Australian Government
Department of Health

phn
An Australian Government Initiative

# Northern Sydney Primary Health Network Needs Assessment 2022-2025

# Contents

*Section 1 – Executive Summary* ..... 4
*Section 2 – Outcomes of the health needs analysis*
**General Population Health**
Demography ..... 13
Health Outcomes ..... 14
Lifestyle Risk Factors ..... 15
Cancer Screening ..... 16
Impact of COVID-19 ..... 18
Childhood Immunisation ..... 19
Potentially Preventable Hospitalisations ..... 20
Aboriginal and Torres Strait Islander People ..... 22
Culturally and Linguistically Diverse (CALD) ..... 24
Socio-economic disadvantage ..... 26
Lesbian, Gay, Bisexual,Transgender and Intersex Population (LGBTI) ..... 26
Homelessness ..... 27
Older People ..... 28
**Primary Mental Health Care**
Prevalence and Suicide Prevention ..... 30
Impact of COVID-19 ..... 32
Psychosocial Support ..... 34
Young People ..... 37
Aboriginal and Torres Strait Islander People ..... 39
CALD ..... 40
Socio-economic disadvantage ..... 40
LGBTI ..... 40
Homelesness ..... 41
Older People ..... 41
Perinatal Depression and Intellectual Disability ..... 41
**Alcohol and other Drugs**
Prevalence and Mortality ..... 43
Young People ..... 45
Aboriginal and Torres Strait Islander people ..... 46
Socio-economic disadvantage ..... 47
LGBTI ..... 47
Homelessness ..... 48
Older people ..... 48
*Section 3 – Outcomes of the service needs analysis*
**General Population Health**
Service access ..... 49
Impact of COVID-19 ..... 52
Aboriginal and Torres Strait Islander people ..... 55
CALD ..... 56
LGBTI ..... 56
Homelessness ..... 57
Older People ..... 58
**Primary Mental Health Care**
Service access ..... 61
Impact of COVID-19 ..... 63
Northern Sydney Joint Reigonal Plan ..... 64
Psychosocial support ..... 67
Children and Young People ..... 70
Aboriginal and Torres Strait Islander People ..... 74
CALD ..... 75
LGBTI ..... 75

Homelessness ..... 76
Older People ..... 76
Perinatal Depression and Intellectual Disability ..... 77
**Alcohol and Other Drug**
Service access ..... 79
***References*** ..... 82
***Index*** ..... 90

# Section 1 – Executive Summary

## 1. Needs Assessment 2022-2025:

The **Northern Sydney PHN (NSPHN) Needs Assessment for 2022-2025** builds upon and compliments findings of previous Needs Assessments submitted to the Department of Health in 2016-2018, reflecting the iterative process of the commissioning and planning cycle of NSPHN.

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

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

- **Mental Health** – supporting vulnerable and hard to reach groups across the stepped care continuum (including psychosocial support and suicide prevention), with additional supports to address specific needs of young people, CALD, Aboriginal and Torres Strait Islander people.
- **Alcohol and Other Drugs –** improving access for young people and adults requiring non-residential rehabilitation and supporting a shared care approach to managing AOD misuse in primary care.
- **After hours** – improving access to after hours primary care services, including residential aged care facilities
- **Aged Care –** supporting older people in residential aged care services requiring mental health and allied health supports
- **Aboriginal Health –** Integrated Team Care
- **Lifestyle Risk Factors (Smoking, Nutrition, Alcohol, Physical Exercise, Obesity, and Social/Emotional wellbeing) –** facilitating targeted interventions for vulnerable population.

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

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

In addition to the above priorities, the NSPHN Needs Assessment 2022-2025 identified the following areas of focus:

- addressing emerging needs of the local population as the impact of COVID-19 continues to evolve
- improving access to and navigation of services in the NSPHN region, with stakeholder consultation identifying a range of barriers to accessing services across the region, particularly among vulnerable population groups

The NSPHN initial Baseline Needs Assessment 2015-2016; NSPHN Needs Assessment Updates 2016-17 and 2017-18; and NSPHN Needs Assessment 2019-2022 remain pertinent and vital resources for the PHN, **the link to the previous Needs Assessments can be found below**:

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

**Impacts of COVID-19 on health and wellbeing of the population** is a focus area of investigation for this 2022-2025 NSPHN Needs Assessment and has been informed by:

- Findings and a gap analysis of previous NSPHN Needs Assessments
- Alignment to NSPHN strategic priorities
- NSPHN Clinical and Community Council direction
- Regional consultation
- Regional data accessed through collaboration with Sax Institute

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

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

# Method:

**The latest Needs Assessment incorporates:**

- Newly released quantitative data
- New qualitative information gained from extensive stakeholder consultation – over 400 stakeholders were engaged through the consultation process between 2019-2021, including representation from a broad cross-section of the local community and service sector. Refer to page 9 for further details regarding stakeholders consulted.
- New and updated access to shared regional data, arising as a result of partnerships and collaboration with research organisations, NGO, and community sector.

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

As part of the prioritisation process, priorities identified in previous Needs Assessments were reconsidered and retained as relevant, with additional priorities added based on identified needs. Identified priorities were reviewed in consultation with the NSPHN Executive Team and nominated NSPHN Board members.

# 2. Key Areas for the 2022-2025 Needs Assessment

The following are a summary of key observations and new additions for 2022-2025 which add to the findings of previous NSPHN Needs Assessments regarding the population, health status, and health services in the region.

### Mental Health:

- Utilising modelled estimates from the National Mental Health Services Planning Framework, 24.4% of the population have a mental health need, ranging from mild to severe illness.
- 13.4% of people aged 16 years and over in the NSPHN region report high or very high psychological distress.
- Suicide death rates have remained at the same level for the previous ten years within the NSPHN region, with a high rate of suicide deaths among males.
- High rate of suicide among Aboriginal population.

### Impact of COVID-19

- Consultation with stakeholders highlighted ongoing impacts of the COVID-19 pandemic on the psychological, social, and emotional needs of the local population. Social isolation, loneliness and separation from families were identified as important precursors contributing to the mental health burden as a result of COVID-19.
- 29.8% of participants in the 45 and Up Study from the NSPHN region reported their emotional and psychological health was worse as a result of COVID-19.
- 14.8% participants in the 45 and Up Study from the NSPHN region reported missing or delaying a visit to a GP as a result of COVID-19.
- Reduced physical activity and increased sedentary behaviours, with 26.6% of participants in the 45 and Up Study from the NSPHN region reporting spending less time on overall physical activity. Consultation identified the need for support targeting parents, children, and young people.
- COVID related anxiety and availability of services were identified as key barriers to accessing health services, with identified need for increasing awareness of available services and pathways to accessing support.

- COVID-19 has facilitated the wide adoption of telehealth across services. Consultation identified the need for sustaining a mixed based approach to service delivery, combining face to face and telehealth services to address barriers specific to varying digital literacy across cohorts.
- Vulnerable groups disproportionately impacted by COVID-19, experiencing additional barriers to accessing services and need for enhanced support to address emerging needs. Vulnerable groups identified include – young people, older people, Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

**Northern Sydney Joint Regional Mental Health, Suicide Prevention, Alcohol and Other Drugs Plan**

- Targeted stakeholder consultation highlighted a need for a regional approach to community-based suicide prevention and greater service coordination across primary, secondary, and tertiary services.
- Consultations also highlighted lack of awareness of available services within the community, limited availability of specialist services for vulnerable population groups and a need to promote holistic wellbeing of clients with mental health and/or AOD issues, addressing physical, social and emotional needs.

**Psychosocial Support Needs of People with Severe Mental Illness**

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

**Youth Mental Health:**

- Nationally, approximately 14% of children aged 4-17 years were reported having a mental illness, with a higher prevalence among males. The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing was based on responses by parents or carers for children aged 4-17 years, with inclusion of self-reported responses for children aged 11 years and over.
- High rate of hospitalisations for intentional self-harm in those aged 15-24 years, with a higher rate among females, and Aboriginal population.
- Disparity in service provision and access to services across the NSPHN region, with consultations identifying need for increased support for children and young people as the impacts of COVID-19 continue to evolve.
- Awareness of mental health and ability to navigate the health system among young people, parents, schools, clinicians, and the wider community is a significant need.

**Alcohol and Other Drugs:**

- High rates of risky drinking in the Northern Beaches LGA (21.2 per 100) compared to the state (15.5 per 100) and national (16.1 per 100) rate.
- Regional variation in Hepatitis C prevalence and uptake of treatment
- Consultations highlighted limited availability of services skilled in addressing co-occurring alcohol and other drug issues within the community.

**Cancer Screening:**

- Variation in breast and cervical cancer screening rates within NSPHN region, with lower rates in Ryde LGA compared to the NSPHN and NSW average.
- Low bowel cancer screening rates across the region, with lower rates among females compared to males.

**Childhood Immunisation:**

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

**Aboriginal and Torres Strait Islander People:**

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

**Health of older people:**

- Geographic hotspots of high population growth in those aged 65+ years.
- The complex needs of an ageing population will impose an increasing demand on healthcare services within the NSPHN region, including the need for appropriate palliative care services within the region.
- Growing CALD population in the region facing additional language and cultural barriers to accessing aged care services.
- Low proportion of those aged 75+ years receiving annual health check.
- Stakeholder consultation identified need for additional support in navigating local services and to address declining physical function as the impacts of COVID-19 continue to evolve.

**Culturally and Linguistically Diverse (CALD) Populations:**

- Higher proportion of CALD population in NSPHN (25.7%) compared to NSW (21%), with the 2016 Census data highlighting a growing CALD population within the NSPHN region, concentrated in specific geographic areas.
- Lower cancer screening rates and specific health literacy needs.
- CALD groups present for a range of mental health and health needs, with a higher risk of suicidal behaviours among humanitarian entrants.
- Consultation with stakeholders also highlighted a need for promoting awareness of available supports and COVID-19 vaccination.

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

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

**Socio-economic disadvantage:**

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

**Climate and Health**

- Climate change significantly impacts people's health and wellbeing, including both direct and indirect impacts.
- Nationally, the prevalence of post-traumatic stress disorder/major depressive disorder or severe distress was 3.9 times higher in communities highly impacted by the 2009 Black Saturday bushfires compared to those less impacted.

- Consultations identified the need for supporting the community and primary care workforce to anticipate climate risks and mitigate impacts of climate change on health and wellbeing.

## 3. Consultation process:

NSPHN has undertaken extensive stakeholder consultation and engagement during the development of the Needs Assessment – providing a rich source of additional qualitative input to inform service planning in the region. Targeted consultation was undertaken throughout 2019 and 2020 to inform development of the Northern Sydney Joint Regional Mental Health, Suicide Prevention and Alcohol and Other Drugs Plan. Additional consultation was also undertaken in 2021 to inform the development of the Needs Assessment 2022-2025. Consultations were undertaken through different modes including group-based discussions, surveys, and one-on-one interviews.

Over 400 stakeholders were engaged through the consultation process between 2019-2021 and included representation from a broad cross-section of the local community and service sector, including the following:

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

The 2022-2025 Needs Assessment also builds upon findings from previous consultation and engagement undertaken during commissioning co-design sessions.

## Data Analysis:

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

- Australian Bureaus of Statistics (ABS) key reports and datasets:
    - Census of Population and Housing, 2016
    - Causes of deaths data, 2021
    - Estimated Resident Population, 2020
    - Household Impacts of COVID-19 Surveys, 2020 and 2021
- Australian Government - Department of Health key reports and datasets:
    - National Mental Health Service Planning Framework (NMHSPF) (2021) - NMHSPF Planning Support Tool (NMHSPF-PST)
    - The Fifth National Mental Health and Suicide Prevention Plan (2017)
    - Health workforce data tool (2021)
- Australian Institute of Health and Welfare (AIHW) key reports and datasets:
    - GEN (AIHW) - People using aged care services 2021
    - Suicide and self-harm-monitoring datasets
    - AIHW analysis of National Hospital Morbidity Database 2015-16, 2014-15 and 2013-14
    - AIHW analysis of the Medicare Benefits Schedule 2010-11 to 2020-21
    - AIHW analysis of National Drug Strategy Household Survey 2019
- MBS claims data 2012-17

- Northern Sydney District Homelessness Project 2016
- NSW Cancer Institute- NSW Cancer Incidence and Mortality Data Set 2017
- NSW Cancer Institute- Reporting for Better Cancer Outcomes Performance Report 2021: Northern Sydney Primary Health Network
- NSW Department of Planning and Environment- Population Projections, 2019
- NSW Health Centre for Epidemiology and Evidence: NSW combined patient epidemiology data 2001-2020; NSW Population Health Survey
- PAT CAT data (regional general practice data) January 2022
- Public Health Information Development Unit (PHIDU) 2018-2021: Social Health Atlases of Australia
- Sax Institute – 45 and Up Study: Analysis of COVID-19 specific questions of the 2020 follow-up survey limited to respondents in the NSPHN region. 5,219 respondents aged 55 years and over within the NSPHN region. Refer to page 89 for further detail regarding the Sax Institute's 45 and up Study.
- Sydney North Primary Health Network (SNPHN) Integrated Mental Health Atlas 2017
- NSPHN Internal database (2021)
- National Primary Mental Health Care Minimum Data Set 2021
- Consultation with stakeholders including SNHN Climate and Health Stakeholder workshop, Northern Sydney Joint Regional Mental Health, Suicide Prevention and Alcohol and other Drugs Plan workshops
- The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing
- National Survey of Mental Health and Wellbeing 2007
- Literature review – journal articles and published reports

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

## Future Considerations:

NSPHN will continue to review and monitor available quantitative and qualitative data annually to identify changing needs and emerging priorities, reflecting the iterative process of the commissioning and planning cycle of NSPHN. NSPHN will undertake ongoing evaluation of approach to developing the Needs Assessment to inform future iterations.

## Conclusion:

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

Population cohorts, geographic hot spots and specific health issues exist and impact the public health profile of the region. There are issues relating to the impact of the social determinants of health, such as access to and navigation of primary care services, stress, and addiction have been further exacerbated as a result of the COVID-19 pandemic and have subsequent impacts on health outcomes across cohorts. Additionally, with an ageing demographic, significant challenges arise for the older population, compounded further by the ongoing impacts of COVID-19 on social isolation and declining physical function.

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

criteria as common barriers to accessing services in the NSPHN region. COVID related anxiety and availability of health services have emerged as key barriers to accessing health services.

Analysis highlights the ongoing mental health burden of the COVID-19 pandemic, with loneliness, social isolation, and separation from families identified as important precursors. Consultation identified the need to expand community-based initiatives to address social isolation and support navigation of services, with a focus on older people, young people, people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander people. Consultation also highlighted a need for community-based initiatives to be developed in collaboration with the local community, facilitated through an asset-based community development approach, leveraging existing strengths within the community.

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

Analysis also highlights underreporting of Aboriginal status by health service providers and limited availability of Aboriginal workers in the region. There is also a significant proportion of the NSPHN population who are physically inactive. Hotspots with higher prevalence of obesity, cohorts with higher smoking rates, and low consumption of the recommended daily intake of fruit and vegetables across the population have both immediate and long-term impacts on health and wellbeing. There are discrete cohorts who do not access preventative and screening measures in the areas of childhood immunisation and cancer screening.

Increasing awareness of health impacts of climate change across the community and supporting the primary care workforce to respond to emergencies continues to evolve as an emerging need.

NSPHN continues to implement the ***Commissioning Evaluation Framework***, which is based on the Quadruple Aim, as a method for evaluating the impact of commissioned services. The Framework supports NSPHN to address elements of needs as identified in this needs assessment and continues to provide an additional source of data to inform subsequent Needs Assessments and planning.

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

# Section 2 – Outcomes of the health needs analysis

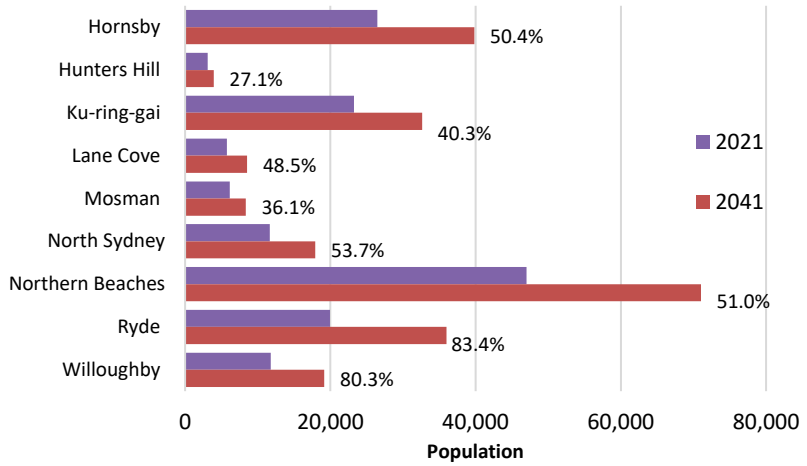
## General Population Health

### Summary:

NSPHN's Needs Assessment utilises the latest qualitative and quantitative data to highlight significant health needs within the region including a focus on the impact of COVID-19 on health and wellbeing across the region. The analysis identifies increased financial distress, physical inactivity, increased sedentary behaviours, and vulnerable population groups disproportionately impacted by the COVID-19 pandemic.

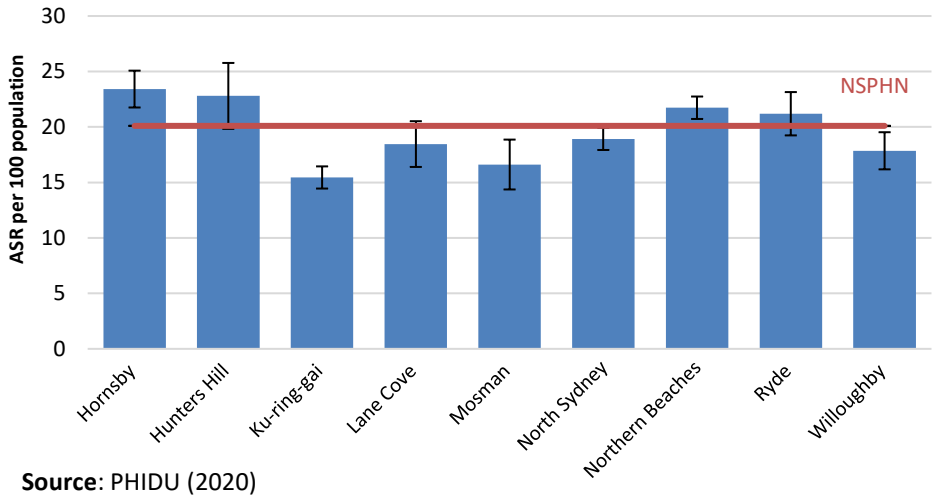
Needs identified in the previous NSPHN Needs Assessments continue to be pertinent - substantial growth in aged and CALD populations, hotspots with greater prevalence of obesity, a need to reduce potentially preventable hospitalisations and population cohorts with complex needs. Where possible, this latest Needs Assessment profile provides an update to relevant data for vulnerable and hard to reach populations and reflects the latest available data for cancer screening, childhood immunisation and potentially preventable hospitalisations.

