 2.9% of the total population. In the western Sydney region, most SA3s generally have much lower proportions of Aboriginal and Torres Strait Islander peoples, with rates less than 1% of the total population. However, the Aboriginal and Torres Strait Islander community in Mount Druitt SA3 is substantially larger, making up 4.7% of the population. This is followed by the Blacktown SA3 at 2.1%.</p> <p>Data indicates that suicide rates are consistently much greater among Aboriginal and Torres Strait Islander Australians than non-Indigenous Australians. In New South Wales, in the 5 years from 2012-2016, ABS data indicates a preliminary death rate of 16.1 per 100,000 for Aboriginal and Torres Strait Islander people, compared to 9.9 per 100,000 among non-Indigenous people.</p>	<p>Australian Bureau of Statistics, DATA BY REGION, 2011-16, POPULATION AND PEOPLE, Australia, State and Territory, Statistical Area Levels 2-4, Greater Capital City Statistical Area, 2011-2016.</p> <p>Australian Bureau of Statistics, 3303.0 - Causes of Death, Australia, 2016 Intentional self-harm in Aboriginal and Torres Strait Islander people, Table 11.4 Intentional self-harm by Indigenous status, 2012-2016.</p>																		
Suicide prevention – Aboriginal and	<p>In the 5 years from 2012-2016, Aboriginal and Torres Strait Islander children aged 5-17 years in New South Wales had suicide death rates</p>	<p>Australian Bureau of Statistics, 3303.0 - Causes of Death, Australia, 2016 Intentional self-harm in Aboriginal and Torres Strait Islander people, Table 11.12 Intentional self-harm, Number of deaths in children aged 5-</p>																		

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Torres Strait Islander youth	nearly three times those of non-Indigenous children (4.6 per 100,000 compared to 1.6 per 100,000) (based on preliminary data).	17 years by Aboriginal and Torres Strait Islander status, NSW, Qld, SA, WA and NT, 2012-2016.																
Suicide prevention – place based needs	<p>In Australia in 2016, suicide was the leading cause of death among all people aged 15-44 years of age.</p> <p>In 2015, based on preliminary data, the western Sydney region reported the second lowest standardised death rate of suicide in New South Wales (7.5 per 100,000). There was an average of 65 deaths per year from suicide among western Sydney residents in the years 2013-2015.</p> <p>However, data indicates a higher level of need for suicide prevention in some LGAs within the region, in particular the Blacktown and Holroyd LGAs, both of which fall above the regional average.</p> <p>Deaths from suicide and self-inflicted injuries, 0 to 74 years: average annual ASR per 100,000 (2010-2014)</p> <table><tr><td>Australia</td><td>11.2</td></tr><tr><td>NSW</td><td>9.4</td></tr><tr><td>WSPHN</td><td>6.8</td></tr><tr><td>Auburn LGA</td><td>6.9</td></tr><tr><td>Blacktown LGA</td><td>7.9</td></tr><tr><td>Holroyd LGA</td><td>7.1</td></tr><tr><td>Parramatta LGA</td><td>5.2</td></tr><tr><td>The Hills Shire LGA</td><td>6.4</td></tr></table>	Australia	11.2	NSW	9.4	WSPHN	6.8	Auburn LGA	6.9	Blacktown LGA	7.9	Holroyd LGA	7.1	Parramatta LGA	5.2	The Hills Shire LGA	6.4	<p>Australian Bureau of Statistics. 3303.0 - Causes of Death, Australia, 2016. Canberra: ABS; 2017</p> <p>Suicide by Primary Health Network, NSW 2001 to 2015, Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health.</p> <p>Public Health Information Development Unit. Social Health Atlas of Australia: Data by Primary Health Network. December 2016. Accessed March 2017.</p>
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Suicide prevention - males	In 2016, the standardised death rate for New South Wales was 10.3 per 100,000 (below the national rate of 11.7 per 100,000). Males accounted for 76% of these deaths (based on preliminary data). In 2016, in the age group 15-24 years, males represented 81% of all deaths from intentional self-harm (89 out of a total 110 suicides).	Australian Bureau of Statistics. 3303.0 - Causes of Death, Australia, 2016. Canberra: ABS; 2017.																

Outcomes of the health needs analysis																	
	<p>Suicide deaths in NSW, 2016</p> <table><tr><th>Age group</th><th>No. suicides</th><th>Percent of all suicides</th></tr><tr><td>15-24 years</td><td>110</td><td>26%</td></tr><tr><td>25-34 years</td><td>147</td><td>35%</td></tr><tr><td>35-44 years</td><td>163</td><td>39%</td></tr></table>			Age group	No. suicides	Percent of all suicides	15-24 years	110	26%	25-34 years	147	35%	35-44 years	163	39%	<p>Australian Bureau of Statistics. 3303.0 - Causes of Death, Australia, 2016 Table 2.3 Underlying cause of death, Selected causes by age at death, numbers and rates, New South Wales, 2016. Canberra: ABS; 2017.</p>	
Age group	No. suicides	Percent of all suicides															
15-24 years	110	26%															
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Intentional self-harm – place based need	<p>In 2015/16, the rates of hospitalisations for self-harm in the Western Sydney PHN region were lower than the national average, however rates in the region are increasing, particularly for young people.</p>			<p>HealthStats Website - NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.</p> <p><i>Data note:</i> <i>Intentional self-harm = suicide (attempted) and purposely self-inflicted poisoning or injury. This indicator measures people admitted to hospital after self-harm. It is not a direct measure of the number of people in the NSW population who make suicide attempts. This indicator only includes people who are admitted to hospital, and does not include people who go home after treatment in the Emergency Department (ED). Therefore changes in this indicator over time may reflect changes in the number of people who come to hospital seeking help, or the proportion who are admitted for treatment rather than treated in the ED. Suicide rates for males may also balance out the variation in these figures.</i></p>													
	<p>Intentional self-harm hospitalisations, persons 15-24 years, 2015/16 (shown as a rate per 100,000)</p>																
		NSW	WSPHN														
	Males	189.9	126.9 (up from 105.8 in 2014/15)														
	Females	480.5	403.8 (up from 323.7 in 2014/15)														
Persons	331.2	260.1 (up from 210.5 in 2014/15)															
	<p>While hospitalisation rates decreased for the majority of catchments in Western Sydney PHN region between 2013/14 and 2014/15, there was an increase in rates for the SA3s of Auburn, Blacktown - North, Carlingford, Pennant Hills – Epping, and Mount Druitt, with Mount Druitt’s increase being the largest.</p>																
	<p>Further, the number of bed days in some parts of the region (i.e. Carlingford, Mount Druitt) is substantially higher than regional and national rates, and these have increased from 2013/14 rates.</p>																