**Projected change in population aged 65+ years by LGA, 2021 to 2041**




**Source:** NSW Department of Planning and Enviroment (2019)

**Obesity prevalence (modelled estimates) in population 18 years and over by LGA, 2017-18**




**Source**: PHIDU (2020)

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| **Demography** | | |
| Ageing population | In the NSPHN region, 16.4% of the population is aged 65+ years.<br><br>The NSPHN 65+ years population is projected to increase by 53.7% between 2021-2041, with an estimated increase of 85,003 residents aged 65+ years by 2041. | **Quantitative evidence:**<br>• 16.4% of the population aged 65+ years in the NSPHN region compared to 16.7% for NSW (ABS 2021).<br>• Between 2021-2041, Ryde (80.3%) and Willoughby (62.8%) LGAs have a higher projected increase in the population aged 65 years and over compared to NSPHN (53.7%). The projected increases in Ryde and Willoughby also exceed the projected increase for NSW (58.9%) (NSW Department of Planning, Industry and Environment 2019).<br>• Whilst 65+ years is the current standard definition of older people, NSPHN will undertake further analysis to review definitions, reflective of increasing life expectancy and impacts of healthy ageing. |
| Ageing population | Healthcare for older people will remain an increasing priority for the NSPHN region, with a rise in chronic disease and comorbidity. The complex needs of an ageing population will impose an increasing demand on healthcare services.<br><br>Successful navigation and access to the health and aged care system is critical for the NSPHN 65+ years population. Older people in the region can face financial barriers to accessing services, previous Needs Assessments highlighted asset rich but income poor cohorts of older people in the region. Navigating the complex aged care system is also a barrier, with a growing CALD population in the region facing additional language and cultural barriers to accessing aged care services. | The Needs Assessments utilises a range of data sources and stakeholder consultation to highlight the health needs of an ageing NSPHN population. Please refer to the relevant description of evidence for specific ageing population health and service needs throughout the document. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| **Health outcomes** | | |
| Premature mortality | Higher rate of premature mortality among males compared to females in the NSPHN region. | **Quantitative evidence:**<br>• Premature mortality rates among males in the NSPHN region 178 per 100,000 (95% CI: 172-184) compared to 118 per 100,000 (95% CI: 114-123) among NSPHN females (2015-19) (PHIDU 2021).<br>• Rates of premature mortality are lower compared to NSW males (297 per 100,000; 95% CI: 294-299) and NSW females (180 per 100,000; 95% CI: 178-182) (PHIDU 2021).<br>• Premature mortality is defined as the average annual aged-standardised rates of death from all causes, per 100,000 population aged 0-74 years. |
| Premature mortality | Cancer is the main cause of premature mortality in the NSPHN region, followed by circulatory system diseases. | **Quantitative evidence:**<br>• 47.9% of premature deaths in the NSPHN region attributed to cancer, with 16.8% of all premature deaths attributed to lung, colorectal and breast cancers (2015-19) (PHIDU 2021).<br>• According to the Cancer Institute NSW, NSPHN has a higher incidence of breast cancer, prostate cancer and melanoma compared to NSW (Cancer Institute NSW 2020). |
| Disability | 3.7% of the NSPHN population have severe or profound disability, measured within the Census using the 'core activity need for assistance' variable developed by the Australian Bureau of Statistics (ABS). The proportion of those with profound or severe disability has remained at the same level within the region, compared to the 2006 and 2011 Census. | **Quantitative evidence:**<br>• 3.7% of the population have a need for assistance with core activities, lower compared to NSW (5.4%). More than 32,000 people in the region have profound or severe disability (ABS 2016).<br>• **Severe disability** is defined as a person sometimes needing help with a core activity task (communication, mobility or self-care). **Profound disability** is defined as a person always needing help with a core activity task. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| **Lifestyle Risk factors- Physical inactivity, hotspots with higher prevalence of obesity and low proportion of the NSPHN population consuming the recommended intake of fruits and vegetables.** | | |
| Smoking | An estimated 56,880 people aged 18 years and over are current smokers within the NSPHN region. | **Quantitative evidence:**<br>• Smoking prevalence is lower in the NPSHN region (7.9 per 100; 95% CI: 7.4-8.4) compared to NSW (14.4 per 100; 95% CI:14.1-14.6) (2017-18). Smoking remains the leading preventable cause of death and disease in Australia (PHIDU 2021; AIHW 2020f).<br>• Higher smoking prevalence in Aboriginal, socio-economically disadvantaged and LGBTI populations. Please refer to pages 22-28 for further detail. |
| Nutrition | Low proportion of children and adults consuming the recommended intake of fruits and vegetables | **Quantitative evidence:**<br>• Within the NSPHN region, 8.2% (95% CI: 5.3-11) of adults and 5.3% (95% CI: 2.4-8.3) of children had the daily recommended intake of **vegetables** compared to 5.9% (95% CI: 5.2-6.7) of adults and 5.2% (95% CI: 4.1-6.3) of children in NSW (2019-20) (HealthStats 2021).<br>• 42.7% (95% CI: 37.9-47.4) of adults and 64.8% (95% CI: 57.3-72.3) of children consumed the daily recommended intake of **fruits** compared to 40.3% of adults (95% CI: 38.6-42) and 64.2% (95% CI: 61.7-66.7) of children in NSW (2019-20) (HealthStats 2021). |
| Physical activity | A significant proportion of adults in the NSPHN region are not undertaking adequate physical activity.<br><br>Please refer to page 23-25 for specific needs within Aboriginal and CALD groups. | **Quantitative evidence:**<br>• In 2020, 31.9% (95% CI: 27.2-36.6) of the NSPHN population 16 years and over did not undertake adequate physical activity, compared to NSW (38.3%; 95% CI: 36.6-40) (HealthStats 2021).<br>• Whilst the proportion in NSPHN has decreased over the past 10 years from 41.1% in 2010 to 31.9% in 2020, a significant proportion continue to be below the threshold for adequate physical activity (HealthStats 2021).<br>• Adequate physical activity for persons aged 18 to 64 years is defined as undertaking moderate intensity exercise for a total of at least 150 minutes per week over 5 separate occasions (HealthStats 2021). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| Obesity | High prevalence of obesity in Hornsby and Northern Beaches LGAs.<br><br>High prevalence of obesity also identified at a lower geographic level (SA2) within Ryde and Hornsby LGAs.<br><br>Limited data available to determine cohorts with high need, to allow provision of targeted local interventions. | **Quantitative evidence:**<br>• Rates of obesity were higher in the Hornsby LGA (23.4 per 100, 95% CI: 21.8-25.1) and the Northern Beaches LGA (21.7 per 100; 95% CI: 20.7-22.7) compared to NSPHN (20.1 per 100; 95% CI: 19.6-20.6) (2017-18) (PHIDU 2021).<br>• North Ryde-East Ryde/Ryde-Putney (26.6 per 100; 95% CI:22.5-30.8), Hornsby/ Waitara - Wahroonga (West) (24.7 per 100; 95% CI: 20.7-28.7) and Asquith-Mount Colah/Berowra-Brooklyn-Cowan (24.4 per 100; 95% CI: 21-27.9) have higher rates compared to NSPHN (2017-18) (PHIDU 2021). |
| **Cancer Screening - Variation in breast and cervical cancer screening rates within NSPHN region and low bowel cancer screening rates across the region.** | | |
| Breast cancer | Higher incidence of breast cancer in NSPHN female population compared to NSW. | **Quantitative evidence:**<br>• Breast cancer incidence 128 per 100,000 for NSPHN female population compared to 124 per 100,000 for NSW (2017) (Cancer Institute NSW 2021a). |
| Breast cancer screening | Regional variation in breast cancer screening rates. | **Quantitative evidence:**<br>• Breast cancer screening rates were lower in Mosman (41.1 per 100; 95% CI: 39.8-42.5), Ryde (44.8 per 100; 95% CI: 44-45.6), and North Sydney (46.8 per 100; 95% CI 45.8-47.8) compared to NSPHN (48.5 per 100; 95% CI: 48.2-48.8) and NSW (49.4 per 100; 95% CI: 49.3-49.5) in 2019-20 (Cancer Institute NSW 2021b). |
| Cervical cancer screening | Lower rates of cervical cancer screening in Ryde LGA.<br><br>The National Cervical Cancer Screening Program changed in December 2017 from a biennial Pap test to HPV test every five years. Latest available data is for 2015-17, capturing biennial cervical cancer screening rates. | **Quantitative evidence:**<br>• Cervical cancer screening rates for NSPHN women aged 20-69 years (62.7 per 100; 95% CI: 62.5-62.9) highest in NSW (55.9 per 100; 95% CI: 55.8-55.9).<br>• Screening participation rates in Ryde (54.6 per 100; 95% CI: 54.1-55.1) lower than both NSW and NSPHN (Cancer Institute NSW 2018). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| Bowel cancer screening | Lower screening rates of bowel cancer in Ryde and Mosman. Latest data is available for 2020. | **Quantitative evidence:**<br>• Bowel cancer screening rates for NSPHN population aged 50-74 years (34.8 per 100; 95% CI: 34.6-35.1) lower than NSW (36.3 per 100; 95% CI: 36.3-36.4) (Cancer Institute NSW 2021b).<br>• Bowel cancer screening rates in North Sydney (24.9 per 100; 95% CI: 24.1-25.7%), Mosman (28.8 per 100; 95% CI: 27.6-29.9), and Willoughby (30.2 per 100; 95% CI: 29.5-30.9) LGAs was lower compared to NSPHN (Cancer Institute NSW 2021b).<br>• Bowel cancer screening rates lower among NSPHN females aged 50-74 years (34.2 per 100; 95% CI: 33.9-34.6) compared to NSPHN males (35.6 per 100; 95% CI: 35.2-35.9) and NSW females (37.1 per 100; 95% CI: 37-37.2). The rates for NSPHN males aged 50-74 years was similar to NSW males (35.6 per 100; 95% CI: 35.4-35.7).<br>• Bowel cancer screening participation rates increase with age for both males and females in NSPHN and NSW (Cancer Institute NSW 2021b). |
| | | **Qualitative evidence:**<br>Consultation has highlighted higher rates of colonoscopy could potentially impact bowel cancer screening rates within the region. Currently screening rates are based solely on results under the National Bowel Cancer Screening Program. Further access to regional data required to understand the impact of colonoscopy on screening rates. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| **Impact of COVID-19 – Physical inactivity, increased sedentary behaviours, reduced breast cancer screening rates and increased financial distress.** | | |
| Physical Activity | Reduced physical activity and increased sedentary behaviours compared to pre-COVID-19 pandemic levels. Physical activity is an important risk factor in preventing or reducing overweight and obesity, and chronic disease (AIHW 2017c). | **Quantitative evidence:**<br>• Respondents from the 45 and Up Study residing in the NSPHN region reported reductions in physical activity compared to pre-COVID-19 (SNHN 2021):<br>  ○ 26.6% reported spending less time on overall physical activity<br>  ○ 25.3% reported spending more time watching TV<br>**Qualitative evidence:**<br>• Consultation with local stakeholders identified reliance on screen-based technologies and its associated negative impact on physical activity was exacerbated further as a result of COVID-19, particularly among children and young people. Identified need to support parents in accessing professional help to support their children. |
| Breast Cancer Screening | Wait times to access breast cancer screening. | **Qualitative evidence:**<br>• According to the AIHW (2020b), breast cancer screening was impacted by COVID-19 restrictions, with number of mammograms declining nationally between Jan-Jun 2020, compared to Jan-Jun 2018. Whilst data is not available at a regional level, consultation with stakeholders in the region identified high wait times for accessing breast cancer screening following easing of COVID-19 restrictions. Consultation identified increasing awareness about the importance of timely screening as an area of ongoing focus for NSPHN. |
| Financial Stress | Increased financial stress compared to pre-COVID-19 pandemic levels. | **Quantitative evidence:**<br>• Data from the 45 and Up Study highlighted that 36.6% of respondents from the NSPHN region aged 55 years and over reported they were worse off financially as a result of COVID-19 (SNHN 2021).<br>• Nationally, data from household impact surveys highlighted a greater impact on household finances during lockdown period with 16% of respondents aged 18 years and over reporting household finances had worsened in September 2020 (ABS 2020b). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| Domestic Violence | Financial instability and access to secure housing. | **Qualitative evidence:**<br>• Consultation with stakeholders identified that women and children experiencing domestic violence often experience financial instability and access to stable/secure housing, with the need exacerbated further because of COVID-19 restrictions. |
| Vulnerable groups | Vulnerable groups disproportionately impacted by COVID-19 requiring additional support. | **Qualitative evidence:**<br>• Consultation identified the following groups at risk and requiring additional support – older people, Aboriginal and Torres Strait Islander people, people from CALD backgrounds, and people experiencing homelessness/at risk of homelessness. Refer to page 56-58 for needs specific to vulnerable groups. |
| **Childhood Immunisation – Childhood immunisation rates in children aged two and five years lower than the national aspirational target, with regional variation in rates.** | | |
| Childhood Immunisation | NSPHN childhood immunisation rates lower than the national aspirational target of 95%, with rates remaining at the same level for the previous eight years. Latest data at an LGA level available for 2020-21.<br><br>NSPHN continues to work closely with the National Centre for Immunisation research and surveillance (NCIRS) to update the immunisation register and with the Public Health Unit to increase immunisation rates in the region by supporting general practice to implement targeted initiatives. | **Quantitative evidence:**<br>• Immunisation rates for NSPHN children aged one year 95.4%, compared to 94.8% for NSW.<br>• Immunisation rates for NSPHN children aged two years 93.0% compared to 92.5% for NSW.<br>• Immunisation rates for NSPHN children aged five years 94.2% compared to 95% for NSW (NSW Ministry of Health 2021a). |
| Childhood Immunisation | Regional variation in childhood immunisation, with lower immunisation rates in Northern Beaches, Mosman, North Sydney, Willoughby, and Ryde LGAs. | **Quantitative evidence:**<br>• Lower immunisation rates for children aged one year in Northern Beaches (94.0%), Hunters Hill (94.6%), and Lane Cove (95%) LGAs in 2020-21.<br>• Lower immunisation rates for children aged two years in Ryde (91.0%), Northern Beaches (92.3%), and Willoughby (92.4%) LGAs in 2020-21.<br>• Lower immunisation rates for children aged five years in Mosman (91.7%) and North Sydney (92.2%) LGAs in 2020-21 (NSW Ministry of Health 2021a). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| **Potentially Preventable Hospitalisations (PPH) – Lower rate of PPHs in the NSPHN region compared to NSW, with regional variation in rates.** | | |
| Potentially Preventable Hospitalisations (PPH) | Rate of PPHs lower for the NSPHN region compared to NSW, with a higher rate in Hornsby and Northern Beaches LGA.<br><br>NSPHN has finalised a data sharing agreement with the Northern Sydney Local Health District (NSLH) to access relevant data to further inform service planning, including generating general practice-level informative data and to identify NSPHN's impact on local hospital avoidance rates. | **Quantitative evidence:**<br>• In 2019-20, the rate of PPHs for NSPHN 1,569 per 100,000 (95% CI: 1,545-1,593) compared to 1,989 per 100,000 (95% CI: 1,980-1,998) for NSW. Dental Conditions, cellulitis and urinary tract infections accounted for 36.2% of potentially preventable hospitalisations in NSPHN (HealthStats 2021).<br>• The rate of PPH in 2019-20 (1,569 per 100,000; 95% CI: 1,545-1,593), is similar to 2014-15 (1,579 per 100,000; 95% CI: 1,553-1,604) (HealthStats 2021). Changes in the rate of PPH is driven by a range of factors including prevalence of disease, coding standards for hospitalisations and access to primary healthcare.<br>• Whilst lower than NSW, Hornsby (1,858 per 100,000; 95% CI: 1,829-1,889) and Northern Beaches (1,778 per 1,761-1,795) LGA had a higher rate of PPH compared to other LGAs in NSPHN; remaining at similar rates compared to the last 10 years. |
| Potentially Preventable Hospitalisations (PPH) | Higher rate of PPH among people in the most socio-economically disadvantaged quintile (20%) of the population. | **Quantitative evidence:**<br>• In the most disadvantaged quintile of the NSW population, the PPH rate 2,437 per 100,000 (95% CI: 2,414-2,461) is higher compared to people in the least disadvantaged quintile (1,590 per 100,000; 95% CI: 1,572-1,609) in 2019-20 (HealthStats 2021), which suggests that there may be a potential need within Ryde, Hornsby and Northern Beaches LGAs which have pockets of socio-economic disadvantage (ABS 2018b). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| **Climate and Health – Exacerbated health risks as a result of climate change, impacting the physical and mental wellbeing of the community.** | | |
| Climate and Health | Physical and mental health impacts of climate change including direct and indirect impacts.<br><br>Climate change refers to the changing weather pattern tracked over a long period of time, this may include rising average temperatures, increased frequency of extreme weather events, and rising sea levels (AIHW 2020d). | **Qualitative evidence:**<br>• Climate change may impact human health through different pathways, for example directly through extreme weather events such as storms, floods, bushfires, droughts, and heatwaves (SNHN 2020a).<br>• Health impacts from bushfires include immediate effects of death and trauma from the fires, as well as exacerbations of some respiratory and cardiovascular conditions (AIHW 2020d). A follow-up study of psychological outcomes five years after the 2009 Black Saturday bushfires found that 22% of people who had been in communities highly affected by the fires were suffering probable post-traumatic stress disorder (PTSD), major depressive episode or severe distress, compared with 5.6% of people who had been in regions that were less affected by the fires (Bryant et al. 2018).<br>• Increased frequency of heatwaves during summers compared to previous decades and exposure to ultraviolet radiation impacting hospitalisations and deaths and prevalence of melanoma nationally (AIHW 2020d). Nationally, an estimated 15,200 news cases of melanoma were diagnosed in 2019, compared to 8,700 cases in 2000. Mortality associated with melanoma has also increased between 2019 and 2000, with 1,700 deaths attributed to melanoma in 2019 and 970 deaths in 2000 (AIHW 2020d).<br>• Climate change can also impact human health indirectly by impacting ecosystems and environment which can result in worsening air and water quality, agricultural losses, changing patterns of disease, decreases in social and community wellbeing (SNHN 2020a).<br>• Consultation with stakeholders across the region have identified a need for increasing awareness of health impacts of climate change across the community. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| Climate and Health | Climate change exacerbates existing health inequalities with some groups placed at greater risk of the negative health and social impacts of climate change. | **Qualitative evidence:**<br>• Key vulnerable groups identified include - Aboriginal and Torres Strait Islander communities, older people, CALD communities, migrants, refugees, homeless people, those living in low-lying flood or bushfire-prone areas, low-income earners, people with disabilities, and children (AIHW 2020d; Watts et al. 2015; SNHN 2020a). |
| Climate and Health | Altered demand of services, with identified need of expanding health workforce capability and capacity in response to emergencies. | **Qualitative evidence:**<br>• Exacerbated health risks from climate change creates increased demand and pressure on the health care system; emphasising the need for workforce expansion, development, and sustainability. |
| **Vulnerable population groups** | | |
| **Aboriginal and Torres Strait Islander People** | | |
| Underreporting of Aboriginal and Torres Strait Islander status | Underreporting of Aboriginal status by service providers leading to lack of Aboriginal-specific programs. Widely reported throughout the region that health professionals do not ask patients regarding their Aboriginal identity. There are significant regional issues relating to a hidden population and the Stolen Generation, with cohorts of the population who do not always self-identify their ethnicity – which impacts on ability to access available health care provision.<br><br>The **Integrated Team Care** NSPHN commissioned service supports the local Indigenous population who have chronic disease and works closely with general practice to enhance culturally appropriate services to improve patient outcomes, and to support identification of Aboriginal status. | **Qualitative evidence:**<br>Stakeholder consultation identified under reporting of Aboriginal status by health care professionals in the region, highlighting that the question is not always asked, and when it is, there is a need to ask respectfully and in a culturally appropriate manner. Underreporting of Aboriginal status leads to lack of Aboriginal specific health and community services for Aboriginal residents in the region, with only one Aboriginal-specific GP clinic in the region operating one day per week. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| Cancer screening rates for Aboriginal and Torres Strait Islander women | Low breast cancer screening rates among Aboriginal women in NSPHN region. | **Quantitative evidence:**<br>• Breast cancer screening rates among Aboriginal women aged 50-74 in the NSPHN region 35.2 per 100 (95% CI: 29.8-40.6) compared to 48.5 per 100 (95% CI: 48.2-48.8) for all women aged 50-74 years in the NSPHN region (2019-20) (Cancer Institute NSW 2021b). |
| Aboriginal and Torres Strait Islander lifestyle behaviours | High smoking prevalence. | **Quantitative evidence:**<br>• In NSW, 22.9% (95% CI: 13.4-32.4) of Aboriginal people report smoking daily; higher compared to non-Aboriginal people (9.2%; 95% CI:8.2-10.2) (2020) (HealthStats 2021). |
| Aboriginal and Torres Strait Islander lifestyle behaviours | High prevalence of overweight and obesity | **Quantitative evidence:**<br>• In NSW, 37.6% (95% CI: 27.3-47.8) of Aboriginal people were classified as obese; higher compared to non-Aboriginal people (22.1%; 95% CI: 20.7-23.5) (2020) (HealthStats 2021) .<br>• In NSW, 66% (95% CI: 55.1-76.8) of Aboriginal people were classified as overweight or obese, compared to non-Aboriginal people (56.7%; 95% CI: 54.9-58.4) (2020) (HealthStats 2021). |
| Aboriginal and Torres Strait Islander lifestyle behaviours | Insufficient physical activity | **Quantitative evidence:**<br>• In 2020, 49.3% (95% CI: 38.5-60.1) of Aboriginal people aged 16 years and over in NSW did not engage in sufficient levels of physical activity, compared to non-Aboriginal people (37.9%; 95% CI: 36.2-39.6) (HealthStats 2021).<br>• Sufficient physical activity has been defined as undertaking moderate intensity physical activity for a total of at least 150 minutes per week over 5 separate occasions (HealthStats 2021). |
| Chronic disease in Aboriginal and Torres Strait Islander population | High prevalence of chronic disease. | **Quantitative evidence:**<br>• Nationally, chronic diseases contribute to 64% of the disease burden among Aboriginal people and 70% of the gap in health outcomes between Aboriginal and non-Aboriginal people (AIHW 2016).<br>• Nationally, cardiovascular diseases and cancer contribute to 21.9% of the total disease burden among Aboriginal people (AIHW 2016). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| **Culturally and linguistically diverse (CALD)** | | |
| CALD population | Growing CALD population within the NSPHN region with specific geographies that have a higher proportion of CALD groups. | **Quantitative evidence:**<br>• According to the 2016 Census, NSPHN has a larger proportion of people from culturally and linguistically diverse backgrounds (25.7%) compared to NSW (21.1%), increasing from 22.1% in 2011.<br>• Chinese, Indian and South Korean are the largest CALD groups within NSPHN. Similar to the national trend, the proportion of people born in China and India has increased compared to the 2011 Census.<br>• Within NSPHN, Ryde has the highest proportion of its population from a CALD background (42%), increasing from 36.5% in 2011, with 47.7% of the total population in Ryde speaking a language other than English.<br>• Mandarin, Cantonese, and Korean are the most commonly spoken languages in the NSPHN region. |
| Health needs | There is a subsequent need to develop culturally appropriate interventions to cater for the diverse health needs of the growing CALD population within the region.<br><br>Limited availability of national and local data to understand the complexities of the multiple CALD groups within the region, who have differing health needs and experiences of accessing and utilising primary care. | **Qualitative evidence:**<br>• Complex health needs of CALD groups can be attributed to the distinct needs of each CALD group (RACGP 2011).<br>• Cultural beliefs and expectations influence how consumers define health and illness, impacting their decision making in how and when healthcare services are accessed (NSW Ministry of Health 2019). There are specific barriers to accessing health services which subsequently impact the health status of CALD groups. Please refer to page 56 for further detail.<br>• Further investigation needed to understand health issues prevalent within different / specific CALD groups to identify issues that can be managed within primary care in a culturally appropriate manner. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| Risk factors | Higher rate of smoking, physical inactivity, and diabetes among Chinese Australians. | **Quantitative evidence:**<br>• According to Jin et al (2017), findings from the 45 and Up Study highlight that Chinese Australians have 22% higher rates of smoking, 48% higher rate of physical inactivity and 25% higher rate of diabetes compared to non-Chinese Australians (Jin et al. 2017).<br>• Limited data available to identify the prevalence of these risk factors in the local Chinese population which is the largest CALD group within the Northern Sydney region, accounting for 5.8% of the total population. |
| Cancer screening in CALD population | Low breast cancer screening rates among CALD women. Lower rates among CALD women in Mosman and Northern Beaches LGAs. | **Quantitative evidence:**<br>• In NSPHN, breast cancer screening rates among CALD women aged 50-74 was 39.7 per 100 (95% CI: 39.2-40.2) compared to 51.7 per 100 (95% CI: 51.4-52) for non-CALD women aged 50-74 years (2019-20) (Cancer Institute NSW 2021b).<br>• Breast cancer screening rates among CALD women in Mosman (34.1 per 100; 95% CI: 30.3-38) and Northern Beaches (35.6 per 100; 95% CI: 34.3-36.8) is lower compared to NSPHN (39.7 per 100; 95%CI: 39.2-40.2) and NSW (39.3 per 100; 95% CI: 39.1-39.5) (Cancer Institute NSW 2021b). |
| At risk and hard to reach CALD populations | Higher rates of domestic violence reported in families from CALD backgrounds. Further investigation needed to determine which CALD groups are most likely to be impacted, with a need to deliver culturally appropriate services to the relevant CALD populations. | **Qualitative evidence:**<br>Consultations with service providers highlighted domestic violence in families from CALD backgrounds, not specific to new migrants and humanitarian entrants. This issue is exacerbated by social isolation, poverty, poor awareness of services and limited health literacy. |
| Refugee population | Refugee population within the region with significant and complex health issues. | **Qualitative evidence:**<br>Northern Sydney currently has Tibetan and Syrian humanitarian entrants residing within the region with specific health needs and barriers to accessing services. Further work is required to understand true population numbers and health needs. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| **Socio-economic disadvantage** | | |
| Socio-economic disadvantage | Pockets of socio-economic disadvantage. | **Quantitative evidence:**<br>Pockets of disadvantage within the region, concentrated in Ryde, Hornsby and Northern Beaches LGAs (ABS 2018b). |
| Smoking | Higher prevalence of smoking among people in the most disadvantaged quintile. | **Quantitative evidence:**<br>In NSW, daily smoking prevalence is higher among people in the most disadvantaged quintile (17.7%; 95% CI: 14.6-20.9) compared to those in the least disadvantaged quintile (5%; 95% CI: 3.5-6.5) (2019) (HealthStats 2020). |
| Life expectancy | Lower life expectancy among people in the most disadvantaged quintile. | **Quantitative evidence:**<br>For NSW, life expectancy among people in the most disadvantaged quintile (81.2 years) is 4.8 years lower compared to those in the least disadvantaged quintile (86 years) (2018) (HealthStats 2020). |
| **Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) population** | | |
| LGBTI population | NSPHN LGBTI population with specific lifestyle behaviours and health issues. | **Quantitative evidence:**<br>An estimated 23,000 LGBTI people (2-3% of the total population) live within the NSPHN region (ACON n.d.). |
| LGBTI lifestyle behaviours | High smoking prevalence among LGBTI population. | **Quantitative evidence:**<br>• Nationally, whilst there has been a decrease in daily smoking rates among homosexual/bisexual Australians from 25.7% in 2010 to 16.7% in 2019; there continues to be a higher prevalence among homosexual/bisexual Australians compared to heterosexual Australians (10.8%) (AIHW 2020a). Smoking prevalence escalates to:<br>○ 44% among transgender men<br>○ 35% among transgender women (Berger and Mooney-Somers 2015)<br>○ 23.5% among lesbian/bisexual/queer women aged 16-24 years (Mooney-Somers et al. 2018) |

| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| LGBTI sexual health | Screening behaviours poorer among homosexual, bisexual, and queer women. | **Quantitative evidence:**<br>21% of 1,272 women surveyed through Sydney Women and Sexual Health (SWASH) study never had a pap smear and 37% never underwent STI screening despite the vast majority being sexually active (Mooney-Somers et al. 2018). |
| LGBTI sexual health | Higher risk of HIV and Hepatitis C due to high-risk sexual practices as well as drug usage patterns (De Wit et al. 2014). | **Quantitative evidence:**<br>• Nationally, the self-reported HIV prevalence among gay and bisexual men participating in the Gay Community Periodic Surveys was 7.9% in 2017 (Kirby Institute 2018).<br>• Male-to-male sex continues to be the major HIV risk exposure in Australia, with 76.2% (2019) of newly diagnosed HIV infections in NSW among men who have sex with men (Kirby Institute 2018; NSW Ministry of Health 2021b).<br>• Despite the high rate of newly diagnosed infections, HIV education and prevention initiatives by Aids Council of NSW (ACON) have contributed to greater knowledge about HIV testing and awareness among gay and homosexual men (ACON 2015). |
| **People experiencing homelessness** | | |
| Homelessness | A cohort in the NSPHN region homeless or at risk of being homeless, with significant and complex health issues. | **Quantitative evidence:**<br>The 2016 Census estimated 2,130 people to be homeless in the NSPHN region with the largest numbers in Neutral Bay/Kirribilli and Macquarie Park/Marsfield (Statistical Area Level 2) (ABS 2018a). Northern Sydney District Homeless Project snapshot of contacts made to organisations in the region seeking a service found (NSLHD 2016):<br>• 56.2% of clients recorded as homeless compared to 41.2% being at risk.<br>• Single men and women most likely to contact services, followed by families with children. Majority of 'families with children' consisted of single mothers.<br>• 3.3% of clients identified as Aboriginal and 17.2% as CALD. |

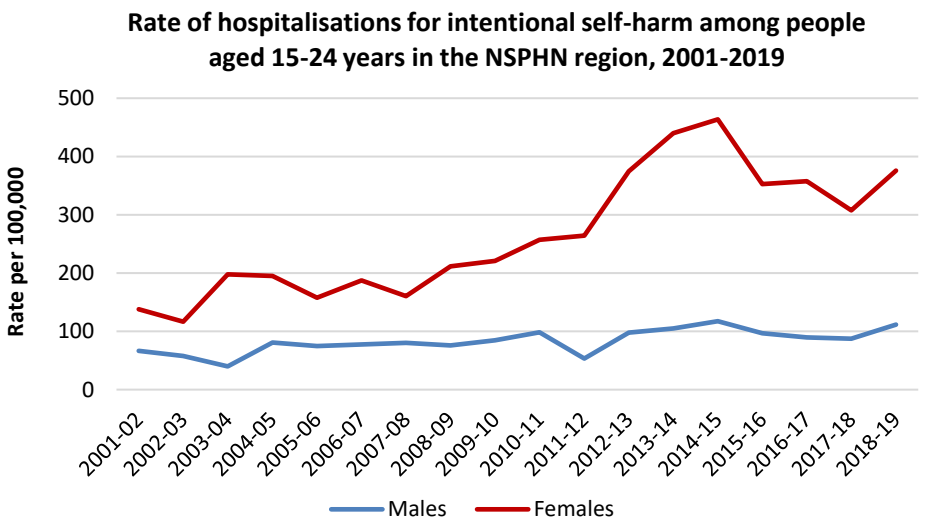
| Outcomes of the health needs analysis | | |
|---|---|---|
| **Identified Need** | **Key Issue** | **Description of evidence** |
| Homelessness | Access to secure and affordable housing. | **Quantitative evidence:**<br>• A snapshot of homelessness in the region identified the most common presenting issue as financial stress (54%), with mental health (38%) and domestic violence (38%) also featuring predominately (NSLHD 2016).<br>• 28.8% of low-income families experience financial stress from mortgage or rent in the NSPHN region (NSW: 29.3%) with higher rates in Ryde (37.2%), Willoughby (34.1%) and North Sydney (33%) LGAs (PHIDU 2018). |
| Homelessness | Risk of poorer outcomes | **Qualitative evidence:**<br>• Although there is a lack of national data pertaining to the prevalence rate of smoking amongst homeless persons, a 1995-1996 Melbourne based study reported that 77% of the 238 homeless people surveyed were current smokers (Kermode et al 2008).<br>• A high rate of smoking amongst this group is problematic because homeless persons may adapt their smoking behaviours to save money (i.e. sharing cigarettes and smoking from used cigarette butts or filters), potentially exposing themselves to greater health risks (AIHW 2018). |
| **Older people** | | |
| Health of older people | Higher rate of fall-related injury hospitalisations within NSPHN region compared to NSW, with a higher rate among females compared to males.<br><br>Dementia hospitalisations rates within the NSPHN region increase with age, a similar trend is evident for NSW (HealthStats 2020). | **Quantitative evidence:**<br>• Whilst the prevalence of falls among people aged 65 years and over within NSPHN (22.1%; 95% CI: 14.9-29.3) is comparable to NSW (22.7%, 95% CI: 20.4-25) (2015), the rate of fall-related injury hospitalisations (3,528 per 100,000; 95% CI: 3,439-3620) is higher in the NSPHN region compared to NSW (2,997 per 100,000; 95% CI: 2,967-3026) (2018-19) (HealthStats 2020). Disaggregating the rates further by gender, rates are higher for both NSPHN males and females compared to NSW males and females respectively (HealthStats 2020).<br>• The rate of hospitalisations among NSPHN females (4,014 per 100,000; 95% CI: 3886-4146) is higher compared to NSPHN males (2,918 per 100,000; 95% CI: 2,794-3045), indicating a greater burden among females (2018-19) (HealthStats 2020). |

# Primary Mental Health Care (including Suicide Prevention)

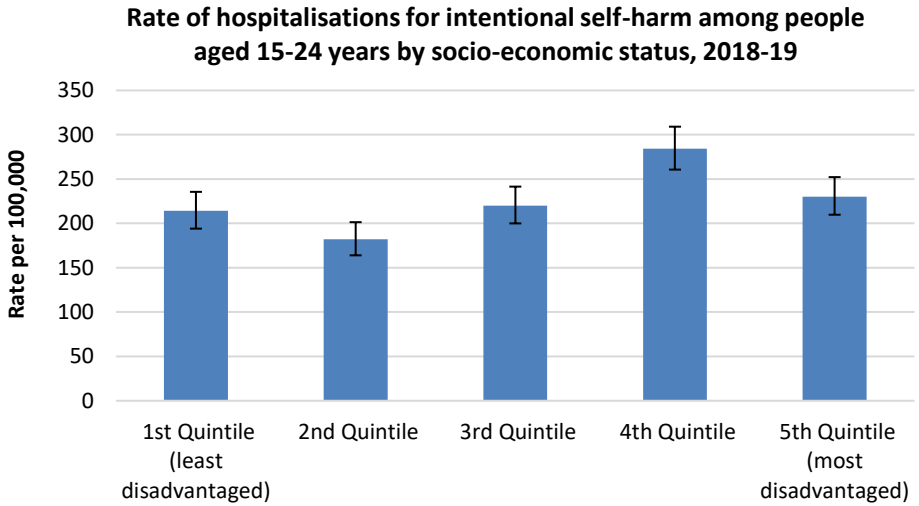
## Summary

The NSPHN Needs Assessment utilises available qualitative and quantitative data to highlight the impact of mental illness across the NSPHN population with a focus on the impacts of COVID-19. The 2022-25 Needs Assessment identifies high levels of psychological distress; precursors for the mental health burden as a result of COVID-19 pandemic including social isolation and separation from families; and increased complexities of mental illness with population cohorts disproportionately impacted by the pandemic.

Findings from the previous Needs Assessments continue to remain valid and identified higher rates of distress among Aboriginal and Torres Strait people, higher rates of intentional self-harm among young people, impacts of social determinants on youth experiences of mental health, specific needs among other vulnerable and hard to reach cohorts, and psychosocial support needs of people with severe and complex mental illness. The following analysis builds upon previous findings to identify mental health needs within the NSPHN region, with relevant data updated where possible.