Outcomes of the health needs analysis

	<p>While SA3 rates of hospitalisations and bed days have fluctuated from 2013/14 to 2014/15, the overall regional rate for both measures remains relatively stable.</p> <p><i>Hospitalisations for Intentional Self-Harm, age standardised rate, per 100,000 people:</i></p> <table><tr><th></th><th>2014/15</th></tr><tr><td>Australia</td><td>161</td></tr><tr><td>Western Sydney</td><td>97</td></tr><tr><td>Mount Druitt</td><td>150</td></tr><tr><td>Blacktown</td><td>125</td></tr><tr><td>Rouse Hill-McGraths Hill</td><td>109</td></tr></table> <p><i>Bed days for Intentional Self-Harm, 2014-15, age standardised rate, per 100,000 people:</i></p> <table><tr><td>Australia</td><td>838</td></tr><tr><td>Western Sydney</td><td>627</td></tr><tr><td>Carlingford</td><td>1,223</td></tr><tr><td>Mount Druitt</td><td>1,006</td></tr><tr><td>Parramatta</td><td>731</td></tr></table>		2014/15	Australia	161	Western Sydney	97	Mount Druitt	150	Blacktown	125	Rouse Hill-McGraths Hill	109	Australia	838	Western Sydney	627	Carlingford	1,223	Mount Druitt	1,006	Parramatta	731	
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Intentional self-harm among females	<p>The rate of hospitalisations for intentional self-harm among western Sydney females aged 15-24 years is increasing. The average rate of hospitalisations for intentional self-harm among this group over the last ten years was 315.22 per 100,000. In 2015/16 the rate was 403.8 per 100,000 (up from 323.7 per 100,000 in 2014/15).</p> <p>In the WSPHN region, intentional self-harm is substantially higher for WSPHN females in the 15-24 years age group, compared with males in</p>	<p>HealthStats Website - NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.</p> <p><i>Data note:</i> <i>Intentional self-harm = suicide (attempted) and purposely self-inflicted poisoning or injury. This indicator measures people admitted to hospital after self-harm. It is not a direct measure of the number of people in the</i></p>																						

Outcomes of the health needs analysis								
	<p>the same age group and compared with overall rates for both genders (all ages).</p> <p>Hospitalisations for intentional self-harm, rate per 100,000 population, 2015/16</p> <table><tr><td>Females (aged 15-24 years)</td><td>403.8</td></tr><tr><td>Males (aged 15-24 years)</td><td>126.9</td></tr><tr><td>Persons (aged 15-24 years)</td><td>260.1</td></tr></table> <p>In 2015/2016, the rate of intentional self-harm hospitalisations in New South Wales was 606.2 per 100,000 for females aged 15-19 years, and 350 per 100,000 for females aged 20-24 years. While data by PHN and 5 year age cohorts is not available, it is possible that there are similarly higher rates of intentional self-harm in the WSPHN region among the 15-19 age cohort.</p>	Females (aged 15-24 years)	403.8	Males (aged 15-24 years)	126.9	Persons (aged 15-24 years)	260.1	<p><i>NSW population who make suicide attempts. This indicator only includes people who are admitted to hospital, and does not include people who go home after treatment in the Emergency Department (ED). Therefore changes in this indicator over time may reflect changes in the number of people who come to hospital seeking help, or the proportion who are admitted for treatment rather than treated in the ED. Suicide rates for males may also balance out the variation in these figures.</i></p> <p>NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health. <i>Intentional self-harm: hospitalisations by age, 2015-16.</i></p>
Females (aged 15-24 years)	403.8							
Males (aged 15-24 years)	126.9							
Persons (aged 15-24 years)	260.1							
Mild to moderate mental illness	<p>Stakeholders confirmed the need for support services for people experiencing moderate levels of mental illness. In explanation, someone with an acute and severe episode of mental illness requiring immediate hospitalisation could typically access services via an acute hospital setting. Similarly, someone with a mild mental illness with a lower sense of urgency, was usually able to receive ongoing care and support via community-based providers. This gap was exemplified through one consumer’s description of suicide prevention services: "When you ring the suicide line, you get a nurse or a doctor, who might give you some advice, tells you to take a few pills and have a cup of tea. Meanwhile, you have the means, you have a plan and need immediate support, but you're all alone and have no one to be with you and support you. You're not sick enough for ED and you can't wait</p>	<p>Brooke, M, 2016. Consumers and after hours health care in Western Sydney: Summary of Research Insights. Report prepared for WSPHN. March 2016.</p>						

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until an appointment next week. It would be great if there was someone available with lived-experience of mental illness to be with you". This stakeholder feedback supports the need for the development of a mental health peer workforce.

Increasing numbers of Mental Health Treatment Plans

Between 2012/13 and 2015/16, the number of patients receiving GP mental health treatment plans increased for all SA3 catchments in the Western Sydney PHN region. Parramatta and Rouse Hill – McGraths Hill experienced substantial growth in both patient and service numbers, while Mount Druitt also experienced a large increase in service numbers. It is unclear from this data whether this represents an increase in need, or increased service utilisation.