**Source**: HealthStats (2020)




**Source:** HealthStats (2020)

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Prevalence and Suicide Prevention** | | |
| Prevalence of mental illness across the spectrum of severity | Stratification of the population into different 'needs groups', ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions is important in understanding the different service responsibilities within the **stepped care approach** (DoH 2017b)**.** | **Quantitative evidence:**<br>• Applying national estimates to the NSPHN population, an estimated 24.4% of the total population have a mental health need ranging from mild to severe (ABS 2021b; NMHSPF 2021). This translates to approximately:<br>○ 15.8% (150,557) with mild mental illness.<br>○ 6.1% (58,691) with moderately severe mental illness.<br>○ 2.5% (23,945) with severe mental illness |
| Prevalence of mental illness | Depression and anxiety account for the largest proportion of diagnosed mental health conditions. | **Quantitative evidence:**<br>• 13.4% (95% CI: 9.7-17) of people aged 16 years and over report high or very high psychological distress in the NSPHN region, similar to NSW (16.7%; 95% CI: 15.4-18.1) in 2020 (HealthStats 2021).<br>• Anxiety and depression are one of the most managed mental health conditions in general practice**,** accounting for 48.7% of mental health related encounters in general practice (AIHW 2017d), consultation with local GPs estimates that the prevalence is higher. |
| | | • Data from 186 NSPHN GP practices extracted through PATCAT estimates the prevalence of mental health conditions at 10.9 per 100, with depression and anxiety accounting for the largest proportion of mental health conditions (January 2022). The data is limited to active patients of GP practices in the NSPHN region. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Suicide prevention | Suicide death rates have remained at the same level for the previous ten years. Higher suicide death rates have been identified at a lower geographic level (SA3) within the NSPHN region. | **Quantitative evidence:**<br>• 82 deaths due to suicide in the NSPHN region in 2020 averaging one death from suicide every four and a half days.<br>• Suicide death rate within the NSPHN region 8.2 per 100,000, lower than the NSW rate of 10.5 per 100,000 (2020) (AIHW 2021h).<br>• Suicide death rates have remained at the same level in NSPHN over the past 10 years – 8.3 per 100,000 in 2010 compared to 8.2 per 100,000 in 2020.<br>• In 2016-2020, Hornsby (10.9 per 100,000) and North Sydney – Mosman (9.3 per 100,000) SA3s had higher suicide death rates compared to the NSPHN region. The rates are similar to NSW (9.4 per 100,000) and the national rate (10.9 per 100,000) (AIHW 2021h).<br>• Suicide rates are influenced by coronial processes, methodologies in defining and determining cases of 'intentional self-harm' in hospital records and procedures for coding deaths data. Limited availability of local data to identify burden across age groups. |
| Suicide prevention | High rate of death by suicide amongst males. | **Quantitative evidence:**<br>• In 2019, rate of deaths from suicide among NSW males (17.5 per 100,000; 95% CI: 16.2-18.8) was 3.3 times higher than the rate for NSW females (5.3 per 100,000; 95% CI: 4.6-6) (HealthStats 2021).<br>• Males aged 45-54 years had the highest rate of suicide deaths in NSW: 28.3 per 100,000 (95% CI:23.8-33.4) compared to 17.5 per 100,0000 among males of all ages (2019) (HealthStats 2021). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Impact of COVID-19 – Ongoing impacts of COVID-19 pandemic on the psychological, social and emotional needs of clients, with increased complexities of presentations.** | | |
| Prevalence of mental illness | Mental health and social/emotional wellbeing continue to be a key priority, with ongoing impacts of the COVID-19 pandemic on psychological, social and emotional needs of individuals. | **Quantitative evidence:**<br>• Results from the 45 and Up Study in the SNHN region indicating impacts on mental health and social isolation (SNHN 2021):<br>  ○ 29.8% of respondents reported their emotional and psychological health was worse as a result of COVID-19<br>  ○ 23.6% of respondents reported that they miss having people around as a result of COVID-19<br>• Nationally, 20% of Australians experienced high or very high levels of psychological distress in June 2021, similar to March 2021 (20%) and November 2020 (21%) (ABS 2021a), but higher than 12.9% in 2017-18 (PHIDU 2021).<br>• Loneliness was identified as the most commonly experienced personal stressor due to COVID-19, with women almost twice as likely to have felt lonely as men (28% compared with 16%) (ABS 2020a).<br>**Qualitative evidence:**<br>• Consultation with psychologists within the region identified isolation, job security, financial stress, domestic violence, and substance abuse as key emerging issues of concern.<br>• Stakeholder consultation also identified social isolation as a key stressor for mental health, with people being conditioned to social isolation as a result of lockdowns. The impact of social isolation was particularly exacerbated for those who are unvaccinated and unable to engage socially despite easing of restrictions.<br>• Separation from families was identified as another precursor contributing to the mental health burden as a result of the COVID-19 pandemic particularly among people from CALD backgrounds. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Prevalence of mental illness | Increased complexity of clients accessing services | **Qualitative evidence:**<br>A survey administered to psychologists within the region indicated clients presented with a range of complex mental health needs requiring long term interventions/additional interventions. Consultations with stakeholders also identified additional focus on addressing broader needs of people experiencing mental health disorders, including physical health needs. |
| Vulnerable groups | Cohorts identified within the region experiencing a greater mental health burden and requiring additional support. | **Qualitative evidence:**<br>Identified vulnerable groups include – young people, people from CALD backgrounds, Aboriginal and Torres Strait Islander people and older people. Please refer to page 70-76 for needs and barriers to accessing support for identified vulnerable groups. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Psychosocial support needs for people with mental illness – Comorbid physical health conditions, risk of social isolation, difficulty in accessing secure housing and lower rates of labour force participation among people with mental illness highlights need for support beyond clinical services.** | | |
| Supporting psychosocial needs of people with severe mental illness | Many people diagnosed with severe mental illness experience additional impacts on their social and emotional functioning, physical health and participation in the community.<br><br>Individuals with severe mental illness and reduced psychosocial functional capacity who currently are unable to access support through the NDIS or other state-based programs will require support through the Commonwealth Psychosocial Support program.<br><br>For people to meet the threshold to access NDIS support they must:<br>• have an impairment or condition that is likely to be permanent (i.e. it is likely to be lifelong) and<br>• have an impairment that substantially reduces their ability to participate effectively in activities, or perform tasks or actions unless they have:<br>  ○ assistance from other people or<br>  ○ assistive technology or equipment (other than common items such as glasses) or<br>  ○ you can't participate effectively even with assistance or aides and equipment and<br>• have an impairment that affects their capacity for social and economic participation and<br>• are likely to require lifetime support under NDIS | **Quantitative evidence:**<br>• An estimated 2.1% of the total population have a severe – not complex mental illness, this equates to approximately 19,576 people within the NSPHN region who require psychosocial support (ABS 2021b; NMHSPF 2021; DoH 2018).<br>• Vulnerable and hard to reach population groups experiencing barriers to accessing NDIS services are the potential target cohorts for the Commonwealth Psychosocial Support program. Please refer to page 68 for further detail on cohorts experiencing barriers to accessing NDIS services. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Impact of mental illness | Morbidity associated with mental illness. | **Quantitative evidence:**<br>Mental illness and substance use disorders accounted for 23.7% of the total non-fatal burden of disease (2018), making it the second largest contributing disease group, emphasising the impact of mental health and substance use disorders on quality of life. Years of life lost due to disability (YLD) owing to a health condition was used as a marker to measure the non-fatal burden. YLD is measured by number of years of 'healthy' life lost due to living with a disability (AIHW 2021a). |
| Physical wellbeing of people with mental illness | Co-morbid physical health conditions impacting health outcomes of people with mental illness. | **Quantitative evidence:**<br>• Data from 186 NSPHN GP practices extracted through PATCAT estimates 38.3% of patients aged 15 years and older with a mental health condition were also diagnosed with a co-morbid physical health condition in one or more of the following categories: diabetes, respiratory, cardiovascular, and/or renal impairment (SNHN 2022).<br>• Underdiagnosis of physical health conditions among people with mental illness and lower rates of treatment for physical health conditions impacts quality of life. Co-morbid physical health conditions are a contributor to lower life expectancy (DoH 2017c) among people experiencing severe mental illness with cardiovascular disease being a common cause of premature mortality (De Hert et al 2011). |
| Social Isolation | Risk of social isolation among people with mental illness. | **Qualitative evidence:**<br>• Mental illness can impact the ability to maintain relationships with friends, family and acquaintances, making individuals susceptible to risk of social isolation with a greater risk among those who have been hospitalised (Rickwood 2006).<br>• According to the 2010 National Survey of Psychotic Illness, social isolation, lack of employment and financial problems were highlighted as key challenges among people living with psychotic illness (Morgan et al. 2011). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Accessing and maintaining secure housing | Challenges in accessing secure housing | **Qualitative evidence:**<br>Severity of symptoms, financial disadvantage, and stigmatisation predispose individuals with mental illness to homelessness with outcomes exacerbated for those with severe mental illness (Costello, Thomson and Jones 2013), co-morbid alcohol, and other drug issues (Rickwood 2006).<br>**Quantitative evidence:**<br>In NSW, 36.1% of clients presenting to specialist homelessness services with mental illness had previously experienced an episode of homelessness in the last 12 months, highlighting the need to prevent repeated cycles of homelessness (AIHW 2020e). |
| Maintaining employment | Lower rates of labour force participation | **Quantitative evidence:**<br>Nationally in 2017-18, 32.2% of people with a self-reported mental illness aged 15-64 did not participate in the labour force compared to 17% of people aged 15-64 without a mental illness (ABS 2018c). |
| Carer/family support | Greater risk of adverse outcomes for people with severe mental illness necessitates the need for psychosocial support. | **Qualitative evidence:**<br>Outcomes related to co-morbidities with physical health conditions, social isolation, housing, and employment can potentially be worse off among people with severe mental illness. The repercussions are not limited to persons with mental illness but also creates economic and social burden for carers and families who are the primary source of ongoing support and recovery for persons with severe mental illness (AIHW 2017c). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Vulnerable Population Groups** | | |
| **Young People** | | |
| Prevalence | Higher prevalence of mental illness among males and adolescents. | **Quantitative evidence:**<br>• According to the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing, nationally, approximately 13.9% of children aged 4-17 years were reported as having a mental illness in the previous 12 months. The survey was based on responses by parents or carers for children aged 4-17 years with inclusion of self-reported responses for children aged 11 years and over when available. Applying the national estimates to the NSPHN population, approximately 21,000 children were estimated to have a mental illness in the previous 12 months.<br>• Higher prevalence (16.3%) among males compared to females (11.5%).<br>• 14.4% of children aged 12-17 years report having a mental illness in the past 12 months compared to 13.6% of children 4-11 years (Lawrence et al. 2015). |
| Prevalence of severe mental illness among young people | 2.1% of children aged 4-17 years have a severe mental disorder (Lawrence et al. 2015). | **Quantitative evidence:**<br>Applying the national estimates to the NSPHN population, approximately 3,100 children were estimated to have severe mental illness. |
| Prevalence based on social determinants of health | Higher prevalence of mental illness among children living in step, blended and single parent families. | **Quantitative evidence:**<br>18.3% of children in stepfamilies, 20.2% in blended families and 22.4% in single parent families report having a mental illness in the past 12 months compared to 10.4% of children in original families (Lawrence et al. 2015). Potential need within Northern Beaches LGA which has a higher proportion of step, blended and single parent families compared to NSPHN (ABS 2016b). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Prevalence based on social determinants of health | Higher prevalence of mental illness among children living in socio-economically disadvantaged families. | **Quantitative evidence:**<br>20.7% of children living in families in the most disadvantaged quintile report having a mental illness in the past 12 months, higher compared to children living in families in the least disadvantaged quintile (10.9%) (Lawrence et al. 2015). Potential need in Ryde LGA which is ranked as the most socio-economically disadvantaged LGA within NSPHN (ABS 2018b). |
| Self-harm in young people | High rate of intentional self-harm in those aged 15-24 years, with a higher rate of hospitalisations among females and higher rate of deaths among males. | **Quantitative evidence:**<br>• Higher rate of hospitalisations due to intentional self-harm among those aged 15-24 years within NSPHN region - 241 per 100,000 (95% CI: 213-272) compared to 69.3 per 100,000 (95% CI: 63.9-75.1) for all ages (2018-19) (HealthStats 2020).<br>• The rate of self-harm hospitalisations among females aged 15-24 within NSPHN has increased from 211 per 100,000 in 2008-09 (95% CI: 173-255) to 376 per 100,000 in 2018-19 (95% CI: 326-431), higher compared to the increase among NSPHN males aged 15-24 within the same time period (75.9 per 100,000, 95% CI: 54.2-103 in 2008-09 to 112 per 100,000, 95% CI: 85.7-143 in 2018-19) (HealthStats 2020).<br>• For NSW, age-specific death rate for intentional self-harm in those aged 15-24 years is 12 per 100,000. The rate among males (17.8 per 100,000) was higher compared to females (5.7 per 100,000) (2019) (ABS 2021c). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Aboriginal and Torres Strait Islander people** | | |
| Aboriginal and Torres Strait Islander people | Direct and indirect effects of the Stolen Generations, poor access to preventative health care, and higher rates of social disadvantage impact rates of psychological distress amongst the Aboriginal and Torres Strait Islander community. | **Qualitative evidence:**<br>• Stakeholder consultations highlighted that mental health issues related to the stolen generation are faced by the Aboriginal population in the NSPHN region. Poor access to preventative health care and higher rates of social disadvantage impact rates of psychological distress amongst the Aboriginal and Torres Strait Islander community.<br>• Consultations have also highlighted the need to gain a better understanding of the diversity of Aboriginal communities within the region to further understand and address health needs and service gaps. |
| Aboriginal and Torres Strait Islander people | Higher rate of hospitalisations for mental health disorders among Aboriginal people compared to non-Aboriginal people. | **Quantitative evidence:**<br>For NSPHN, higher rate of hospitalisations for mental health disorders among Aboriginal people 2,956 per 100,000 (95% CI: 2,880-3,033) compared to 1,785 per 100,000 (95% CI: 1,775-1,794) for non-Aboriginal people in NSPHN (2019-20) (HealthStats 2021). |
| Suicide in Aboriginal and Torres Strait Islander people | Higher rates of suicide among Aboriginal people compared to non-Aboriginal people. | **Quantitative evidence:**<br>• Suicide rates among Aboriginal people across NSW – 19.5 per 100,000 (95% CI: 16.8-22.6) compared to 10.6 per 100,000 for non-Aboriginal people (95% CI: 10.3-10.9) (2015-19) (HealthStats 2021). |
| Self-harm in young Aboriginal and Torres Strait Islander people | Higher rate of hospitalisations due to intentional self-harm among Aboriginal people aged 15-24 years compared to non-Aboriginal people. | **Quantitative evidence**:<br>• Rates of hospitalisations in NSW for intentional self-harm among 15-24 years old Aboriginal people 411 per 100,000 (95% CI: 359-469) compared to 265 per 100,000 (95%CI: 213-233) for non-Aboriginal people (2018-19) (HealthStats 2020).<br>• The rates of intentional self-harm among Aboriginal people aged 15-24 years in NSW has remained relatively stable between 2013-14 (442 per 100,000; 95% CI: 385-506) and 2018-19 (411 per 100,000: 95% CI: 359-469) (HealthStats 2020). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Culturally and linguistically diverse (CALD)** | | |
| Prevalence of mental illness in CALD population | Complex presentations in CALD groups within the NSPHN region. | **Qualitative evidence:**<br>Stakeholder consultation highlighted the complexities of mental health need and service provision for CALD groups in the NSPHN region. CALD groups presenting for a range of mental health and health needs e.g. trauma, migration, career change, physical health, social isolation, and separated families. |
| Suicide prevention in CALD population | Higher risk of suicidal behaviours among humanitarian entrants. | **Qualitative evidence:**<br>Overrepresentations in acute services are related to lower service utilisation, greater stigma related to mental health, limited knowledge about available services as well as language and cultural barriers (MHiMA 2014). |
| **Socio-economic disadvantage** | | |
| Self-harm in socio-economically disadvantaged population | Higher rates of intentional self-harm in socio-economically disadvantaged population. | **Quantitative evidence:**<br>• For NSW, rate of intentional self-harm in the most disadvantaged quintile (106 per 100,000; 95% CI: 101-112) and the second most disadvantaged quintile (122 per 100,000; 95% CI: 116-128) were higher in 2018-19 compared to the least disadvantaged quintile (67.8 per 100,000; 95% CI: 63.8-72.1) (HealthStats 2020). |
| **Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) population** | | |
| Prevalence of mental illness in LGBTI population | Elevated risk of anxiety, depression, self-harm, and suicide compared to non-LGBTI population. This risk is further elevated in LGBTI people from CALD backgrounds.<br><br>Suicidal ideation higher among young LGBTI people, partly due to higher rates of violence and harassment (beyondblue 2010). | **Quantitative evidence:**<br>• An Australian study (Ritter, Matthew-Simmons and Carragher 2012) has found that LGBTI people are:<br>○ 2.9 times more likely to experience post-traumatic stress disorder<br>○ 2.4 times more likely to experience social phobia.<br>○ 1.7 times more likely to experience major depression<br>○ 4.1 times more likely to attempt suicide |

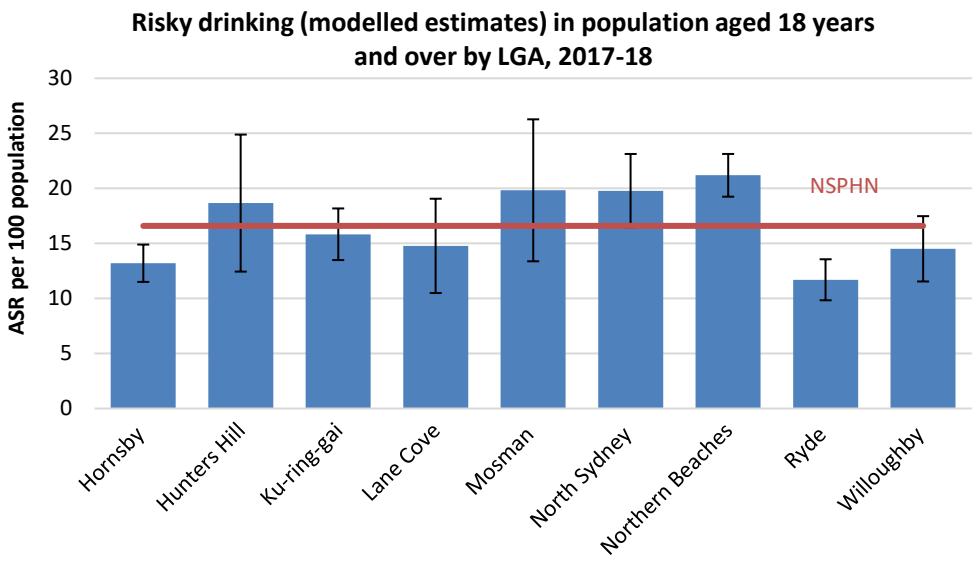
| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **People experiencing homelessness** | | |
| Homelessness | High prevalence of mental health issues in homeless population. | **Quantitative evidence:**<br>• A snapshot of homelessness in the NSPHN region identified that 38% of contacts seeking a homeless service related to mental health issues (NSLHD 2016). Similarly, 36.1% of people in NSW accessing specialist homelessness services reporting a current mental health issue in 2019-20 (AIHW 2020e). |
| **Older People** | | |
| Mental health of older people | Mental health issues among older people in residential care facilities. Nationally, males aged 85+ years have higher rates (36.2 per 100,000) of suicide in 2020 compared to other age-groups (ABS 2021c). | **Quantitative evidence:**<br>• According to the Mental Commission of NSW (2017), approximately 50% of older people living in residential aged care facilities report mild, moderate, or severe symptoms of depression (Mental Health Commission of NSW 2017). |
| **Other vulnerable population groups** | | |
| Prevalence of perinatal depression | 20% of Australian mothers experience depression, with 10% of mothers diagnosed with depression in the perinatal period. | **Quantitative evidence:**<br>• Nationally, young mothers (under 25 years), mothers who smoke, mothers from low-income households, and mothers who are overweight or obese are at greater risk of experiencing perinatal depression (AIHW 2012). |
| Prevalence of perinatal depression | Stigma associated with perinatal depression. | **Qualitative evidence:**<br>Stakeholder consultation highlighted stigma attached to perinatal depression for women in the NSPHN region, with women being underdiagnosed and falling through gaps in service provision. |
| People with intellectual disability | Approximately 3% of Australians are diagnosed with intellectual disability (ABS 2014). | **Quantitative evidence:**<br>• Comorbidity with mental disorders especially psychiatric and mood disorders are very common. However, diagnosis of these disorders are often difficult especially among people with speech difficulties (Simpson 2012).<br>• Nationally, 57% of people with intellectual disability also have psychiatric disability (AIHW 2008). |

# Alcohol and Other Drug Treatment Needs

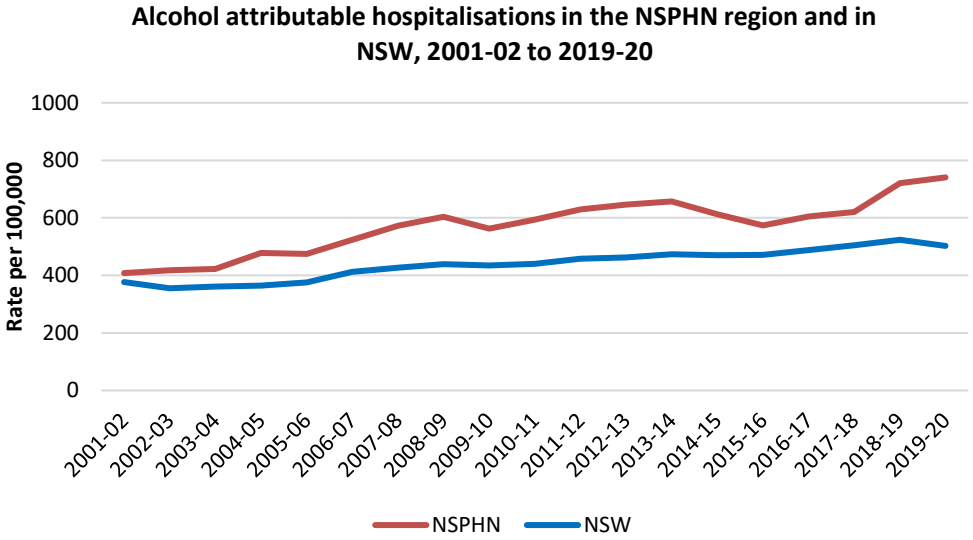
## Summary

NSPHN's Alcohol and Other Drugs (AOD) Needs Assessment builds upon previous AOD Needs Assessments to identify vulnerable cohorts and geographic hotspots of need within the NSPHN region. The analysis indicates higher rates of risky drinking, illicit drug use and alcohol attributable hospitalisations and regional variation in prevalence of Hepatitis C.

Needs identified in previous NSPHN Needs Assessments continue to remain pertinent including high rates of illicit drug use among Aboriginal males, binge drinking in young people, hidden drinking in CALD groups, increasing use of ice and polysubstance abuse in young people, and population cohorts with specific needs. The following analysis builds upon previous findings to identify AOD needs across population cohorts utilising the latest qualitative and quantitative data.