Patients receiving GP Mental Health Plans (MBS Items 2700, 2701, 2712, 2713, 2715, 2717)

	2015/16	% increase from 2012/13
Western Sydney PHN	82,614	22%
Auburn	6,560	14%
Baulkham Hills	14,089	19%
Blacktown	17,708	20%
Blacktown North	5,648	29%
Carlingford	4,716	20%
Dural - Wisemans Ferry	2,621	11%
Merrylands-Guildford	9,291	23%
Mount Druitt	10,306	29%
Parramatta	12,569	39%
Rouse Hill – McGraths Hill	4,921	44%

Department of Health (2016a), MBS Items Time Series.

Outcomes of the health needs analysis

	<p><i>Services for GP Mental Health Plans (MBS Items 2700, 2701, 2712, 2713, 2715, 2717), by SA3</i></p> <table> <tr> <th></th><th>2015/16</th><th>% increase from 2012/13</th></tr> <tr> <td>Western Sydney PHN</td><td>115,135</td><td>25.6%</td></tr> <tr> <td>Auburn</td><td>8,368</td><td>13.1%</td></tr> <tr> <td>Baulkham Hills</td><td>18,659</td><td>19.4%</td></tr> <tr> <td>Blacktown</td><td>23,462</td><td>15.0%</td></tr> <tr> <td>Blacktown North</td><td>7,390</td><td>34.6%</td></tr> <tr> <td>Carlingford</td><td>6,260</td><td>16.4%</td></tr> <tr> <td>Dural - Wisemans Ferry</td><td>3,333</td><td>-7.0%</td></tr> <tr> <td>Merrylands-Guildford</td><td>12,689</td><td>31.7%</td></tr> <tr> <td>Mount Druitt</td><td>15,924</td><td>47.7%</td></tr> <tr> <td>Parramatta</td><td>19,412</td><td>57.0%</td></tr> <tr> <td>Rouse Hill – McGraths Hill</td><td>6,264</td><td>44.4%</td></tr> </table>		2015/16	% increase from 2012/13	Western Sydney PHN	115,135	25.6%	Auburn	8,368	13.1%	Baulkham Hills	18,659	19.4%	Blacktown	23,462	15.0%	Blacktown North	7,390	34.6%	Carlingford	6,260	16.4%	Dural - Wisemans Ferry	3,333	-7.0%	Merrylands-Guildford	12,689	31.7%	Mount Druitt	15,924	47.7%	Parramatta	19,412	57.0%	Rouse Hill – McGraths Hill	6,264	44.4%	
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<p>Hospitalisations and bed days for all mental health conditions</p>	<p>Overall, hospitalisations for all mental health conditions in the Western Sydney region were lower than the national rate in 2014/15. This was also the case for the majority of SA3s in the region, with the exception of Auburn, Dural-Wisemans Ferry and Carlingford, which were higher.</p> <p>Further, the rate of bed days is higher than national average for more than half the region's SA3s. The top five SA3s are shown below, notably the SA3 of Auburn. Rates for both measures are relatively consistent from 2013/14.</p> <p>All mental health conditions, 2014/15, age standardised, per 100,000 people (SA3s listed in order of highest number of bed days)</p>	<p>Australian Institute of Health and Welfare analysis of the National Hospital Morbidity Database 2014–15 and Australian Bureau of Statistics, Estimated Resident Population 30 June 2014.</p>																																				

Outcomes of the health needs analysis																										
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Hospitalisations for schizophrenia and delusional disorders – place based need	<p>The western Sydney region has a higher than national rate of hospitalisations and bed days for people with schizophrenia and delusional disorders. More than half of the region's SA3s have a bed day rate higher than the national average, and rates have increased from 2013/14.</p> <p>In Auburn, hospitalisations are more than double the national rate, and the rate of bed days is more than five times the national rate.</p> <p>Auburn previously recorded the highest rate of hospitalisations in 2013/14, and the rate of bed days has increased the most out of all the region's SA3s from 2013/14 to 2014/15.</p> <p><i>Schizophrenia and Delusional Disorders, 2014/15, age standardised, per 100,000 people</i></p> <table> <tr> <th></th><th>Hospitalisations</th><th>Bed days</th></tr> <tr> <td>Australia</td><td>164</td><td>3,615</td></tr> <tr> <td>Western Sydney</td><td>172</td><td>5,499</td></tr> <tr> <td>Auburn</td><td>445</td><td>18,301</td></tr> <tr> <td>Merrylands-Guildford</td><td>203</td><td>6,107</td></tr> <tr> <td>Carlingford</td><td>196</td><td>5,406</td></tr> </table>		Hospitalisations	Bed days	Australia	164	3,615	Western Sydney	172	5,499	Auburn	445	18,301	Merrylands-Guildford	203	6,107	Carlingford	196	5,406	AIHW (2015), Analysis of the National Hospital Morbidity Database.						
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Hospitalisations for Bipolar and Mood Disorders	<p>All SA3 catchments in western Sydney had lower hospitalisation rates compared to the national average, except Dural-Wiseman's Ferry. However, hospitalisations increased between the 2013/14 and 2014/15 reporting periods for half the areas.</p> <p>In 2014/15, Auburn and Ryde-Hunters Hill SA3s had higher rates of bed days, compared to the regional and national average.</p> <p><i>Bipolar and Mood disorders, 2014/15, age standardised, per 100,000 people</i></p> <table> <tr> <th></th><th>Hospitalisations</th><th>Bed days</th></tr> <tr> <td>Australia</td><td>101</td><td>1,781</td></tr> <tr> <td>Western Sydney</td><td>71</td><td>1,436</td></tr> <tr> <td>Dural – Wisemans Ferry</td><td>112</td><td>1,723</td></tr> <tr> <td>Auburn</td><td>95</td><td>2,925</td></tr> <tr> <td>Ryde – Hunters Hill</td><td>91</td><td>1,926</td></tr> </table>		Hospitalisations	Bed days	Australia	101	1,781	Western Sydney	71	1,436	Dural – Wisemans Ferry	112	1,723	Auburn	95	2,925	Ryde – Hunters Hill	91	1,926	AIHW (2015), Analysis of the National Hospital Morbidity Database.			
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Hospitalisations for Anxiety and Stress	<p>Anxiety and stress hospitalisations were relatively consistent between 2013/14 and 2014/15 reporting periods, with four SA3 areas reporting rates higher than regional and national averages.</p> <p><i>Anxiety and Stress disorders, 2014-15, age standardised, per 100,000 people (SA3s listed in descending order of hospitalisation rates)</i></p> <table> <tr> <th></th><th>Hospitalisations</th><th>Bed days</th></tr> <tr> <td>Australia</td><td>142</td><td>1,239</td></tr> <tr> <td>Western Sydney</td><td>134</td><td>1,156</td></tr> <tr> <td>Rouse Hill-McGraths Hill</td><td>173</td><td>1,568</td></tr> <tr> <td>Carlingford</td><td>159</td><td>2,294</td></tr> <tr> <td>Parramatta</td><td>147</td><td>1,224</td></tr> <tr> <td>Blacktown</td><td>146</td><td>941</td></tr> </table>		Hospitalisations	Bed days	Australia	142	1,239	Western Sydney	134	1,156	Rouse Hill-McGraths Hill	173	1,568	Carlingford	159	2,294	Parramatta	147	1,224	Blacktown	146	941	AIHW (2015), Analysis of the National Hospital Morbidity Database.
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Hospitalisations for Depressive Episodes	<p>While the regional rate of hospitalisations for depressive disorders was slightly lower than national average, rates increased between 2013/14 and 2014/15, with the biggest increase occurring in Carlingford SA3. Five SA3 catchments had higher rates compared to the national average.</p> <p>Further, the majority of catchments in the region had higher rates of bed days compared to the national average for 2014/15, though rates have decreased from 2013/14.</p> <p><i>Depressive Disorders, 2014-15, age standardised, per 100,000 people (SA3s listed in descending order of hospitalisation rates)</i></p> <table> <tr> <th></th><th>Hospitalisations</th><th>Bed days</th></tr> <tr> <td>Australia</td><td>118</td><td>1,678</td></tr> <tr> <td>Western Sydney</td><td>103</td><td>1,664</td></tr> <tr> <td>Dural-Wisemans Ferry</td><td>194</td><td>3,129</td></tr> <tr> <td>Rouse Hill-McGraths Hill</td><td>135</td><td>1,950</td></tr> <tr> <td>Baulkham Hills</td><td>132</td><td>2,161</td></tr> <tr> <td>Parramatta</td><td>119</td><td>1,829</td></tr> </table>		Hospitalisations	Bed days	Australia	118	1,678	Western Sydney	103	1,664	Dural-Wisemans Ferry	194	3,129	Rouse Hill-McGraths Hill	135	1,950	Baulkham Hills	132	2,161	Parramatta	119	1,829	AIHW (2015), Analysis of the National Hospital Morbidity Database.
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Variations in care - Antidepressant prescriptions	<p>There is a high variation in prescription rates for antidepressant medication within the WSPHN region.</p> <p>In western Sydney, the SA3 with the highest age standardised rate of antidepressant prescriptions for people aged 17 years and under (Rouse Hill – McGraths Hill), is more than three times that of the lowest SA3 (Auburn). Also of note is that there appears to be an inverse correlation between the rate of prescriptions and socio-economic disadvantage, with lowest prescription rates in the lowest SES areas in the region (Mount Druitt, Merrylands-Guildford and Auburn SA3s).</p>	Australian Atlas of Healthcare Variation, 2015. Australian Atlas of Healthcare Variation, 2015.																					