**Source**: PHIDU (2021)




**Source:** HealthStats (2021)

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Prevalence and mortality** | | |
| Alcohol consumption | Higher rate of risky drinking in Northern Beaches LGA. | **Quantitative evidence:**<br>• According to the Australia Health Survey (2017-18), higher rate of people aged 18 years and over consuming more than two standard drinks per day on average in Northern Beaches LGA (21.2 per 100; 95% CI: 19.2-23.1) compared to Australia (16.1 per 100; 95% CI: 16.1-16.1) and NSW (15.5 per 100; 95% CI: 15.2-15.7) (PHIDU 2021). |
| Alcohol consumption | Higher rate of alcohol attributable hospitalisations compared to NSW. Females and males in the NSPHN region have the highest rate of alcohol attributable hospitalisations in NSW. | **Quantitative evidence:**<br>• NSPHN's rate of alcohol attributable hospitalisations 741 per 100,000 (95% CI: 724-758) compared to 503 per 100,000 (95% CI: 498-508) for NSW (2019-20).<br>• NSPHN males (816 per 100,000; 95% CI: 791-842) and females (673 per 100,000; 95% CI: 651-696) have the highest rate of alcohol attributable hospitalisations in NSW (2019-20) (HealthStats 2021).<br>• Limited availability of local data to identify underlying causes of alcohol attributable hospitalisation including the impact of better access to private healthcare and prevalence of alcohol consumption on rates of hospitalisations. |
| Alcohol consumption | North Sydney and Northern Beaches LGAs have a high rate of alcohol attributable hospitalisations in the region.<br><br>NSPHN continues to work with the Northern Sydney Local Health District (NSLHD) to access data that identifies areas and cohorts with higher rates of alcohol related hospitalisations. | **Quantitative evidence:**<br>• All NSPHN LGAs had a higher spatially adjusted rate of alcohol related hospitalisations compared to the NSW rate (513 per 100,000; 95% CI: 510-518) in 2018-2020. North Sydney LGA (918 per 100,000; 95% CI: 881-958) and Northern Beaches LGA (836 per 100,000; 95% CI: 826-847) had the highest spatially adjusted rates in the NSPHN region (HealthStats 2021).<br>• The rate of liquor offences in North Sydney (131 per 100,000) was 1.15 times higher than the rate for NSW (114 per 100,000) in 2018-20 (BOCSAR 2021). Alcohol related crimes are influenced by a range of factors including policing; regulations around liquor licences and, recording, reporting and classification of offences (BOCSAR 2017). Limited availability of local data to draw inferences about the impact of prevalence of alcohol consumption on alcohol related crime. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Alcohol consumption | Cultural acceptance of alcohol. | **Qualitative evidence:**<br>Stakeholder consultation highlighted the cultural acceptance of alcohol can create challenges in identifying a need to seeking help, highlighting people are able to be high functioning and often not seeking help until entering the criminal justice system or other crises. |
| AOD misuse- population prevalence | The National Drug and Alcohol Clinical Care and Prevention (DA-CCP) tool estimates the prevalence of alcohol and other drugs misuse disorder to provide an understanding of the health needs of the population which can inform subsequent planning of AOD services (Ritter et al. 2014). | **Quantitative evidence:**<br>Applying the national estimates from the DA-CCP tool to the NSPHN regional population, it can be estimated that approximately 124,400 people residing within NSPHN exhibited alcohol and other drug misuse in the past 12 months. This can be further stratified into:<br>• 84,300 with alcohol misuse<br>• 6,200 with amphetamine misuse<br>• 4,500 with benzodiazepine misuse<br>• 21,900 with cannabis misuse<br>• 7,500 with opioids misuse |
| AOD mortality | Drug related deaths within the NSPHN region | **Quantitative evidence:**<br>• Between 2015-19, 274 drug related deaths occurred within the NSPHN region (5.6 per 100,000), with the highest rates in Warringah and Pittwater SA3s (Penington Institute 2021).<br>• Further analysis is required to understand the underlying causes and confounders of drug related deaths and identify cohorts that are at greater risk of drug related mortality. |
| Illicit drug use | Significant increase in hospitalisations due to methamphetamine usage in NSPHN region. Latest data available is from 2019-20. | **Quantitative evidence:**<br>• The rate of methamphetamine related hospitalisations in the NSPHN region has increased significantly over the last 6 years from 25.8 per 100,000 (95% CI: 22.1-30) in 2013-14 to 109 per 100,000 (95% CI: 102-117) in 2019-20 (HealthStats 2021).<br>• NSPHN had a lower rate of methamphetamine related hospitalisations in 2019-20 (109 per 100,000; 95% CI: 102-117) compared to NSW (155 per 100,000; 95% CI: 151-158) (HealthStats 2021). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Illicit drug use | Higher methamphetamine use among males. | • In NSW, the rate of methamphetamine hospitalisations was significantly higher for males aged 16 years and older at 211 per 100,000 (95% CI: 206-216) compared to females (98.8 per 100,000; 95 CI: 95.2-102) in 2019-20 (HealthStats 2021).<br>• In NSW, the rate of methamphetamine hospitalisations was the highest for people aged 35-44 years (282 per 100,000; 95%CI: 272-292) in 2019-20 (HealthStats 2021). |
| Hep C prevalence | Variation in prevalence of Hep C across SA3s in the region. | • Manly (0.48%) and Pittwater (0.46%) SA3s had the highest prevalence of Hep C, compared to the NSPHN rate (0.36%) (MacLachlan, Stewart and Cowie 2021). |
| **Vulnerable Population Groups** | | |
| **Young people** | | |
| Illicit drug use among young people | Overrepresentation of people aged 16-34 years in methamphetamine related hospital admissions and ED presentations. | **Quantitative evidence:**<br>• Nationally in 2019, higher proportion of young people aged 20-29 years reported using illicit drugs in the last 12 months (30.6%) compared to other age groups (range: 7.2-19.1) (AIHW 2020c).<br>• In 2019-20, hospitalisations for people aged 16-34 years in NSW accounted for 47.5% of all methamphetamine related hospitalisations and 52.9% of all methamphetamine related ED presentations in 2020-21 (HealthStats 2021). |
| Steroid use among young men | Increasing steroid use among young men. | **Quantitative evidence:**<br>In 2016, 30.6% of young people aged 15-19 years in NSW highlighted that they were extremely concerned or very concerned about their body image (NSW Ministry of Health 2017). |
| Steroid use among young men | Increasing steroid use among young men and subsequent impacts on ED presentations. | **Qualitative evidence:**<br>Stakeholder consultations highlighted growing perception of 'self-image' among young men is contributing to increasing prevalence of steroid use with combined steroid and methamphetamine usage imposing a burden on ED presentations. Consultation identified social media, advertising projecting 'ideal' body types and peer pressure as potential drivers. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Aboriginal and Torres Strait Islander people** | | |
| Alcohol consumption in Aboriginal and Torres Strait Islander population | Higher rate of alcohol related hospitalisations | **Quantitative evidence:**<br>• Higher rate of hospitalisations for alcohol among Aboriginal people (933 per 100,000; 95% CI: 888-980) compared to non-Aboriginal people (482 per 100,000; 95% CI: 478-487) in 2019-20 (HealthStats 2021).<br>• The prevalence of daily or weekly alcohol consumption among Aboriginal people across NSW was lower compared to estimates among non-Aboriginal people in 2019-20. However, among Aboriginal people aged 16 years and older, those who drink engage in risky drinking posing long-term risk to health (41.5%; 95% CI: 31.2-51.8) compared to the non-Aboriginal population (32.1%; 95% CI: 30.4-33.9) in 2020 (HealthStats 2021).<br>• Limited availability of data to evaluate the impact of drinking patterns on the rate of alcohol related harm and hospitalisation. |
| Illicit drug use in Aboriginal and Torres Strait Islander population | Higher usage of illicit substances among Aboriginal population, particularly among Aboriginal males. | **Quantitative evidence:**<br>• Nationally, 23.3% of Aboriginal people reported using illicit drugs in the last 12 months compared to 16.6% of non-Aboriginal people (2019) (AIHW 2020c).<br>• Cannabis is the most commonly used illicit drug with 15.5% of Aboriginal people reporting cannabis use in the past 12 months compared to 12% of non-Aboriginal people (AIHW 2020c).<br>• Nationally, 36.7% of Aboriginal males reported using illicit substances compared to 21.1% of Aboriginal females (AIHW 2020a).<br>• Nationally, higher rate of accidental drug related deaths among Aboriginal people (20.0 per 100,000) compared to non-Aboriginal people (5.9 per 100,000) (2019) (Penington Institute 2021). |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Socio-economic disadvantage** | | |
| Alcohol related mortality in socio-economically disadvantaged population | Higher rate of alcohol attributable deaths among those who are socio-economically disadvantaged. | **Quantitative evidence:**<br>In NSW, the rate of alcohol attributable deaths was higher among people in the most disadvantaged quintile (25 per 100,000; 95% CI: 23.4-26.7) compared to those in the least disadvantaged quintile (14.4 per 100,000; 95% CI: 13.2-15.6) in 2018-19 (HealthStats 2021). |
| **Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) population** | | |
| Alcohol consumption in LGBTI population | LGBTI populations are more likely to engage in risky drinking behaviours. | **Quantitative evidence:**<br>• Across Australia, 24.6% of the LGBTI population aged 14 years and over reported engaging in risky drinking behaviours compared to 16.9% of the non-LGBTI population in 2019 (AIHW 2020a). LGBTI data from the National Drug Strategy Household survey refers to Homosexual and Bisexual orientations.<br>• The prevalence of risky drinking has remained relatively stable between 2016-19. |
| Illicit drug use in LGBTI population | Higher prevalence of illicit substance abuse among the LGBTI population compared to the non-LGBTI population. | **Quantitative evidence:**<br>• Across Australia, 36.0% of the LGBTI population aged 14 years and over reported illicit drug use in the previous 12 months compared to 16.1% of the non-LGBTI population in 2019 (AIHW 2020a).<br>• LGBTI populations in the previous 12 months were:<br>  ○ 9.0 times more likely to have used inhalants<br>  ○ 3.9 times more likely to have used meth/amphetamines<br>  ○ 3.5 times more likely to have used hallucinogens<br>  ○ 2.6 times more likely to have used ecstasy (AIHW 2021a)<br>• The prevalence of illicit drug use has remained relatively stable between 2016-19. |

| Outcomes of the health needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **People experiencing homelessness** | | |
| AOD use among people experiencing homelessness | Alcohol dependence and its associated impact on maintaining tenancies. | **Quantitative evidence:**<br>Nationally, 9.8% of specialist homelessness service clients were identified as having problematic drug and/or alcohol misuse in 2019-20 compared to 10.9% in NSW (AIHW 2020e).<br><br>**Qualitative evidence:**<br>Research indicates that alcohol dependence is common amongst populations that are experiencing chronic homelessness (Ezard et al. 2018). In particular, a strong association has been established between recent or current problematic drug use and the maintenance of ongoing tenancy (AIHW 2019). Other adverse associations include higher levels of chronic illness, increased duration of hospital stays and higher mortality rates (Ezard et al. 2018). |
| **Older people** | | |
| Alcohol consumption among older people | Daily drinking in people aged 60 years and over. | **Quantitative evidence:**<br>• Nationally, the prevalence of daily drinking was higher among those aged 70+ years (12.6%) and 60-69 years (9.6%) compared to other age groups (range: 1.4%-7.3%) in 2019 (AIHW 2020a).<br>• In NSW, the prevalence of daily drinking was higher among those aged 75+ years (15.3%; 95% CI: 13-17.5) and 65-74 years (14.7%; 95% CI: 12.2-17.2) compared to other age groups (16-54 years range: 1.1%-5.7%) in 2020 (HealthStats 2021). |

# Section 3 – Outcomes of the service needs analysis

## General Population Health

### Summary

The NSPHN Needs Assessment utilises the latest quantitative and qualitative data to highlight key service needs across the NSPHN population, with a focus on impacts of COVID-19. The analysis indicates barriers to accessing health services as a result of COVID-19, with a need for targeted community led initiatives to support navigation of health of services, particularly for CALD groups and older people.

Needs identified in the previous NSPHN Needs Assessment continue to remain valid and identified ongoing focus on improving access to health services for Aboriginal people in the region, potential financial barriers for socio-economically disadvantaged groups, and specific barriers to accessing services for the LGBTI population and people experiencing homelessness. NSPHN continues to commission the Integrated Care Program, specifically targeting Aboriginal people; and care coordination services focussed on supporting vulnerable population groups at risk of hospital admission/re-admission. The following section builds upon previous findings with relevant data updated where possible.

| **Outcomes of the service needs analysis** | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Service access** | | |
| Access – availability | Financial barrier to accessing primary health services due to low number of bulk-billing GPs | **Quantitative evidence:**<br>• The NSPHN region currently has 296 general practices.<br>• Lower proportion of bulk-billed GP attendances in the NSPHN region – 76.2% of GP attendances bulk-billed within the NSPHN region compared to 85.7% nationally (2016-17). The rate of bulk billed GP attendances in NSPHN has remained at the same level for the past three years (AIHW 2018c).<br>• North Sydney- Mosman SA3 has lower proportion of bulk-billed GP attendances (57.8%) compared to NSPHN and Australia (AIHW 2018c). Lower rates of bulk billing medical services and practitioners charging higher gap fees creates a financial barrier to access. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| GP workforce | Hotspots considered as distribution priority areas. | **Quantitative evidence:**<br>• The rate of FTE GPs per 100,000 in NSPHN (132 per 100,000) is similar to NSW (123 per 100,000) (2020) (DoH 2021a).<br>• Areas around Dural-Wisemans Ferry and Warringah SA3s are considered distribution priority areas, indicating a shortage of general practitioners. Distribution priority areas are defined as catchments with low levels of provision of GP services compared to a benchmark calculated based on demographic and socio-economic status. (DoH 2021b). |
| Health and Wellbeing | Need for continued engagement and collaboration with the community to deliver targeted interventions. | **Qualitative evidence:**<br>• Consultation with local councils, community groups and service providers identified opportunities to collaborate and build partnerships on new and existing programs addressing:<br>  ○ lifestyle risk factors across vulnerable population groups including culturally appropriate interventions for Aboriginal and CALD populations<br>  ○ social isolation across the population to promote emotional wellbeing and build community capacity to mutually support one another<br>• Consultation also highlighted a need for family-based interventions that facilitated participation from both parents and children to target physical and mental wellbeing. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| After hours<br><br>Access – availability | Higher rate of ED attendances for lower urgency care after-hours compared to in-hours, with higher rates in Hornsby SA3 and a greater burden on younger age-groups.<br><br>Lower urgency care are ED presentations at a formal public hospital ED where the patient did not arrive by an emergency services vehicle, was assessed as needing semi-urgent (triage category 4) or non-urgent care (triage category 5) and was discharged without referral to another hospital (AIHW 2020g). | **Quantitative evidence:**<br>• In 2018-19, there was a higher rate of ED attendances for lower urgency care after-hours (45.3 per 1,000) compared to in-hours (41.1 per 1,000) in the NSPHN region. This trend varies from ED attendances in Australia, with fewer ED attendances for lower urgency care after-hours (55.8 per 1,000) compared to in-hours (61.6 per 1,000) nationally.<br>• Hornsby SA3 has the highest rate of ED attendances for lower urgency care after hours (61.4 per 1,000) compared to the NSPHN region (45.3 per 1,000) and Australia (55.8 per 1,000).<br>• In the NSPHN region, people aged 0-14 years have the highest rate of both in-hours (68.2 per 1,000) and after-hours (79.1 per 1,000) ED attendances for lower urgency care (2018-19). In NSPHN, the rate of after-hours ED attendances for lower urgency care decreases with age (AIHW 2020g). |
| After hours<br><br>Access – availability | Similar to the national trend, decreasing proportion of people accessing after hours services over the past four years.<br><br>Improving access to primary care services in the after hours period continues to a key area of focus for NSPHN. | **Quantitative evidence:**<br>• The proportion of patients accessing GP services after hours in the NSPHN region has decreased from 23.6% in 2016-17 to 15.8% in 2020-21, similar to the national rate of 17.2% (AIHW 2021e).<br>• Whilst there is a high availability of after-hours providers within the NSPHN region (124 per 100,000) compared to NSW (101 per 100,000) and Australia (107 per 100,000); there are hotspots within the region with lower availability of after-hours providers concentrated in Dural-Wisemans Ferry SA3 (DoH 2017a). |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Impact of COVID-19: Barriers to accessing health services, adoption of telehealth and identified need to increase community-based literacy initiatives and address physical and mental stress among health professionals.** . | | |
| Access to healthcare | Delayed or missed visits to health care, with barriers to accessing local services compounded as a result of COVID-19. | **Quantitative evidence:**<br>Data from the 45 and Up Study indicates delays in people accessing GP or specialist services within the region as a result of COVID-19, with a greater burden among females (SNHN 2021):<br>• 14.8% of respondents reported missing or delaying a visit to a GP as a result of COVID-19. A greater proportion of females (17.4%) missed or delayed a visit to a GP compared to males (11.5%).<br>• 13.4% of respondents reported missing or delaying a visit to a specialist as a result of COVID-19. A greater proportion of females (16.2%) missed or delayed a visit to a specialist compared to males (10%).<br>**Qualitative evidence:**<br>• Post lockdown anxiety and associated risk and fear of COVID-19 infection was identified as a key barrier impacting the ability of individuals to access services, with ongoing concerns about waiting lists across health services (including mental health and alcohol and other drug services).<br>• Please refer to page 56-60 for needs specific to CALD groups and older people. |
| Health literacy | Need for community-based health literacy initiatives to support people in navigating health services and facilitate greater understanding of vaccination in the community. | **Qualitative evidence:**<br>• Consultation with stakeholders identified a need for broader education in the community to address differences in opinions in terms of COVID-19 vaccination and build a greater understanding of impact of vaccination in the community including an acknowledgement of reasons why people might refrain from getting vaccinated.<br>• Consultations also indicated ongoing need for greater support in navigating health services across the population, utilising an asset-based community development approach. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Telehealth | Adoption of telehealth as an alternative to face-to-face delivery, with the introduction of Medicare subsidised telehealth items promoting utilisation of telehealth technologies across medical practitioners in metro regions. | **Quantitative evidence:**<br>• Analysis of local data from the *45 and Up study* indicated that 42% of respondents indicated that they used telehealth services since January 2020 (SNHN 2021).<br>• 20.9% of all GP Non-Referred attendances between October 2020 and September 2021 in Australia were delivered using telehealth, with phone being the main mode of service delivery (DoH 2021d). Local data extracted through PATCAT also suggests that majority of GP telehealth services have been provided via telephone between October 2020 and October 2021. The data is limited to active patients of a GP practice in the NSPHN region (SNHN 2022).<br>**Qualitative evidence:**<br>• Consultation with stakeholders highlighted access to information and treatments were impacted by disparities in digital literacy across cohorts, with a greater need of increasing awareness of utilising digital services effectively across the population. Population cohorts disproportionately impacted by the disparities include older people and people experiencing intellectual disability. Whilst telehealth provided greater flexibility with accessing services across cohorts, a mixed based approach to service delivery combining face to face and telehealth service delivery was identified as being prudent to address any adverse outcomes and health inequalities.<br>• Consultations with clinicians across the region identified a need for increasing video conferences as telephone has been the main mode of telehealth delivery. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Workforce | Support to address physical and mental stress among health professionals | **Qualitative evidence:**<br>Stakeholder consultation indicated burnout within general practices, as general practitioners and nurses are operating at capacity. |
| | Need for training and collaboration across general practices as management of COVID-19 shifts to a community-based approach. | **Qualitative evidence:**<br>Increasing training and capability of general practitioners as care for COVID-19 patients shifts from a hospital to community-based approach, including establishment of clusters to facilitate collaboration, engagement and integration with allied health practitioners working across practices and enable sharing of resources. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Vulnerable Groups** | | |
| **Aboriginal and Torres Strait Islander people** | | |
| Aboriginal and Torres Strait Islander People<br><br>Access – availability | Low proportion of the Aboriginal population receiving MBS 715 health check.<br><br>Improving access and navigation of services for Aboriginal people continues to be an area of focus for NSPHN, with significant efforts occurring in the past three years to address this. | **Quantitative evidence:**<br>• In 2019-20, the rate for Indigenous specific health checks of patients in the NSPHN region (5.2%) was lower compared to NSW (26.9%) and national (27.9%) rates (AIHW 2021d).<br>• There has been an increase in the proportion of Indigenous people accessing GPs for their annual health checks from 1.2% in 2012-13 to 5.2% in 2019-20. However, the proportion is still lower compared to NSW and Australia (AIHW 2021d). |
| Aboriginal and Torres Strait Islander People<br><br>Access - availability | Limited access to culturally appropriate services. | **Qualitative evidence:**<br>Stakeholder consultation highlighted limited availability of Aboriginal workers within the region, with a need to develop a more culturally aware and appropriate primary care workforce to promote access. Lack of access to cultural competence training and availability of culturally aware information for staff. Consultations also emphasised this need within mental health and AOD services. |
| Aboriginal and Torres Strait Islander People<br><br>Access - availability | Need for flexibility in how and where sessions are delivered. | **Qualitative evidence:**<br>Lack of flexibility in provision of health services to Aboriginal population in NSPHN region. Lack of services open to a client's family and a need to provide outreach services within the Aboriginal community. Consultations also highlighted this need within mental health and AOD services. |
| Aboriginal and Torres Strait Islander People<br><br>Access – availability | Need for holistic focus within health care, current focus on illness rather than wellness. | **Qualitative evidence:**<br>Stakeholder consultation highlighted the need for a holistic approach in primary care services, focusing on the social, emotional, and cultural well-being of the whole community rather than solely on illness. Consultations also highlighted this need within mental health and AOD services. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Culturally and linguistically diverse (CALD)** | | |
| CALD<br><br>Access - availability | Limited providers with local CALD language skills. | **Qualitative evidence:**<br>Stakeholder consultation identified the need for better access to interpreters for CALD clients in the NSPHN region. Consultation highlighted health service providers with relevant ethnic backgrounds and language-speaking abilities are limited, with a need for sustainable key bilingual GPs and psychologists in the region. |
| CALD<br><br>Access - availability | Financial barriers to access. | **Qualitative evidence:**<br>Stakeholder consultation highlighted potential financial barriers for CALD groups accessing primary health services due to visa status. |
| CALD<br><br>Access – availability | Need for ongoing and culturally appropriate health promotion. | **Qualitative evidence:**<br>Stakeholder consultation highlighted a need for ongoing and culturally appropriate health promotion for sexual health, nutrition, and oral health, highlighting a need to focus on women and older CALD groups. |
| CALD<br><br>Impact of COVID | Need for facilitating additional support groups targeting CALD population to promote awareness of available supports and COVID-19 vaccination. | **Qualitative evidence:**<br>• Multi-generational households with transient elderly visitors experiencing a range of barriers to accessing care including language barriers, lack of established connection with primary care and lack of awareness of available supports. The barriers are further compounded with uncertainty around ability to safely travel back home with ongoing COVID-19 travel restrictions.<br>• There is a need to address concerns around immunisation through targeted education and support groups, particularly in the lower North Shore. |
| **Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI)** | | |
| LGBTI | Need for collaboration across different domains of health promotion to ensure inclusivity of the LGBTI population. | **Qualitative evidence:**<br>ACON (2013) highlights a number of service needs for the LGBTI population:<br>• Training of the health workforce to ensure inclusivity<br>• Early intervention<br>• Broader health promotion strategies that include LGBTI people (ACON 2013). |