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	<p><i>Number of PBS prescriptions dispensed for antidepressant medicines per 100,000 people aged 17 years and under, 2013–14</i></p> <table><tr><td>SA3 name</td><td>ASR rate per 100,000</td><td>Decile of ASR (of all Aus SA3s)*</td><td>SES quintile</td></tr><tr><td>Rouse Hill–McGraths Hill</td><td>7,430</td><td>6</td><td>5 (highest)</td></tr><tr><td>Dural–Wisemans Ferry</td><td>7,332</td><td>7</td><td>5</td></tr><tr><td>Baulkham Hills</td><td>6,783</td><td>7</td><td>5</td></tr><tr><td>Blacktown</td><td>5,889</td><td>8</td><td>2</td></tr><tr><td>Blacktown North</td><td>5,756</td><td>8</td><td>5</td></tr><tr><td>Carlingford</td><td>5,422</td><td>9</td><td>4</td></tr><tr><td>Parramatta</td><td>5,306</td><td>9</td><td>3</td></tr><tr><td>Mount Druitt</td><td>5,298</td><td>9</td><td>1</td></tr><tr><td>Merrylands Guildford</td><td>2,819</td><td>10</td><td>1</td></tr><tr><td>Auburn</td><td>2,452</td><td>10</td><td>1 (lowest)</td></tr></table> <p>*where 1 = occurring the most; 10 = occurring the least)</p>			SA3 name	ASR rate per 100,000	Decile of ASR (of all Aus SA3s)*	SES quintile	Rouse Hill–McGraths Hill	7,430	6	5 (highest)	Dural–Wisemans Ferry	7,332	7	5	Baulkham Hills	6,783	7	5	Blacktown	5,889	8	2	Blacktown North	5,756	8	5	Carlingford	5,422	9	4	Parramatta	5,306	9	3	Mount Druitt	5,298	9	1	Merrylands Guildford	2,819	10	1	Auburn	2,452	10	1 (lowest)	
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Variations in care - ADHD	<p>There is a high variation in prescription rates for ADHD medication within the region. The Mount Druitt prescription rate places it in the decile with the highest prescription rate in Australia, and Blacktown falls in the second highest decile.</p> <p><i>Number of PBS prescriptions dispensed for ADHD medicines per 100,000 people aged 17 years and under, age standardised, by SA3, 2013–14</i></p> <table><tr><td></td><td>SES</td><td>Age standardised rate per 100,000</td><td>Decile of age standardised rate</td></tr><tr><td>SA3 name</td><td>quintile</td><td></td><td></td></tr><tr><td>Mount Druitt</td><td>1</td><td>19,482</td><td>1</td></tr><tr><td>Blacktown</td><td>2</td><td>14,612</td><td>2</td></tr></table>				SES	Age standardised rate per 100,000	Decile of age standardised rate	SA3 name	quintile			Mount Druitt	1	19,482	1	Blacktown	2	14,612	2	Australian Atlas of Healthcare Variation, 2015. Australian Atlas of Healthcare Variation, 2015.																												
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Outcomes of the health needs analysis																																
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Variations in care - Antipsychotic prescriptions	<p>PBS Prescriptions for antipsychotic medicines appear to be relatively higher in the Mount Druitt SA3, particularly among people 65 years and older, which in 2013/14 amounted to 2,937 prescriptions. It is also worth noting that, with the exception of Carlingford, the SA3 areas with relatively higher prescription rates are in lower SES areas.</p> <p><i>Number of PBS prescriptions dispensed for antipsychotic medicines per 100,000 people aged 65 years and over, age standardised, 2013–14</i></p> <table><thead><tr><th>SA3 name</th><th>SES quintile</th><th>Age standardised rate per 100,000</th><th>Decile of age standardised rate</th></tr></thead><tbody><tr><td>Mount Druitt</td><td>1 (lowest)</td><td>30,960</td><td>2nd highest</td></tr><tr><td>Parramatta</td><td>3</td><td>29,241</td><td>3rd highest</td></tr></tbody></table> <p><i>Number of PBS prescriptions dispensed for antipsychotic medicines per 100,000 people aged 18 to 64 years, age standardised, 2013–14</i></p> <table><thead><tr><th>SA3 name</th><th>SES quintile</th><th>Age standardised rate per 100,000</th><th>Decile of age standardised rate</th></tr></thead><tbody><tr><td>Merrylands - Guildford</td><td>1 (lowest)</td><td>20,539</td><td>3rd highest</td></tr><tr><td>Mount Druitt</td><td>1 (lowest)</td><td>18,628</td><td>4th highest</td></tr><tr><td>Carlingford</td><td>4 (2nd highest)</td><td>19,299</td><td>4th highest</td></tr></tbody></table>			SA3 name	SES quintile	Age standardised rate per 100,000	Decile of age standardised rate	Mount Druitt	1 (lowest)	30,960	2 nd highest	Parramatta	3	29,241	3 rd highest	SA3 name	SES quintile	Age standardised rate per 100,000	Decile of age standardised rate	Merrylands - Guildford	1 (lowest)	20,539	3 rd highest	Mount Druitt	1 (lowest)	18,628	4 th highest	Carlingford	4 (2 nd highest)	19,299	4 th highest	Australian Atlas of Healthcare Variation, 2015.
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Outcomes of the health needs analysis

Number of PBS prescriptions dispensed for antipsychotic medicines per 100,000 people aged 17 years and under, age standardised, 2013–14

SA3 name	SES quintile	Age standardised rate per 100,000	Decile of age standardised rate
Mount Druitt	1	2,405	3 rd highest

SECTION 3 – OUTCOMES OF THE SERVICE NEEDS ANALYSIS

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Service utilisation summary	<p>For 2014/15, the western Sydney population accessed services in the following ranked order:</p> <ol style="list-style-type: none"> 1. MBS 2. PBS (Blacktown-North, and Merrylands-Guildford ranked ATAPs 2nd); (Dural-Wiseman's Ferry and Mount Druitt had about 1/3 of services made up by PBS) 3. ATAPS 4. Hospitalisations (Auburn had the highest rates within the region, making up 3% of that SA3's service utilisation). 5. 	<p>AIHW (2015), Analysis of the National Hospital Morbidity Database.</p> <p>Department of Health (2016a), MBS Items Time Series.</p>
Health literacy responsiveness	<p>Health literacy responsiveness is a measure of how organisations support and build the health literacy of consumers. The higher the health literacy responsiveness of an organisation, the lower the health literacy required by consumers to engage with health care.</p> <p>94 local stakeholders from the mental health sector responded to a health literacy responsiveness survey. Respondents included clinicians, government departments, non-government organisations, hospitals, and private practices. Across the seven health literacy responsiveness themes, collectively, local services were all either performing well or could be improved.</p> <p>However, when results were disaggregated by organisation type, it is clear that some organisations are performing significantly better in some areas than others. Non-government organisations had the highest levels of health literacy responsiveness, and government organisations are perceived to</p>	<p>The Science of Knowing. 2017. <i>Connections Conference May 2017, Health Literacy Responsiveness Survey, Results Summary</i>, report prepared for WSPHN. August 2017.</p>

Outcomes of the service needs analysis		
	<p>have the lowest levels of health literacy responsiveness. Hospitals and private practice also ranked low on certain domains.</p>	
<p>PMHC – Primary Mental Health Care (previously known as ATAPS) – referrals and provider satisfaction</p>	<p>Referral processes</p> <p>Overall, providers were satisfied with the program, particularly in addressing patient needs, appropriately identifying eligible patients and creating the correct referral pathways.</p> <p>Almost 60% responded that the referrals received through WSPHN were of a high quality, with an additional third responding that the referrals were of reasonable quality. No providers responded that the referrals were of poor quality.</p> <p>85% of providers actively respond to referrals within 48 hours, showing a high level of responsiveness amongst providers.</p> <p>Providers highlighted the need for better education of referring GPs to be aware of the program.</p> <p>Wait times</p> <p>Providers vary greatly in their wait times, with approximately one third having no wait lists, another third having less than a one week wait time, just over 20% having a 1-2 week wait time, and just under 20% having a wait time longer than 2 weeks. This suggests that there may be benefit in allocating referrals to providers according to their current wait times, to ensure that patients receive services as quickly as possible.</p> <p>Opportunities for WSPHN to assist providers in service delivery</p>	<p>WentWest. 2017. <i>Survey of Mental Health Service Providers, February to October 2017.</i></p>