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

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Older People** | | |
| Older people<br><br>Ageing population | Reflected by General Practice data (Pat Cat), an ageing population within the NSPHN region will see an increase in co-morbidities and dementia, increasing the need for aged care services. | **Quantitative evidence:**<br>• Ryde (80.3%) and Willoughby (62.8%) LGAs have higher projected increases in 65 years and older population compared to the NSPHN region (53.7%) between 2021 and 2041 (NSW Department of Planning, Industry and Environment 2019), indicating a potential need for increased aged care services.<br>• Nationally in 2021, the prevalence of dementia was estimated between 8.5% and 10.5% among people aged 65 years and over (ABS 2021b; AIHW 2021b; Dementia Australia 2018). Estimates from Dementia Australia suggest that there may be higher proportions of dementia prevalence in Hornsby (13.2%) and Hunters Hill (12.5%) LGAs compared to the NSPHN region (11.3%) for people aged 65 years and over in 2021 (ABS 2021; Dementia Australia 2018). |
| Older people<br><br>Impact of COVID-19 | Need for additional allied health support to address declining physical function. | **Qualitative feedback:**<br>Consultation with stakeholders across the region identified declining physical function, associated frailty, and high falls risk as key emerging needs for older people across the region, requiring additional access to allied health supports. |
| Older people<br><br>Access to primary care | Low rate of health assessments among people aged 75 years and over within the NSPHN region.<br><br>Rate of health assessments from a GP includes claims for MBS items 701,703,705, 707, 224, 225, 226, or 227 in the previous 12 months among people aged 75 years and over. | **Quantitative evidence:**<br>General practice data from 186 practices within the NSPHN region highlights that 18.1% of active patients aged 75 years and over received a health assessment from their GP in the past 12 months (January 2022) (SNHN 2022). Active patients defined as people with three or more visits to a general practice in the past two years. |
| Older people<br><br>Access to primary care | GP attendance at residential aged care facility comparable to Australia. | **Quantitative evidence:**<br>The number of GP attendances per person in residential aged care facilities in the NSPHN region (17) was similar to Australia (17.8) in 2020-21 (AIHW 2021e). Limited availability of data to assess regional variation. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Aged Care services<br><br>Access – availability | Large waiting list for people accessing Level 1 and 2 Home Care Packages.<br><br>The ageing NSPHN population will increase the demand for aged care services across the region. This will have significant strain and impact upon the aged care, primary care, and hospital sectors, with an increase in preventable hospitalisations, residential aged care admissions and carer stress. | **Quantitative evidence**<br>• Northern Sydney has the third highest number of Residential Aged Care Facilities in Australia by Aged care planning region (ACPR), with 106 facilities in the region.<br>• In the NSPHN region, 11,738 people aged 65 years and over accessed aged care services as at 30 June 2020. The majority of aged care services provided were Residential Aged Care (66.3%), followed by Home Care packages (32.9%) and Transition Care (0.8%).<br>• The process for accessing Home Care Packages has now been centralised nationally. Previous needs assessment highlighted an undersupply of Level 3 and 4 Home Care packages within NSPHN compared to NSW. Similar to the NSW trend, there has been an increase in the number of people aged 65+ years accessing Level 3 and 4 Home Care packages within the NSPHN region from 4.3 per 1,000 in 2016 to 11.6 per 1,000 in 2020. The rates are lower compared to NSW (15.0 per 1,000 in 2020) (AIHW 2021c).<br>• The rate of Level 1 and 2 Home Care packages for people aged 65+ years within NSPHN (13.0 per 1,000) was lower compared to NSW (19.6 per 1,000) in 2020. According to the latest Home Care Packages Program Data Report (2021), NSPHN has the highest number of people awaiting allocation to a Level 1 and 2 Home Care Package (1,063) in NSW (DoH 2021d). Level 1 and 2 Home Care Packages are aimed at supporting people with low level care needs to avoid premature admissions into residential care (AIHW 2021c). A large waitlist for Level 1 and 2 Home Care packages can potentially impact on the demand and utilisation of residential aged care services within the region.<br>• Further analysis required to ascertain the varying care and service needs of the older population and its subsequent impact on the demand and utilisation of Home Care packages, residential aged care services, and Commonwealth Home Support Services (aimed at providing care for people with lower-level care needs). |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Aged care services<br><br>Impact of COVID-19 | Need for additional support in navigating local services | **Qualitative feedback:**<br>• Fragmentation of the aged care service system being further exacerbated as a result of the COVID-19 pandemic with segmented communication across the system around service availability, capability, and capacity. Consultation highlighted a need for increasing awareness of available local services to support navigation of pathways for both service providers and community members. |
| Palliative care services | Increased demand for palliative care services, with an ageing population and subsequent increases in the prevalence of cancer and other chronic conditions.<br><br>Palliative care is person and family-centred care provided to people with a life-limiting illness. Palliative care is provided in almost all settings where health care is provided, including neonatal units, paediatric services, general practices, acute hospitals, residential and community aged care services, and generalist community services. | **Quantitative evidence**<br>• Nationally, 83,430 palliative care-related hospitalisations were reported from public acute and private hospitals in Australia in 2018–19 (AIHW 2021g).<br>• Palliative care hospitalisations and other end of life care hospitalisations have increased by 17.7% and 47.5% respectively between 2014-15 and 2018-19, compared to a 13.7% increase in hospitalisations for all reasons over the same time period (AIHW 2021g).<br>• 53.6% of palliative care hospitalisations and 54.2% of other end-of-life care hospitalisations were for people aged 75 years and over (AIHW 2021g).<br>• Average length of stay for palliative care hospitalisations (9.4-10.9 days) was 3.5-4 times higher compared to all hospitalisations (2.7 days), indicating the complexity associated with palliative care patients and health care resources required to address their health care needs (AIHW 2021g).<br>• Limited availability of local level data to map availability and utilisation of palliative care services within the NSPHN region. |

# Primary Mental Health Care (including Suicide Prevention)

## Summary

The NSPHN Needs Assessment includes emerging themes from extensive consultation with a range of stakeholders. Analysis highlights emerging needs to address the mental health burden as a result of COVID-19, with additional supports required to address social isolation and specific needs among young and older people. The analysis also indicated a need for greater service coordination, regional community-based approach to suicide prevention, and need to increase awareness of available services.

Findings from the previous needs assessment continue to remain pertinent and highlighted a need for practical, flexible, and integrated psychosocial support services in the region for cohorts experiencing severe mental illness; specific barriers to accessing services for Aboriginal people, those from CALD backgrounds, people with intellectual disability, and women experiencing perinatal depression. NSPHN continues to commission services across the stepped care continuum, with a specific focus on identified vulnerable groups. Speciality services are also commissioned targeting Aboriginal people, people from Chinese speaking backgrounds, and young people. The following analysis builds upon findings from the previous Needs Assessment, with relevant data updated where possible.

| **Outcomes of the service needs analysis** | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Service access** | | |
| Access to mental health care | Lower MBS GP mental health treatment rate compared to Australia.<br><br>Treatment rate dependent on prevalence of mental illness and accessibility and availability of mental health services, both public and private. | **Quantitative evidence:**<br>• In 2020-21, 8.6% of the NSPHN population accessed an MBS funded GP mental health service compared to 9.3% of people in Australia (AIHW 2021e).<br>• In 2020-21, 2.2% of the NSPHN population accessed an MBS funded Psychiatry service compared to 1.7% of people in Australia (AIHW 2021e).<br>• In 2020-21, 2.7% of the NSPHN population accessed an MBS Clinical Psychologist service compared to 2.2% of people in Australia (AIHW 2021e).<br>• In 2020-21, 5.8% of the NSPHN population accessed an MBS funded Allied Health mental health service compared to 5.4% of people in Australia (AIWH 2021e). |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Workforce | Regional variation in rate of psychologists and psychiatrists. Latest data available for 2020. | **Quantitative evidence:**<br>• NSPHN has a higher proportion of psychiatrists per population (2.0 per 10,000) compared to NSW (1.3 per 10,000). The rate varied across LGAs, ranging 0.8 per 10,000 in Northern Beaches LGA to 7.3 per 10,000 in Willoughby LGA (DoH 2021a).<br>• NSPHN has a higher proportion of psychologists per population (15.5 per 10,000) compared to NSW (11.4 per 10,000). The rate varied across LGAs, ranging 12 per 10,000 in Hunters Hill to 26 per 10,000 in Willoughby LGA (DoH 2021a). |
| Mental Health Hospitalisations | Higher rate of hospitalisations for mental disorders, with rates increasing in the past 10 years and a greater burden among females. | **Quantitative evidence:**<br>• The rate of hospitalisations for mental disorders has increased within NSPHN from 1,767 per 100,000 (95% CI: 1,738-1,795) in 2009-10 to 2,407 per 100,000 (95% CI: 2,376-2,438) in 2019-20. The rate continues to be higher compared to NSW (1,857 per 100,000; 95% CI: 1,848-1,867) (HealthStats 2021).<br>• Rate of hospitalisations for mental disorders is influenced by prevalence of mental disorders, access to and availability of mental health services, and coding standards for classification of mental disorders. Limited availability of local data to identify the underlying precursors for increasing rates of hospitalisations for mental disorders within NSPHN and assess regional variation.<br>• Higher rate of hospitalisations for mental disorders among NSPHN females (2,728 per 100,000; 95% CI: 2,682-2,775) compared to NSW females (2,066 per 100,000; 95% CI: 2,052-2,080) in 2019-20 (HealthStats 2021). |
| | Anxiety and stress disorders account for largest proportion of mental health overnight hospitalisations. Schizophrenia and delusional disorders account for the largest number of bed days. | • Anxiety and stress disorders accounted for 16.9% of all mental health overnight hospitalisations in the NSPHN region. Warringah, North Sydney-Mosman, and Chatswood-Lane Cove SA3s had the highest rate of hospitalisations for anxiety and stress disorders (AIHW 2017).<br>• Schizophrenia and delusional disorders accounted for 28.4% of all bed days in the NSPHN region (AIHW 2017b). |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Impact of COVID-19:** Identified needs for initiatives to address social isolation and promote early identification/intervention across the population, with additional workforce training to respond to emerging mental health needs. | | |
| Health literacy and awareness | Need for broader community-based initiatives to address social isolation, promote early identification/intervention and increase awareness of available support across the population. | **Qualitative feedback:**<br>• Consultation with stakeholders identified that mental health burden as a result of COVID-19 will evolve over time as the impacts of social isolation are realised and psychological issues emerge over time. Broader community-based connectedness initiatives facilitated through an asset-based approach to community development were identified as key to addressing social isolation. Please refer to page 70-76 for needs specific to young people and older people.<br>• Consultations also identified that it is likely that for a significant proportion of the population COVID related anxiety is underdiagnosed, with impacts emerging over time. Consultations identified a need for broader community-based initiatives to promote early identification and intervention. |
| Workforce | Building workforce capability and capacity to respond to emerging needs. | **Qualitative feedback:**<br>• Consultation with stakeholders identified need for additional training specific to trauma, suicide and self-harm, eating disorders, and specialisations in delivering services to children/young people. |
| | High demand for clinical mental health services, with need for integration across services to support holistic wellbeing of clients. | **Qualitative feedback:**<br>• Consultation with stakeholders identified that clinical mental health services continue to operate at capacity, with workforce shortage across primary and acute services. Consultations identified a need to facilitate greater linkages to community-based supports to address holistic client needs and provide a soft entry to mental health support, alleviating pressure from mainstream clinical mental health services. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Northern Sydney Joint Regional Mental Health, Suicide Prevention and Alcohol and Other Drugs Plan**: The Northern Sydney Joint Regional Mental Health, Suicide Prevention and Alcohol and Other Drugs Plan has been developed in partnership with NSLHD. Extensive regional consultation has been undertaken with a range of stakeholders across the region, including people with lived experience, carers, community managed organisation (CMO) representatives, NSLHD staff, GPs, and allied health professionals. Key themes from the consultations have been summarised below. | | |
| Service integration | Need for structured pathways to facilitate transition of care between primary, secondary, and tertiary services | **Qualitative evidence:**<br>• Consultation highlighted fragmentation in referral pathways within and across health and social sectors, creating difficulties for clients in accessing appropriate services relative to need. |
| Access-community response | Need for a regional community-based approach to suicide prevention, with a focus on early intervention and targeting at risk groups | **Qualitative evidence:**<br>• Consultation highlighted specific high-risk groups including divorced and separated men as well as young people.<br>• Additionally, consultation highlighted a need to facilitate community capacity building activities (including school-based initiatives), focused on reducing stigma and being able to identify those at risk, with targeted activities for CALD, Aboriginal, and LGBTI population groups. |
| Awareness of services | Lack of awareness of available services in the community | **Qualitative evidence:**<br>• Stakeholder consultation highlighted that people at risk, family members and carers are often unaware of what local services (including mental health, AOD, and suicide prevention services) are available and where to seek help in case an issue emerges. The lack of awareness often delays access to support, impacting on the wellbeing of clients and their family members/carers.<br>• Additionally, there is also a need to increase awareness of local services among clinicians and support workers to ensure clients/family members/carers are linked to appropriate services tailored to their needs.<br>• Consultation identified a need for resources such as web-based directories that provide up to date and timely information for community members. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Access- availability | Limited availability of services skilled in addressing holistic wellbeing of clients with mental health and/or AOD issues. | **Qualitative evidence:**<br>• Consultation identified the need for adoption of social emotional wellbeing service models, addressing physical, social, and emotional needs of clients experiencing mental health and/or AOD issues. Expanding access to support for family members and carers was also identified as a key need to promote holistic wellbeing of clients, particularly for those seeking support following a recent suicide attempt. Currently, there are limited number of services delivering this integrated model of care within the region.<br>• Medication management was also identified as a key need, with stakeholders highlighting lack of understanding about unwanted effects and physical impacts of medications used in treatment of mental health and/or AOD issues. |
| Access-availability | Limited availability of specialist services for vulnerable groups within the region. | **Qualitative evidence:**<br>• Consultation highlighted that specialist services for vulnerable population groups are limited within the region. Identified need for capacity building activities for local staff to service special needs of vulnerable population groups.<br>• Vulnerable groups identified in the Regional Plan include Aboriginal and Torres Strait Islander people, CALD population, young people, and older people. Specific needs for these vulnerable population groups have been described further on pages 70-77. |