Outcomes of the service needs analysis												
	<p>Providers suggested various ways that WSPHN could better assist practices in delivering services, including better matching of provider expertise to client needs, enabling more outreach and telephone service delivery, and improving online information resources.</p> <p>Providers also indicated they would offer the following additional supports to clients, if they were available free of charge:</p> <table><tr><td>Psychiatrist</td><td>85.2%</td></tr><tr><td>Post-treatment follow-up phone call</td><td>84.6%</td></tr><tr><td>24 hour telephone help line</td><td>77.8%</td></tr><tr><td>Mental health education courses</td><td>77.8%</td></tr><tr><td>Peer support group</td><td>72.0%</td></tr></table>	Psychiatrist	85.2%	Post-treatment follow-up phone call	84.6%	24 hour telephone help line	77.8%	Mental health education courses	77.8%	Peer support group	72.0%	
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ATAPS – Collaboration and coordination of care	<p>The vast majority (more than 85%) of ATAPS providers engage with the referring GP when submitting progress or final reports and/or if they are concerned about a client's welfare. However, only two-thirds of providers reported that they engage with the referring GP to discuss a client's treatment. Literature shows that ongoing communication between providers facilitates continuity of care for patients. As such, encouraging providers to communicate treatment plans with the referring GPs may improve patient outcomes and experiences.</p>	WentWest. 2017. <i>Survey of Mental Health Service Providers, February to October 2017.</i>										
After hours access to General Practitioners	<p>Across the region, there were 344 general practices (as at 2017). Of these, 86 (25%) are not open at all on Saturdays, and the majority (268, 78%) are not open at all on Sundays.</p> <p><i>Total number of general practices across the region</i></p> <table><tr><td>LGA</td><td>No.</td></tr><tr><td>Blacktown</td><td>122</td></tr><tr><td>Cumberland</td><td>90</td></tr></table>	LGA	No.	Blacktown	122	Cumberland	90	WSPHN GP database.				
LGA	No.											
Blacktown	122											
Cumberland	90											

Outcomes of the service needs analysis		
	<p>The Hills 54 Parramatta 78 WSPHN 344</p> <p>Overall, 231 practices have after hours arrangements in place (e.g. 13SICK, Sydney Medical Service Cooperative, DoctorDoctor). However, of the 82 practices that are not open on weekend days, only 29 (35%) have after hours arrangements in place.</p> <p>Amongst consumers with a long-term mental health condition, only 33% were aware of any of the after-hours services listed. Awareness of after hours advice and visiting services is sub-optimal amongst general consumers; and poor amongst consumers with CALD backgrounds. Mental health consumers also expressed a need for continuity of care, with 97% using the same GP or practice. Both of these represent demand-side barriers in terms of using deputising services to reach mental health consumers.</p> <p>A supply-side barrier is the clearly expressed preference of deputising services to try to avoid being involved in, or initiating, treatment with mental health patients, especially in more acute situations where scheduling may be the only treatment option. Similarly, they avoid getting involved in changes to mental health care plans. When they are seeing patients that do need to be re-assessed, they may need to meet with mental health teams, especially when there are repeat caller scenarios.</p> <p>Deputising services are not often in treating contact with patients with a mental health issue and do not feel well-prepared for this. When they are, they often feel inadequate and unable to assist, feeling care delivery is "too</p>	<p>WentWest. 2017. Survey of Mental Health Service Providers, February to October 2017.</p>

Outcomes of the service needs analysis

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Workforce development	<p>In a recent survey of regional mental health service providers, respondents indicated that there were several other services that they would want to know about or be involved with. These included:</p> <table><tr><td>Private practice model</td><td>66.7%</td></tr><tr><td>Local networking</td><td>66.7%</td></tr></table>	Private practice model	66.7%	Local networking	66.7%	<p>WentWest. 2017. Survey of Mental Health Service Providers, February to October 2017.</p>																																																																
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Outcomes of the service needs analysis		
	Support groups	55.6%
	Peer work	48.1%

SECTION 4 – OPPORTUNITIES, PRIORITIES AND OPTIONS

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Maternal and perinatal mental health Data gap	Existing Programs <ul style="list-style-type: none"> Priority Area 3.2 Expansion of Psychological therapies to priority areas: Child, ATSI, Perinatal, Suicide Prevention Possible Options <ul style="list-style-type: none"> Stakeholder and consumer consultation to identify the extent of the issue in the region; and to identify possible solutions, such as working with the LHD to consider options to increase coverage and utilisation of the Midwifery@Home program. 	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan
Children and young people	Existing programs	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
<ul style="list-style-type: none"> - high levels of psychological distress - suicide in ATSI children - self-harm in females - childhood development 	<ul style="list-style-type: none"> • Priority Area 2.1 Headspace (primary) – 3 sites – Parramatta Mt Druitt and Castle Hill. Targets mild-moderate. • Priority Area 2.2 Headspace hYEPP (Hub and Spoke – 2 sites) – Mt Druitt and Parramatta. YP experiencing severe mental health condition which may also be attributable to drug and alcohol misuse • Priority Area 3.2 Expansion of Psychological therapies to priority areas: Child, ATSI, Perinatal, Suicide Prevention • Development of a participatory suicide prevention modelling tool in partnership with Western Sydney University and the Sax Institute. <p>Possible Options</p> <ul style="list-style-type: none"> • Stakeholder and consumer consultation and solution design, based on the current and ongoing Consumer Needs Assessment and 	<ul style="list-style-type: none"> • The identification of the most effective suicide prevention strategies for the region. • Reduction in suicides/suicide attempts. 	<ul style="list-style-type: none"> • Increased service utilisation by vulnerable groups. • Suicide rate (long term) 	<p>WSPHN</p>