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

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Psychosocial support needs of people with severe mental illness** | | |
| Access to services | Limited availability of services for those with chronic and moderate to severe mental illness.<br><br>NSPHN commissions the Commonwealth Psychosocial Support program to address the psychosocial support needs of people with severe mental illness who are not receiving support through the NDIS. | **Qualitative evidence:**<br>The type of services provided in NSPHN may cover the needs of the two extremes of the lived experience of mental illness - those with mental health problems needing low-level support and those in severe crisis requiring acute care in a hospital setting. However, there is a need for more community-based alternatives for people with chronic and moderate to severe mental illness (Salvador-Carulla et al. 2017).<br><br>Existing programs and services providing support to people in the region experiencing psychosocial disability include Housing and Accommodation Support Initiative (HASI), Community Living Supports (CLS) and Pathways to Community Living Initiative (PCLI). The NSW Health funded programs HASI, CLS and PCLI are intended for people with severe mental illness who are also consumers of the Local Health District Community Mental Health Teams or hospital services. |
| Psychosocial support<br><br>Access- availability | Need for holistic care to foster wellbeing among persons with mental illness, carers, and family. | **Qualitative evidence:**<br>• Interventions targeting physical health needs, building social relationships, employment opportunities and support for accessing secure housing are key to improve the quality of life for people with severe mental illness, carers, and families (Lawrence and Kisely 2010; DoH 2017c).<br>• Stakeholder consultation highlighted limited availability of support services for carers/family who are central to the recovery process. |
| Psychosocial support<br><br>Access- flexibility | Need for flexible services | **Qualitative evidence:**<br>• Stakeholder consultation highlighted the need for outreach and centre-based services that are conducive to the target population.<br>• Consultation also highlighted the need for after-hours services, particularly for groups that are difficult to engage. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| National Disability Insurance Scheme (NDIS) | Transition of care for consumers with severe and complex needs under NDIS. | **Qualitative evidence:**<br>• Stakeholder consultation highlighted the likelihood of the NDIS application process acting as a barrier to accessing psychosocial support services for persons with a mental illness. Additional concerns were raised regarding the instability of funding streams for NGO mental health services and the impact that this and the casualisation of the workforce would have on the provision of quality care to consumers (Salvador-Carulla et al. 2017).<br>• Stakeholder consultation has highlighted barriers to accessing NDIS services for specific cohorts experiencing severe mental illness and corresponding psychosocial disability, including:<br>○ younger people<br>○ people experiencing homelessness<br>○ people with co-morbid mental health and substance misuse issues<br>○ people from CALD backgrounds<br>○ people with a primary diagnosis of depression or anxiety and<br>○ people with a personality disorder disability<br>○ Aboriginal and Torres Strait Islander people |
| Psychosocial support<br><br>Service Integration | Need for service integration | **Qualitative evidence:**<br>• Stakeholder consultation highlighted the need to increase awareness of referral pathways to help navigate access to different services, particularly among vulnerable population groups such as CALD, young people, and people experiencing homelessness. Psychosocial service needs specific to these vulnerable groups have been discussed further on pages 72-76.<br>• Consultation also highlighted the need for:<br>○ integrating clinical and non-clinical services within the stepped care continuum to prevent silos, and<br>○ linking with pre-existing services providing psychosocial support to avoid service duplication. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Psychosocial support<br><br>Workforce | Limited workforce capacity | **Qualitative evidence:**<br>• Stakeholder consultation highlighted limited availability of workers (e.g. peer support workers) and service providers in providing wrap around holistic services to support the psychosocial needs of people with severe mental illness.<br>• Stakeholder consultation also highlighted the need to leverage support from the community via adequate training to facilitate a community driven response.<br>• Stakeholder consultations raised concerns about under skilled or insufficiently trained workers providing support services to people experiencing psychosocial disability. |
| Psychosocial support<br><br>Community Response | Need for community driven response to support psychosocial needs of people with severe mental illness | **Qualitative evidence:**<br>Stakeholder consultation highlighted the need for interventions that are led by people with lived experience and are focussed on engagement with the target population to plan and deliver services. |
| People with severe mental illness and complex needs<br><br>Access – availability | Financial barrier due to lack of bulk-billing private psychiatrists. | **Qualitative evidence:**<br>Stakeholder consultation highlighted that whilst Northern Sydney has a relatively high supply of psychiatrists, many of them do not bulk bill and charge higher than average gap payments. People with severe mental illness and complex needs who are not clients of public mental health services have difficulty accessing affordable and appropriate psychiatric support. |
| People with severe mental illness and complex needs<br><br>Access – availability | Limited early intervention treatments. | **Qualitative evidence:**<br>Stakeholder consultation highlighted limited early intervention treatments for patients with severe mental illness and limited alternatives to hospitals. Stakeholders highlighted the management of suicide in public hospital can be very traumatising, leading to marked deterioration in a patient's mental illness. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Vulnerable Groups** | | |
| **Children and Young people** | | |
| Access to mental health care for children and young people | Low rate of subsidised mental health treatment in those aged under 25 years relative to need.<br><br>Youth mental health continues to remain an area of ongoing focus for NSPHN, with NSPHN commissioned local headspace services operating across two centres within the region. | **Quantitative evidence:**<br>• Approximately 20.1% of the NSPHN population aged under 25 years accessed MBS subsidised GP mental health services in 2020-21 compared to 19.2% for Australia (AIHW 2021e).<br>• Between 2013-14 to 2020-21, the proportion of people aged under 25 years accessing MBS subsidised GP mental health services has increased by 9.7% in NSPHN compared to 7.9% for Australia.<br>• MBS service data indicates a higher mental health service utilisation for females compared to males in NSPHN and Nationally (AIHW 2021e).<br>• Treatment rate dependent on prevalence of mental illness and accessibility and availability of mental health services, both public and private. |
| Impact of COVID-19 | Need for increased support for children and young people. | **Qualitative evidence:**<br>• Consultation with psychologists within the region identified increased demand for psychological services from younger people, with a need for additional supports targeting children and young people as psychological issues emerge over time.<br>**Quantitative evidence:**<br>• Data from commissioned NSPHN mental health services highlights that proportion of referrals for people under 25 years has increased between 2019 and 2021. Referrals for people under 25 years accounted for 32% of total referrals to commissioned mental health services in 2019, increasing to 38.1% in 2021 (SNHN 2022a). |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Service usage | Barriers to accessing services | **Quantitative evidence:**<br>• The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing highlighted some common barriers among parents or carers of children with mental illness to accessing mental health services:<br>  ○ Affordability - 37% of the respondents identified affordability of the service as a barrier preventing them from accessing mental health services. This was a more common issue among parents/carers of children aged 4-11 years compared to parents/carers of those aged 12-17 years, highlighting a need for pathways that facilitate access to services for families who are socio-economically disadvantaged.<br>  ○ Uncertainty around 'where to seek help': 39.6% of parent/carers highlighted that they were unsure about where to seek help (Lawrence et al. 2015). |
| Young people<br><br>Psychosocial support | Need for psychosocial support to address gaps in service provision through NDIS | **Quantitative evidence:**<br>For the majority of children with a mental disorder, the disorder impacted their functioning in different domains of life including school/work, friend/social activities, and family, emphasising the need for support beyond clinical services (Lawrence et al. 2015).<br>**Qualitative evidence:**<br>Stakeholder consultation have highlighted barriers for younger people in accessing NDIS services associated with challenges in qualifying the NDIS eligibility criteria, reiterating the need for targeted service delivery to address the gaps. |
| Children and young people<br><br>Access and awareness | Lack of awareness of local health services | **Qualitative evidence:**<br>Stakeholder consultation identified young people are often unwilling to share concerns with parents/carers which is compounded by a lack of awareness of local mental health services. These barriers are further exacerbated within CALD and socio-economically disadvantaged groups. Consultation highlighted a need for technology based & cyber-safe access pathways that raise awareness of health services that are available and empower young people to seek help appropriately. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Children and young people<br><br>Access and awareness | Additional barriers to access for young people and their families from CALD backgrounds. | **Qualitative evidence:**<br>Stakeholder consultation identified the need for peer or community led services that allow young people and families in need to access culturally appropriate services that best cater their needs. |
| Children and young people<br><br>Community response | Need for a community driven response to improve health literacy, raise awareness about mental health, and cater to psychosocial needs of young people with mental illness. | **Qualitative evidence:**<br>• Stakeholder consultation identified the need for educating and empowering parents, GPs, schools, councils, businesses, and sports and recreational clubs to identify early signs of mental illness to facilitate early intervention.<br>• Consultation also highlighted leveraging support from these networks for delivering flexible and practical interventions that actively engages young people to adequately address psychosocial needs of the cohort. |
| Children and young people<br><br>Self-awareness | Need for educating and empowering to identify early signs of mental illness | **Qualitative evidence:**<br>Stakeholder consultation identified that often mental illness is diagnosed at later stages resulting in acute psychosis requiring mitigation through pharmaceutical therapy. Consultation identified the need for increasing awareness among young people to allow them to identify early signs/symptoms of mental illness. |
| Young people<br><br>Impact of COVID-19 – resilience training | Need for additional skills training to build self-reliance among young people | **Qualitative evidence:**<br>• Consultation with stakeholders across the region identified uncertainty about the future as a key stressor for young people, contributing to the mental health burden as a result of COVID-19. Virtual learning and reduced opportunities for face-to-face skills training were highlighted as key barriers to enter the workforce, impacting financial and emotional stress.<br>• Additional support needs among young people with cognitive impairment experiencing disparities in learning outcomes because of virtual learning. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Children and young people<br><br>Prevention and early intervention | Need to facilitate early intervention. | **Qualitative evidence:**<br>Stakeholder consultation highlighted that mental health education in its current form commences in high school. Consultation identified the need for commencing mental health education in concluding years of primary school to provide an opportunity for early intervention and primary prevention. |
| Children and young people<br><br>Access - availability | Limited availability of services for children aged under 12 years. | **Qualitative evidence:**<br>Stakeholder consultation identified limited availability of services for children aged under 12 years in comparison to those aged 12+ years. Consultation highlighted less recognition of early indicators in those aged under 12 years, with limited availability of mental health services for children with mild to moderate mental health issues. |
| Children and young people<br><br>Access | Complex health system a barrier to families accessing mental health services. | **Qualitative evidence:**<br>Stakeholder consultation identified navigating a complex health system as a barrier to families, children and young people accessing services; highlighting services predominantly utilised by proactive and health literate families. |
| Children and young people<br><br>Access - availability | Lack of services for young people with moderate to severe mental health issues. | **Qualitative evidence:**<br>Stakeholder consultation identified a service gap for young people whose mental health issues are too severe or complex for Headspace, but level of acuity ineligible for the LHD Child and Youth Mental Health Services (CYMHS). NSPHN has commissioned services to meet this gap through youth severe funding, however, this remains an ongoing need. |
| Children and young people<br><br>Access – availability | Limited group programs for families, with additional support needs arising as a result of COVID-19. | **Qualitative evidence:**<br>• Stakeholder consultation identified a lack of group programs available in the region for families, highlighting the limited availability of family intervention treatments, including integrated child and parent interventions.<br>• Stakeholder consultation identified increased exposure to online gaming as a result of COVID-19, with children often demonstrating aggression. Consultation highlighted a need for family-based interventions to support parents and children in addressing addiction to online gaming. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Children and young people<br><br>Access - availability | Lack of outreach services for young people. | **Qualitative evidence:**<br>Stakeholder consultation identified the need to provide outreach or in-place, rather than centre-based support to young people. Young people may not engage in a clinical environment, requiring a safe and neutral environment. Consultation highlighted services need to be flexible in where services are delivered. |
| Children and young people<br>Access - availability | Financial barrier to access. | **Qualitative evidence:**<br>Stakeholder consultation highlighted financial barriers for socio-economically disadvantaged families and children in the region. Lower rates of bulk billing medical services and practitioners charging higher gap fees providing a financial barrier to access. |
| **Aboriginal and Torres Strait Islander People** | | |
| Aboriginal and Torres Strait Islander People<br><br>Access-availability | Limited access to culturally appropriate services. | **Qualitative evidence:**<br>• Stakeholder consultation conducted by Relationships Australia NSW and the Gaimaragal Group identified the need for a culturally competent, trauma informed workforce with 'cultural' accreditation, recognising champions in providing care for people from Aboriginal and Torres Strait Islander backgrounds (Relationships Australia NSW and The Gaimaragal Group 2017).<br>• Consultations have also identified limited availability of Aboriginal workers in the region. |
| Aboriginal and Torres Strait Islander people<br><br>Access | Need to enhance integrated care. | **Qualitative evidence:**<br>There is a need for holistic integrated approaches to care that are driven by focus on early intervention to better capacitate young Indigenous people and professionals for crisis management (Relationships Australia NSW and The Gaimaragal Group 2017). |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Aboriginal and Torres Strait Islander people<br><br>Access- awareness & Early intervention | Lack of awareness of health services available. | **Qualitative evidence:**<br>Consultations have highlighted that lack of awareness of available health services within the region creates structural barriers for people trying to access health services especially among Indigenous youth who have moved into the region from other parts of the state and country. There is a need for an integrated platform that facilitates dialogue between Indigenous youth and allows seamless transition of care between health services, breaking down silos existing between services (Relationships Australia NSW and The Gaimaragal Group 2017). |
| **Culturally and linguistically diverse (CALD)** | | |
| CALD<br><br>Psychosocial support | Need for culturally appropriate psychosocial support services. | **Qualitative evidence:**<br>Stakeholder consultation highlighted the need to address stigma related to mental illness to facilitate holistic, culturally appropriate services that adequately addresses the psychosocial needs of people experiencing mental illness. |
| CALD<br><br>Access - availability | Provision of culturally appropriate services. | **Qualitative evidence:**<br>Stakeholder consultation highlighted that understanding complexities related to cultural background is not always addressed by service providers. Barriers relating to utilisation of psychological services for CALD populations include stigma (including intergenerational stigma within different cultures) and limited availability of bilingual workers. |
| **Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) population** | | |
| LGBTI<br><br>Access - availability | Service gap for the LGBTI population. | **Qualitative evidence:**<br>Stakeholder consultation highlighted a gap in service provision for the LGBTI population with mental health issues, with a lack of culturally appropriate services specific to the community. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **People experiencing homelessness** | | |
| Psychosocial support for people experiencing homelessness | Need for support in accessing secure housing | **Qualitative evidence:**<br>Stakeholder consultation have highlighted barriers to accessing NDIS services for people experiencing homelessness. Adequate support provided to accessing secure housing can prevent repeated episodes of homelessness that might be common among people with mental illness, facilitating pathway to recovery (AIHW 2018d). |
| **Older People** | | |
| Health of Older People<br><br>Access – availability | Low uptake of GP mental health services in those aged 65+ years.<br><br>Treatment rate dependent on prevalence of mental illness and accessibility of mental health services, both public and private. | **Quantitative evidence:**<br>• In 2020-21, approximately 7.1% of people aged 65+ years in NSPHN accessed MBS subsidised GP mental health services compared to 8.3% for Australia (AIHW 2021e). Between 2013-14 to 2020-21, the proportion of people aged 65+ years accessing MBS subsidised GP mental health services in NSPHN has increased by 2.2% between 2013-14 and 2020-21, compared to 2.1% for Australia.<br>• In 2020-21, approximately 4.3% of people aged 65+ years in NSPHN accessed MBS subsidised Psychiatry mental health services compared to 2.2% and for Australia (AIHW 2021e). |
| Health of Older People<br><br>Access and awareness/ Impact of COVID-19 | Barriers to access and awareness of available services, with needs further exacerbated as a result of COVID-19. | **Qualitative evidence:**<br>• Stakeholder consultation identified challenges for those aged 65+ years accessing mental health services when living in a residential aged care facility and those aged 65+ years with comorbidities. Barriers to access intensified for those experiencing social isolation, with needs further exacerbated as a result of COVID-19. Consultation identified social isolation for older people compounded their ability to access services by variable access to technology. Consultation highlighted the need to expand existing community-based initiatives to address social isolation among older people. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Health of Older People<br><br>Integration/Early intervention | Need for holistic services across the stepped care continuum, addressing concurrent physical and mental health needs of older people. | **Qualitative evidence:**<br>• Overprescribing of psychotropic medications compounded with social isolation and biological factors associated with ageing presents challenges in addressing co-morbid physical and mental health conditions (Mental Health Commission of NSW 2017; AIHW 2017a). This highlights a need for integrated services that address both physical and mental health needs of older people to facilitate early intervention (DoH 2017c).<br>• Identified need for capacity building activities for staff in residential aged care facilities to assist in identifying early signs of mental illness and link residents to appropriate services. |
| **Other vulnerable groups** | | |
| People with Intellectual Disability<br><br>Access – availability | Limited services available for people with intellectual disability, increased rate for potentially preventable hospitalisations for people with intellectual disability (ABS 2014). | **Qualitative evidence:**<br>Stakeholder consultation highlighted limited options available for clients with intellectual disability and a lack of awareness from GPs around suitable services.<br>**Quantitative evidence:**<br>The annual age-standardised rate of potentially preventable hospitalisations for people in NSW with an intellectual disability was 5286 per 100,000, higher compared to the total NSW population (1511 per 100,000) in 2014–15 (Weise, Srasuebkul and Trollor 2021). |
| People with Intellectual Disability<br><br>Access | Barriers to accessing appropriate health care service for people with intellectual disability. | **Qualitative evidence:**<br>Communication is a significant barrier for people with autism and/or intellectual disabilities. It causes problems in primary care as inadequate communication can result in difficulties obtaining accurate patient histories, lead to the wrong diagnosis and inappropriate medication prescriptions, and it can prevent a person's access to receiving adequate health care (Doherty et al. 2020; Lennnox, Diggens and Ugoni 1997). A lack of training in how to manage and support people with intellectual disabilities in both primary and acute care has also been cited as potential barries to accessing appropriate health care services (Doherty et al. 2020; Lennnox, Diggens and Ugoni 1997). |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| People with Intellectual Disability<br><br>Access – availability | Limited skills and workforce capability in diagnosing mood or psychiatric disorders often delays treatment. | **Qualitative evidence:**<br>Families and disability professionals often struggle to identify signs of mood disorders. There are limited number of psychiatrists specialising in treatment of mental health issues in people affected by intellectual disability. This often leaves diagnosis at the hands of GPs who often find it difficult to make differential diagnosis (Simpson 2012). |
| Women experiencing perinatal depression<br><br>Access – availability | Low uptake of psychological services. | **Qualitative evidence:**<br>Stigma associated with diagnosis acts as a barrier to accessing support services, this is exacerbated in women from Aboriginal and CALD backgrounds. Women often self-diagnose and classify symptoms of distress as 'normal part of motherhood' restricting them from accessing services (beyondblue 2011). Majority of women seek assistance from GPs for perinatal depression. However, limitations in dealing with mental conditions often creates a barrier for both women and health professionals (AIHW 2012). |
| Women experiencing perinatal depression<br><br>Access - availability | Financial barriers to access. | **Qualitative evidence:**<br>Stakeholder consultation highlighted the importance of engaging mothers with perinatal depression at the antenatal stage (if required) as clients will present postnatal at higher acuity. However, there is a financial barrier as not all antenatal care is subsidised, with patients unable to determine what services are available privately and publicly. |

# Alcohol and Other Drug Treatment Needs

## Summary

NSPHN's Alcohol and Other Drug (AOD) Needs Assessment highlights geographic variation in drug and alcohol related hospitalisations and Hep C treatment uptake across the region and builds upon findings from previous Needs Assessments, highlighting gaps in service provision in relation to residential rehabilitation beds and day/outpatient programs within the region, and a lack of services addressing co-occurring AOD and mental health issues.

Previous Needs Assessments highlighted need for early identification, screening, and support to accessing services which remains pertinent. Consultations also highlighted undersupply of detox beds relative to need, no Aboriginal-specific drug and alcohol services, and Residential Aged Care Facilities poorly equipped to meet the needs of older people. NSPHN continues to commission two alcohol and other drugs services, targeting vulnerable and at-risk groups, including Aboriginal people, young people, and people from CALD backgrounds. The services are also aligned to the stepped care continuum to facilitate integration between mental health and AOD services. The following update for alcohol and other drugs utilises the latest qualitative and quantitative data where possible to compliment findings from previous Needs Assessments.

| **Outcomes of the service needs analysis** | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| **Service access** | | |
| AOD combined morbidity | Drug and alcohol related hospitalisations. | **Quantitative evidence:**<br>• Nationally drug and alcohol hospitalisations accounted for 18.8% of all mental health related overnight hospitalisations (AIHW 2021f).<br>• In the NSPHN region, alcohol was the principal drug of concern for 45% of all alcohol and other drug hospital episodes (SNHN 2020b). |
| Alcohol | Alcohol is a leading contributor to self-harm and overdose related ambulance attendances in NSW. | **Quantitative evidence:**<br>• Alcohol intoxication (NSW) involved in (Lloyd et al. 2015):<br>  ○ 18% of suicide attempts cases<br>  ○ 28% of accidental overdose cases<br>  ○ 20% of suicide attempts involving overdose |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Hepatitis C screening | Low treatment uptake among people with Hepatitis C, with regional variation in rates. | **Quantitative evidence:**<br>• NSPHN has lower uptake of Hepatitis C treatment (45.7%) compared to the national average (47%). Similar to the national trend, treatment uptake rates declined in the NSPHN region in 2020 compared to 2017, reflecting the disparate effects on access to and provision of services as a result of COVID-19 (MacLachlan, Stewart and Cowie 2021).<br>• Manly (31.9%) and Kur-ring-gai (34%) SA3s had the lowest uptake of treatment compared to the NSPHN average (MacLachlan, Stewart and Cowie 2021). |
| Access | Lack of bulk billing GPs creates financial barriers to accessing AOD services | **Qualitative evidence:**<br>Stakeholder consultations identified a financial barrier to clients accessing AOD services due to the lack of bulk billing GPs. Majority of AOD services supplied through private healthcare. People in this cohort who are not clients of public AOD services have difficulty accessing affordable and appropriate support. |
| Access | Limited recognition of appropriate screening and referral pathways amongst primary health care providers. | **Qualitative evidence:**<br>Stakeholder consultation identified confusion for clients around AOD services available and access pathways. Complex health care system, navigation challenging for clients and service providers. |
| Access | Limited early intervention programs for AOD. | **Qualitative evidence:**<br>Limited early intervention programs for AOD, with an identified service gap around improving physical health screening among people with AOD misuse. |
| Access – availability | Lack of day/out-patient programs. | **Qualitative evidence:**<br>Stakeholder consultations identified a need for bulk-billing day/out-patient programs in the region. Northern Sydney Local Health District operate outpatient clinics and community based residential rehabilitation services across the region. |

| Outcomes of the service needs analysis | | |
|---|---|---|
| Identified Need | Key Issue | Description of Evidence |
| Access – availability | Undersupply of residential rehabilitation beds. | **Qualitative evidence:** Stakeholder consultation identified the demand for residential rehabilitation beds placement outstrips supply and people seeking residential rehabilitation either face long wait times or travel out of area to access support. This acts as a barrier to people obtaining support for AOD misuse disorders. |
| Access – availability | Services have limited capacity to provide AOD support outside of business hours. | **Qualitative evidence:** Stakeholder consultation identified most non-residential AOD services in the region only provide service during business hours. This makes access to specialist support difficult for people who attend work or education and for the families of people receiving AOD treatment. |
| Access – availability<br><br>Service coordination | Poor coordination between detox and availability of residential rehabilitation. | **Qualitative evidence:** Stakeholder consultation identified people seeking to access residential rehabilitation are often required to go through detox first. This creates delays in accessing treatment and can serve to diminish peoples' willingness to pursue rehabilitation. |
| Access – availability<br><br>Service coordination | Lack of services skilled in addressing co-occurring AOD and mental health issues. | **Qualitative evidence:** Stakeholder consultation identified clients with complex presentations (esp. with trauma) and multiple needs can experience barriers to service/insufficient service. Whilst the AOD services in the region receiving state funding are required to service people with co-occurring AOD and mental health issues, stakeholder reports highlighted the need for the wider service sector to respond better to people with co-morbid conditions. Many services address one issue to the exclusion of the other. |
| Integration | Limited coordination and integration between services. | **Qualitative evidence:** Stakeholder consultation highlighted the need for coordination and integration between services as silos currently exist between services, with a need for collaboration across multiple services. |

# References


ABS (Australian Bureau of Statistics) (2014) *Intellectual disability - Australia 2012* [data set], ABS website, accessed October 2017.
https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4433.0.55.003Main+Features12012?OpenDocument

ABS (2016a) *2016 Census - Employment, income and education* [TableBuilder], ABS website, accessed October 2018. https://auth.censusdata.abs.gov.au/webapi/jsf/login.xhtml

ABS (2016b) *2016 Census - Selected family characteristics* [TableBuilder], ABS website, accessed October 2018. https://auth.censusdata.abs.gov.au/webapi/jsf/login.xhtml

ABS (2018a) *Census of Population and Housing*: *Estimating homelessness*, ABS website, accessed October 2018. https://www.abs.gov.au/statistics/people/housing/census-population-and-housing-estimating-homelessness/2016#data-download

ABS (2018b) *Census of Population and Housing*: *Socio-economic indexes for areas (SEIFA) - Australia 2016*, ABS website, accessed October 2018.
https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/2033.0.55.001Main+Features12016?OpenDocument

ABS (2018c), *Mental health - 2017-18 financial year*, ABS Website, accessed October 2021. https://www.abs.gov.au/statistics/health/mental-health/mental-health/2017-18

ABS (2020a) *Household impacts of COVID-19 survey - 29 Apr – 4 May 2020*, ABS website, accessed October 2021. https://www.abs.gov.au/statistics/people/people-and-communities/household-impacts-covid-19-survey/29-apr-4-may-2020

ABS (2020b) *Household impacts of COVID-19 survey - September 2020*, ABS website, accessed October 2021. https://www.abs.gov.au/statistics/people/people-and-communities/household-impacts-covid-19-survey/sep-2020

ABS (2021a) *Household impacts of COVID-19 survey - June 2021*, ABS website, accessed October 2021. https://www.abs.gov.au/statistics/people/people-and-communities/household-impacts-covid-19-survey/jun-2021

ABS (2021b) '*Population estimates by age and sex, by LGA 2020*' [data set], *Regional population by age and sex*, ABS website, accessed October 2021.
https://www.abs.gov.au/statistics/people/population/regional-population-age-and-sex/2020

ABS (2021c) '*Underlying causes of death (New South Wales) 2020*' [data set], *Cause of death* Australia, ABS website, accessed October 2021.
https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2020

ACON (Aids Council of NSW) (2013) *Submission to: NSW Mental Health Commission towards a draft strategic plan for mental health in NSW- the life course and the journeys*, ACON, Sydney.

ACON (2015) *Annual report 2014/15*, ACON website, accessed October 2017.
https://www.acon.org.au/about-acon/annual-reports/

ACON (n.d.) *Estimating the prevalence and distribution of LGBTI adults in NSW*, ACON, Sydney.

AIHW (Australian Institute of Health and Welfare) (2008) *Disability in Australia: intellectual disability*, catalog number AUS 110, AIHW website, accessed October 2017. https://www.aihw.gov.au/reports/disability/intellectual-disability-australia/summary

AIHW (2012) *Perinatal depression: data from the 2010 Australian national infant feeding survey*, AIHW website, accessed October 2017. https://www.aihw.gov.au/reports/primary-health-care/perinatal-depression-data-from-the-2010-australia/summary

AIHW (2016) *Australian burden of disease study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011*, AIHW website, accessed October 2021. https://www.aihw.gov.au/reports/burden-of-disease/illness-death-indigenous-australians/summary

AIHW (2017a) '*Australia's welfare 2017*', *Australia's welfare series number 13*, catalog number AUS 216, AIHW website, accessed October 2018. https://www.aihw.gov.au/reports/australias-welfare/australias-welfare-2017/contents/summary

AIHW (2017b) *Hospitalisations for mental health conditions and intentional self-harm reporting years 2013-14,2014-15 and 2015-16* [data set], AIHW, Australian Government.