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	Ophelia (OPTimising HEalth LiterAcy process). ³			
Dementia and aged care	<ul style="list-style-type: none"> • Address workforce capability issues, through dementia and mental health professional development programs for local geriatricians. • Consider engaging regional psychogeriatrician/s to support the needs of patients. • Address health literacy and access to dementia care in the CALD community. 	<ul style="list-style-type: none"> • Increased health literacy for people from culturally and linguistically diverse communities around mental health and available services and support. • Increased usage of available support services (early intervention) and reduction in acute hospital presentations. 	<ul style="list-style-type: none"> • Increased health literacy levels • Increased access and usage of appropriate services • Increased earlier help seeking for mental illness 	WSPHN MH NGOs
Aboriginal and Torres Strait Islander peoples <ul style="list-style-type: none"> - Suicide prevention - Homeless population - Health literacy (navigation of the health system and social support) 	Existing Programs <ul style="list-style-type: none"> • Priority Area 6.1 Mental Health First aid training (for carers and consumers from specific Aboriginal background) & cultural competency training (for mental health care professionals). 	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan

³ The Optimising Health LiterAcy (Ophelia) process involves the collaboration of a wide range of community members, community leaders, and workers to develop health literacy interventions that are based on needs identified within a community. Each Ophelia project seeks to improve health and equity by increasing the availability and accessibility of health information and services in locally-appropriate ways (Deakin University <https://www.ophelia.net.au/about-ophelia>)

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	<ul style="list-style-type: none"> • Priority Area 6.2 Consortium managed mobile Aboriginal mental wellbeing team. • Priority Area 6.3 Workforce and traineeship development for Aboriginal health workers. • Priority Area 3.2 Expansion of Psychological therapies to priority areas: Child, ATSI, Perinatal, Suicide Prevention • Implementation of regional data planning group (utilising Data and geo-mapping tools) to identify target groups, cohorts and place-based needs. • Development of a participatory suicide prevention modelling tool in partnership with Western Sydney University and the Sax Institute. <p>Possible Options</p> <ul style="list-style-type: none"> • Consumer consultation and solution design, based on the current and ongoing Consumer Needs Assessment and Ophelia 	<ul style="list-style-type: none"> • Development and implementation of appropriate service options that meet consumer needs. • The identification of the most effective suicide prevention strategies for the region. 	<ul style="list-style-type: none"> • Increased service utilisation by vulnerable groups. • Suicide rate (long term) 	<p>WSPHN</p>

[illegible]

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
People experiencing homelessness - Data gap	Possible Options <ul style="list-style-type: none"> Stakeholder and consumer consultation and solution design, based on the current and ongoing Consumer Needs Assessment and Ophelia (OPTimising HEalth LiterAcy process). Service mapping and stakeholder consultation to determine the level of need/service gaps in the region. 	<ul style="list-style-type: none"> Reduction in stigma, and increased service access and support options for patients. Improved consumer awareness, and utilisation of ATAPS and other mental health services. 	<ul style="list-style-type: none"> Development and implementation of strategies to address findings of service mapping and stakeholder consultation. Increased service utilisation among the homeless population. Consumer mental health outcomes. 	WSPHN
People experiencing mild to moderate mental illness	Existing programs <ul style="list-style-type: none"> Priority Area 1.1 MindGuide Navigation tool - Forge – (www.mindguide.org.au) wrong door) Priority Area 1.2 Clevertar – (Online recovery based coaching services – www.clevertar.com) Priority Area 1.3 Western Sydney Recovery College (Psychoeducational support services – www.wsydrecoverycollege.org.au) 	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	<ul style="list-style-type: none"> • Priority Area 1.4 On the Line – Western Sydney Support & Helpline (extension of previous ATAPS support services). www.ontheline.org.au/WSHelpline <p>Possible Options</p> <ul style="list-style-type: none"> • Consumer consultation and solution design, based on the current and ongoing Consumer Needs Assessment and Ophelia (OPTimising HEalth LiterAcy process). • Develop 24hr peer support model for people experiencing moderate mental illness (phone and face-to-face). • Development of follow-up links and support options for people leaving Emergency Departments. • Consider options for mental health phone support, such as improvements to NSW Mental Health Line, and improving service availability (i.e. extended hours, through night shifts). 	<ul style="list-style-type: none"> • Improved health literacy among consumers, and improved health literacy responsiveness among service providers, in particular government organisations and hospitals. 	<ul style="list-style-type: none"> • Development and implementation of fit-for-purpose response strategies that optimise opportunities to improve equity in health outcomes and access. 	<p>WSPHN</p>

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	<ul style="list-style-type: none"> • Improve access and affordability for vulnerable groups (i.e. people of low income). • Consumer consultation and solution design, based on the current and ongoing Consumer Needs Assessment and Ophelia (OPTimising HEalth LiterAcy process). 	<ul style="list-style-type: none"> • Development of options for appropriate services that meet consumer needs. 	<ul style="list-style-type: none"> • Services located in accessible areas, in identified areas of high need (low SES, lack of existing services). 	
People with severe and complex mental illness	Existing Programs <ul style="list-style-type: none"> • Priority Area 4.1 Mental Health Nurse Incentive Program – Activity based services • Priority Area 4.2 Mental Health Nurse expansion, recruitment and sponsorship program • Priority Area 4.3 Hospital to Home – 2 Providers supporting people who present or are discharged from hospital as a result of a mental health condition, to community support. • Priority Area 4.4 Psychiatric Liaison Service – Primary Care. Psychiatrist deployed to support people with severe and complex 	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	<p>mental health condition in a primary care setting across 10 GP practices in Western Sydney.</p> <ul style="list-style-type: none"> Continued implementation of the PIR/NDIS transition process. <p>Possible Options</p> <ul style="list-style-type: none"> Development of follow-up links and support options for people leaving Emergency Departments Consider options for mental health phone support, such as improvements to WS Connections helpline, NSW Mental Health Line, and improving service availability (i.e. extended hours, through night shifts). 			
Suicide prevention – particularly in Blacktown and Holroyd.	<p>Existing Programs</p> <ul style="list-style-type: none"> Priority Area 5.1 Afterhours service extension Priority Area 5.2 Men’s Shed – Mt Druitt Priority Area 5.3 On the Line – WS Connections helpline, Helpline Call back service 	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan	As per 2016-2018 Activity Work Plan