AIHW (2017c) '*Impact of physical activity as a risk factor for chronic conditions: Australian burden of disease study*', *Australian burden of disease series number 15*, catalog number 16, AIHW website, accessed October 2020. https://www.aihw.gov.au/reports/burden-of-disease/impact-of-physical-inactivity-chronic-conditions/summary

AIHW (2017d), '*Mental health-related care in general practice', Mental health services in Australia*, AIHW, Australian Government, accessed October 2018. https://www.aihw.gov.au/getmedia/a0dd44d9-d597-49aa-b92b-a943fcb00b88/Mental-health-related-services-provided-by-general-practice-2009-10.pdf.aspx

AIHW (2018a) *Alcohol, tobacco & other drugs in Australia*, AIHW website, accessed October 2018.

AIHW (2018b) '*Australia's health 2018*', *Australia's health series number 16*, catalog number AUS 221, AIHW website, accessed October 2018. https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/overview

AIHW (2018c) *Medicare benefits schedule GP and specialist attendances and expenditure in 2016–17* [data set], AIHW website, accessed October 2021. https://www.aihw.gov.au/reports/health-welfare-expenditure/mbs-gp-and-specialist-attendances-2016-17/contents/summary

AIHW (2018d) '*Specialist homelessness services annual report 2016–17', Specialist homelessness services collection number 6*, catalog number WEB 217, AIHW website, accessed October 2018. https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-2016-17/contents/about

AIHW (2019) '*Specialist homelessness services annual report 2017-18*', *Specialist Homelessness Services Collection number 7,* catalog number HOU 299, AIHW website, accessed October 2021. https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-2017-18/contents/contents

AIHW (2020a) *Alcohol, tobacco & other drugs in Australia* [data set], AIHW website, accessed October 2020. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia

AIHW (2020b) *Cancer screening and COVID-19 in Australia* [data set], AIHW website, accessed October 2020. https://www.aihw.gov.au/reports/cancer-screening/cancer-screening-and-covid-19-in-australia/data

AIHW (2020c) *National drug Strategy household survey 2019* [data set], AIHW website, accessed October 2021. https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/contents/summary

AIHW (2020d) *Natural environment and health*, AIHW website, accessed January 2022. https://www.aihw.gov.au/reports/australias-health/natural-environment-and-health

AIHW (2020e) *Specialist homelessness services annual report 2019-20* [data set], AIHW website, accessed October 2021. https://www.aihw.gov.au/reports/homelessness-services/shs-annual-report-2019-20/contents/about

AIHW (2020f) *Tobacco smoking*, AIHW website, accessed October 2020. https://www.aihw.gov.au/reports/australias-health/tobacco-smoking

AIHW (2020g) *Use of emergency departments for lower urgency care: 2015–16 to 2018–19* [data set], AIHW website, accessed October 2020. https://www.aihw.gov.au/reports/primary-health-care/use-of-ed-for-lower-urgency-care-2018-19/contents/lower-urgency-care/summary

AIHW (2021a) '*Australian burden of disease Study: Impact and causes of illness and death in Australia 2018*', *Australian burden of disease study series number 23*, catalog number BOD 29, AIHW website, accessed January 2022. https://www.aihw.gov.au/reports/burden-of-disease/abds-impact-and-causes-of-illness-and-death-in-aus/summary

AIHW (2021b) *Dementia in Australia* [data set], AIHW website, accessed February 2022. https://www.aihw.gov.au/reports/dementia/dementia-in-aus/contents/population-health-impacts-of-dementia/prevalence-of-dementia

AIHW (2021c) *GEN data: services and places in aged care* [data set], AIHW GEN website, accessed October 2021. https://www.gen-agedcaredata.gov.au/Resources/Access-data?page=1

AIHW (2021d) *Indigenous health checks and follow-ups* [data set], AIHW website, accessed October 2021. https://www.aihw.gov.au/reports/indigenous-australians/indigenous-health-checks-follow-ups

AIHW (2021e) *Medicare-subsidised GP, allied health and specialist health care across local areas: 2019–20 to 2020–21* [data set], AIHW website, accessed January 2022. https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-health-local-areas-201

AIHW (2021f) *Mental health services in Australia* [data set], AIHW website, accessed January 2022. https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia

AIHW (2021g) *Palliative care services in Australia* [data set], AIHW website, accessed January 2022. https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia/data

AIHW (2021h) *Suicide and self-harm monitoring* [data set], AIHW website, accessed January 2022. https://www.aihw.gov.au/suicide-self-harm-monitoring/data

Berger I and Mooney-Somers J (2015) '*Smoking cessation programs for LGBTI people: A systematic review of content and effect*', *VELiM*, University of Sydney, accessed October 2020. http://hdl.handle.net/2123/14075

beyondblue (2010) *Clinical practice guidelines: Depression in adolescents and young adults*, The National depression initiative, beyondblue, Melbourne.

beyondblue (2011) *Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period: A guideline for primary care health professionals,* The National depression initiative, beyondblue, Melbourne.

BOCSAR (NSW Bureau of Crime Statistics and Research) (2017) *New South Wales Recorded Crime Statistics 2016*, prepared by Goh D and Holmes J, Department of Justice, NSW Government, accessed October 2017. https://www.bocsar.nsw.gov.au/Pages/bocsar_media_releases/2017/mr-NSW-Recorded-Crime-Statistics-2016.aspx

BOCSAR (2021), *NSW Crime Tool* [data set], accessed October 2021. http://crimetool.bocsar.nsw.gov.au/bocsar/

Bryant RA, Gibbs L, Gallagher HC, Pattison P, Lusher D, MacDougall C, Harms L, Block K, Sinnott V, Ireton G, Richardson J and Forbes D (2018) '*Longitudinal study of changing psychological outcomes following the Victorian Black Saturday bushfires', Australian & New Zealand Journal of Psychiatry,* 52(6):542–551, doi: 10.1177/0004867417714337.

Cancer Institute NSW (2018) *Reporting for better cancer outcomes performance report 2018: Northern Sydney Primary Health Network*, Cancer Institute NSW.

Cancer Institute NSW (2020) *Reporting for better cancer outcomes performance report 2020: Northern Sydney Primary Health Network*, Cancer Institute NSW.

Cancer Institute NSW (2021a) *Cancer statistics NSW*, Cancer Institute NSW website, accessed October 2021. https://www.cancer.nsw.gov.au/research-and-data/cancer-data-and-statistics/cancer-statistics-nsw#//

Cancer Institute NSW (2021b) *Reporting for better cancer outcomes performance report 2021: Northern Sydney Primary Health Network* [unpublished data set], Cancer Institute NSW.

Costello L, Thomson M, and Jones K (2013) *Mental health and homelessness final report*, NSW Mental Health Commission, accessed October 2017. https://www.nswmentalhealthcommission.com.au/content/mental-health-and-homelessness-report

De Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, Detraux J, Gautam S, Möller HJ, Ndetei DM, Newcomer JW, Uwakwe R and Leucht S (2011) *'Physical illness in patients with severe mental disorder. I. Prevalence, impact of medications and disparities in health care'*, *World Psychiatry*, 10:52-77, doi: 10.1002/j.2051-5545.2011.tb00014.x

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

Dementia Australia (2018) *Dementia prevalence data 2018-2058*, commissioned research undertaken by NATSEM (National Centre for Social and Economic Modelling), University of Canberra, accessed November 2021.

DoH (Department of Health) (2017a) *MBS data by PHN- MBS item and reporting group 2012-13 to 2016-17*, Department of Health, Australian Government, viewed October 2018.

DoH (2017b) *PHN primary mental health care flexible funding pool implementation guidance- Stepped care*, Department of Health, Australian Government.

DoH (2017c) *The Fifth National Mental Health and Suicide Prevention Plan*, Department of Health, Australian Government.

DoH (2018) *Specialised community mental health support services and the National Mental Health Service Planning Framework,* Department of Health, Australian Government.

DoH (2021a) *Health workforce data tool* [data set], National Health Workforce Dataset, Department of Health, Australian Government, accessed September 2021.
https://hwd.health.gov.au/datatool/

DoH (2021b) *Health workforce locator*, Department of Health, Australian Government, viewed October 2021.
https://www.health.gov.au/resources/apps-and-tools/health-workforce-locator/health-workforce-locator

DoH (2021d) *Home care packages program data report 3rd Quarter 2020-21: 1 January – 31 March 2021*, Department of Health, Australian Government, accessed October 2021. https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2021/June/Home-care-packages-program-data-report-1-January-%E2%80%93

DoH (2021d) *Medicare statistics by COVID item type Oct-2020 to Sep-2021*, Department of Health, Australian Government, accessed January 2022.
https://www1.health.gov.au/internet/main/publishing.nsf/Content/Medicare%20Statistics-1

DoHA (Department of Health and Ageing) (2012) National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, DoHA, Australian Government.

Doherty AJ, Atherton H, Boland P, Hastings R, Hives L, Hood K, James-Jenkinson L, Leavey R, Randell E, Reed J, Taggart L (2020) 'Barriers and facilitators to primary health care for people with intellectual disabilities and/or autism: an integrative review', BJGP open, 4(3)1-10,
doi:10.3399/bjgpopen20X101030.

Ezard N, Cecilio ME, Clifford B, Baldry E, Burns L, Day CA, Shanahan M and Dolan K (2018) '*A managed alcohol program in Sydney, Australia: Acceptability, cost-savings and non-beverage alcohol use*', *Drug and Alcohol Review*, 37:184-94, doi:10.1111/dar.12702.

HealthStats NSW (Centre for Epidemiology and Evidence) (2020) *Health statistics New South Wales* [data set], HealthStats NSW website, accessed October 2020.
http://legacy.healthstats.nsw.gov.au/

HealthStats NSW (Centre for Epidemiology and Evidence) (2021) *Health statistics New South Wales* [data set], HealthStats NSW website, accessed January 2022.
https://www.healthstats.nsw.gov.au/#/home

Jin K, Neubeck L, Gullick J, Koo F and Ding D (2017) '*Marked differences in cardiovascular risk profiles in middle-aged and older Chinese residents: Evidence from a large Australian cohort*', *International Journal of Cardiology*', 227:347-354, doi:10.1016/j.ijcard.2016.11.062.

Kermode M, Crofts N, Miller P, Speed B and Streeton J (2008) '*Health Indicators and risks among people experiencing homelessness in Melbourne 1995-1996*', *Australia and New Zealand Public Health*, 22:464-70, doi: 10.1111/j.1467-842X.1998.tb01415.x.

Kirby Institute (2018) *HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2018*, Kirby Institute, UNSW Sydney, accessed October 2020. https://kirby.unsw.edu.au/report/hiv-viral-hepatitis-and-sexually-transmissible-infections-australia-annual-surveillance

Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J and Zubrick SR (2015) *The mental health of children and adolescents: Report on the second Australian child and adolescent survey of mental health and wellbeing*, Department of Health, Australian Government, accessed October 2017. https://www.health.gov.au/resources/publications/the-mental-health-of-children-and-adolescents

Lawrence D and Kisely S (2010) '*Inequalities in healthcare provision for people with severe mental illness', Journal of psychopharmacology*,24(4_suppl):61-68, doi:10.1177/1359786810382058.

Lennox NG, Diggens JN and Ugoni AM (1997) '*The general practice care of people with intellectual disability: barriers and solutions', Journal of Intellectual Disability Research,* 41(5):380-90, doi:10.1111/j.1365-2788.1997.tb00725.x.

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

MacLachlan JH, Stewart S and Cowie BC (2021) *Viral hepatitis mapping project: National report 2020, ASHM (Australasian Society for HIV, Viral Hepatitis, and Sexual Health Medicine*, accessed January 2022. https://www.ashm.org.au/resources/hcv-resources-list/viral-hepatitis-mapping-project-national-report-2020/

Mental Health Commission of NSW (2017) *Living well in later life: The case for change*, Mental Health Commission of NSW, accessed October 2017. https://www.nswmentalhealthcommission.com.au/report/living-well-later-life-case-change

MHiMA (Mental Health in Multicultural Australia) (2014) *Framework for mental health in multicultural Australia - Towards culturally inclusive service delivery*, MHiMA, Queensland.

Mooney-Somers J, Deacon RM, Scott P, Price K and Parkhill N (2018) '*Women in contact with the Sydney LGBTQ communities: Report of the SWASH Lesbian, Bisexual and Queer Women's Health Survey 2014, 2016, 2018'*, Sydney Health Ethics, University of Sydney, accessed October 2020. http://hdl.handle.net/2123/20157

Morgan VA, Waterreus A, Jablensky A, Mackinnon A, McGrath JJ, Carr V, Bush R, Castle D, Cohen M, Harvey C, Galletly C, Stain HJ, Neil A, McGorry P, Hocking B, Shah S and Saw S (2011) *People living with psychotic illness 2010: Report on the second Australian national survey of psychotic illness*, National Mental Health Strategy, Commonwealth of Australia.

NMHSPF (National Mental Health Service Planning Framework) (2021), *NMHSPF planning support tool (NMHSPF-PST),* Commissioned by the Australian Government Department of Health. Version AUS V4.0, University of Queensland, accessed January 2022. https://www.aihw.gov.au/nmhspf

NSLHD (Northern Sydney Local Health District) (2016) *Northern Sydney District homelessness project 2016*, NSLHD.

NSW Department of Planning, Industry and Environment (2019) *Population, household and implied dwelling projections by LGA (ASGS 2019)* [data set], NSW Planning Department of Planning, Industry and Environment website, accessed September 2020.
https://www.planning.nsw.gov.au/Research-and-Demography/Population-projections/Projections

NSW Ministry of Health (2017) *NSW Youth Health Framework 2017-24,* NSW Ministry of Health website, accessed October 2017. https://www.health.nsw.gov.au/kidsfamilies/youth/Pages/yh-framework.aspx

NSW Ministry of Health (2019) *NSW plan for healthy culturally and linguistically diverse communities: 2019-2013,* NSW Ministry of Health website, accessed October 2020.
https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2019_018

NSW Ministry of Health (2021a) *Children fully immunised in NSW by local government area 2020-21*, NSW Ministry of Health website, accessed January 2022.
https://www.health.nsw.gov.au/immunisation/Pages/coverage-by-lga.aspx

NSW Ministry of Health (2021b), *NSW HIV Strategy 2016-2020: Quarter 4 & Annual 2019 Data Report*, NSW Ministry of Health website, accessed October 2021.
https://www.health.nsw.gov.au/endinghiv/Pages/tools-and-data.aspx

Penington Institute (2021) *Australia's annual overdose report 2021*. Penington Institute accessed October 2021.
https://www.penington.org.au/publications/australias-annual-overdose-report-2021/

PHIDU (Public Health Information Development Unit) (2018) *Social health atlas of Australia: Data by primary health network (PHN)/local government area (LGA*), *October 2018 release* [data set], PHIDU website, accessed October 2021. https://phidu.torrens.edu.au/social-health-atlases/data

PHIDU (Public Health Information Development Unit) (2021) *Social health atlas of Australia: Data by primary health network (PHN)/local government area (LGA*), *September 2021 release* [data set], PHIDU website, accessed October 2021.
https://phidu.torrens.edu.au/social-health-atlases/data

RACGP (The Royal Australian College of General Practitioners) (2011) *The RACGP curriculum for Australian general practice 2011- Multicultural health*, RACGP website, accessed October 2020.
https://www.racgp.org.au/education/education-providers/curriculum/previous-versions

Relationships Australia NSW and The Gaimaragal Group (2017) *Indigenous wellbeing in Northern Sydney roundtable report*, Relationships Australia (NSW) Limited.

Rickwood D (2006) *Pathways of recovery: Preventing further episodes of mental illness (Monograph)*, National Mental Health Promotion and Prevention Working Party, Department of Health and Ageing, Australian Government.

Ritter A, Berends L, Chalmers J, Hull P, Lancaster K and Gomez M (2014) *New Horizons: The review of alcohol and other drug treatment services in Australia*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW.

Ritter A, Matthew-Simmons F and Carragher N (2012) *'Prevalence of and interventions for mental health and alcohol and other drug problems amongst the Gay, Lesbian, Bisexual and Transgender Community: A review of the literature', Drug Policy Modelling Program Monograph Series,* Monograph 23, National Drug and Alcohol Research Centre, accessed October 2017. https://ndarc.med.unsw.edu.au/resource/23-prevalence-and-interventions-mental-health-and-alcohol-and-other-drug-problems-amongst

Salvador-Carulla L, Bell T, Furst M, McLoughlin L, Mendoza J and Salinas-Perez JA (2017) *The integrated mental health atlas of Sydney North PHN*. The Menzies Centre for Health Policy, University of Sydney and ConNetica, accessed October 2017.
https://www.researchgate.net/publication/326368741_The_Integrated_Mental_Health_Atlas_of_Sydney_North_PHN

SNHN (Sydney North Health Network) (2020a) *Climate and health strategy*, SNHN website, accessed January 2022.
https://sydneynorthhealthnetwork.org.au/about-us/climate-and-health-strategy/

SNHN (2020b) *Northern Sydney Mental Health, Suicide Prevention and Alcohol and other drugs Regional Plan*, SNHN website, accessed February 2022.
https://sydneynorthhealthnetwork.org.au/thenorthernsydneyregionalplan/

SNHN (2021) *Sax Institute - 45 and Up Study* [unpublished internal analysis], SNHN, Sydney.
The Sax Institute's 45 and Up Study is Australia's largest ongoing study of health and ageing, following over 267,000 participants aged 45 and over recruited in NSW between 2006-2009. The 45 and Up Study is managed by the Sax Institute in collaboration with major partner Cancer Council NSW; and partners: the Heart Foundation; NSW Ministry of Health; NSW Department of Communities and Justice; and Australian Red Cross Lifeblood. Further detail regarding the Sax Institute's 45 and Up Study can be accessed via the link below:
https://www.saxinstitute.org.au/our-work/45-up-study/

SNHN (2022a) *Commissioned services data* [unpublished internal analysis], SNHN, Sydney.

SNHN (2022b) *GP practice data from PATCAT database* [unpublished internal analysis], SNHN, Sydney.

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

Watts N, Adger WN, Agnolucci P, Blackstock J, Byass P, Cai W, ... and Costello A (2015) *'Health and climate change: policy responses to protect public health', The Lancet,* 386(10006):1861-1914, doi:10.1016/S0140-6736(15)60854-6.

Weise JC, Srasuebkul P and Trollor JN (2021) *'Potentially preventable hospitalisations of people with intellectual disability in New South Wales', Medical Journal of Australia,* 215(1):31-6, doi: doi.org/10.5694/mja2.51088.

# Index


***Aboriginal and Torres Strait Islander People***
AOD....46
Breast Cancer Screening....23
Culturally appropriate services....55
Holistic Services....55
MBS 715....55
Mental Health Services....74
Riskfactors....23
Self-harm....39
Suicide....39
***Access***
After hours....51
Impact of COVID-19....52
***Alcohol***
AOD misuse....44
Hospitalisations....43
Prevalence....43
***Cancer Screening....16***
***Childhood Immunisation....19***
***Climate and Health....21***
***Culturally and Linguistically Diverse (CALD)***
**B**reast Cancer Screening....25
Health needs....24
Mental Health....40
Population....24
Psychosocial Support....75
Culturally appropriate services....56
Impact of COVID-19....56
***Demography....13***
***Homelessness***
Access to housing....28
AOD use....48
Early Intervention....57
Population....27
Prevalence of mental illness....41
Pyschosocial support....76
***Intellectual Disability***
Prevalence....41
Services....77
***Lesbian, Gay, Bisexual,Transgender and Intersex Population (LGBTI)***
Alcohol....47
Illicit drug use....47
Prevalence of mental illness....40
Sexual Health....27
Smoking....26
***Mortality***
AOD....44
Premature....14
***Older People***
Aged Care services....59
Alcohol consumption....48
Dementia....58
Depression....41
Falls....28
Impact of COVID-19....60
Mental Health Services
Access....76
***Perinatal Depression***
Services....78
***Prevalence***
Mental illness....30
Obesity....16
Physical Activity....15
Smoking....15
Suicide....31
*See also Alcohol*
***Primary Mental Health Care***
Impact of COVID-19....32, 63
Regional Plan....64
***Psychosocial support***
Health needs....34
Service needs....67–68
***Risk Factors***
Impact of COVID-19....18
Interventions....50
***Socio-economic disadvantage***
Alcohol....47
Areas of disadvantage....26
Life expectancy....26
PPH....20
Self-harm....40
Smoking....26
***Young People***
Illicit drug use....45
Impact of COVID-19....72
Mental Health prevalence....37
Mental Health services....70
Self harm....38