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	<ul style="list-style-type: none"> • Priority Area 5.4 Primary Mental Health Care – Service providers • Priority Area 3.2 Expansion of Psychological therapies to priority areas: Child, ATSI, Perinatal, Suicide Prevention • Development of a participatory suicide prevention modelling tool in partnership with Western Sydney University and the Sax Institute <p>Possible Options</p> <ul style="list-style-type: none"> • Consider options for mental health phone support, such as improvements to WS Connections helpline, NSW Mental Health Line, and improving service availability (i.e. extended hours, through night shifts). • Development of follow-up links and support options for people leaving Emergency Departments 	<ul style="list-style-type: none"> • The identification of the most effective suicide prevention strategies for the region. • Reduction in suicides/suicide attempts. 	<ul style="list-style-type: none"> • Increased service utilisation by vulnerable groups. • Reduction in presentations (re-presentations) to EDs • Suicide rate (long term) 	WSPHN
Variations in care – prescription rates - Data gap	<p>Possible Options</p> <ul style="list-style-type: none"> • Stakeholder consultation to determine the cause of the 		<ul style="list-style-type: none"> • Development of solutions (e.g. service provider 	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	<p>variations in mental health related prescriptions (i.e. genuine higher levels of need in certain SA3s or lower accessibility and uptake in areas with lower SES).</p> <ul style="list-style-type: none"> Investigate possible overuse of mental health related prescriptions in higher SES areas, which actually have lower levels of psychological distress. 	<ul style="list-style-type: none"> The identification of unwarranted variations in care. Reduction in over-prescribing of mental health related prescriptions. Increased access to mental health related prescriptions in lower SES areas with high need. 	<p>education programs, increased utilisation of HealthPathways).</p> <ul style="list-style-type: none"> Decreased variations in care. 	
Health Literacy Responsiveness - CALD - Government organisations - Hospitals	Possible Options <ul style="list-style-type: none"> Consumer consultation and solution design, based on the current and ongoing Consumer Needs Assessment and Ophelia (OPTimising HEalth LiterAcy process). 	<ul style="list-style-type: none"> Improved health literacy among consumers, and improved health literacy responsiveness among service providers, in particular government organisations and hospitals. 	<ul style="list-style-type: none"> Development and implementation of fit-for-purpose response strategies that optimise opportunities to improve equity in health outcomes and access. 	WSPHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Workforce capacity and capability planning	<p>Existing programs</p> <ul style="list-style-type: none"> • Priority Area 7.1 GP and Community Referral form redesign (Best Practice & Practice support) • Priority Area 7.2 Strategic and operational design of Stepped Care service delivery. • Priority Area 8.1 Regional data planning group (utilising Data and Geo-mapping tool – Interactive mental health mapping. • Priority Area 8.2 Developing a Participatory suicide prevention modelling tool (in collaboration with Sax Institute and Western Sydney University) <p>Possible Options</p> <ul style="list-style-type: none"> • Workforce and service mapping project, incorporating the National Health Service Planning Framework. 	<p>As per 2016-2018 Activity Work Plan</p> <ul style="list-style-type: none"> • Identification of current and future workforce and service gaps/deficits, oversupply, and/or distribution. • A range of strategies and programs to build confidence of local GPs to work with 	<p>As per 2016-2018 Activity Work Plan</p> <ul style="list-style-type: none"> • The development and implementation of a range of strategies to ensure current and future workforce and service gaps/deficits, oversupply, and/or distribution. • Increased service options and better health outcomes for refugees. 	<p>As per 2016-2018 Activity Work Plan</p> <p>WSPHN</p>

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	<ul style="list-style-type: none"> • Consult with GPs who work with refugees to build understanding of challenges, and solution design. • Review referral processes to develop a system of assessing wait times and areas of speciality, and referring clients to appropriate service providers, with no wait time where possible. • Address workforce capability issues, through dementia and mental health professional development programs for local geriatricians. • Consider options for mental health phone support, such as improvements to NSW Mental Health Line, and improving service availability (i.e. extended hours, through night shifts and/or improved training for current night shift staff taking calls). 	<ul style="list-style-type: none"> refugees and know who to refer for further support. • Improved referral processes. • Increased workforce capacity and capability. • Improved access to services. 	<ul style="list-style-type: none"> • Reduced waiting times. • More appropriate referrals. • Improved access to mental health services for people with dementia. 	

Section 5 - Checklist

Requirement	✓
Governance structures have been put in place to oversee and lead the needs assessment process.	Yes
Opportunities for collaboration and partnership in the development of the needs assessment have been identified.	Yes
The availability of key information has been verified.	Yes
Stakeholders have been defined and identified (including other PHNs, service providers and stakeholders that may fall outside the PHN region); Community Advisory Committees and Clinical Councils have been involved; and Consultation processes are effective.	Yes
The PHN has the human and physical resources and skills required to undertake the needs assessment. Where there are deficits, steps have been taken to address these.	Yes
Formal processes and timeframes (such as a Project Plan) are in place for undertaking the needs assessment.	Yes
All parties are clear about the purpose of the needs assessment, its use in informing the development of the PHN Annual Plan and for the department to use for programme planning and policy development.	Yes
The PHN is able to provide further evidence to the department if requested to demonstrate how it has addressed each of the steps in the needs assessment.	Yes
Geographical regions within the PHN used in the needs assessment are clearly defined and consistent with established and commonly accepted boundaries.	Yes
Quality assurance of data to be used and statistical methods has been undertaken.	Yes
Identification of service types is consistent with broader use – for example, definition of allied health professions.	Yes
Techniques for service mapping, triangulation and prioritisation are fit for purpose.	Yes
The results of the needs assessment have been communicated to participants and key stakeholders throughout the process, and there is a process for seeking confirmation or registering and acknowledging dissenting views.	Yes
There are mechanisms for evaluation (for example, methodology, governance, replicability, experience of participants, and approach to prioritisation).	Yes