Clarence Valley Mental Health & Wellbeing

PLAN 2016-2018

Table of Contents

1. Overview

In late 2015, the National Health and Medical Research Council (NHMRC) Centre for Research Excellence in Suicide Prevention and Black Dog Institute prepared a proposed *Suicide Prevention Framework for NSW*[1] for the NSW Mental Health Commission. The Framework identifies nine evidence-based strategies for suicide prevention which if implemented simultaneously are expected to reduce suicide deaths by 21%, and suicide attempts by up to 30%[2].

The Clarence Valley has experienced higher than state average rates of suicide since early 2015[3]. In response, a four-phase process has been implemented: community meetings to discuss the issue; community interviews to identify risk and protective factors and existing mental health and wellbeing strategies; two workshops to commence development of local strategies, and formation of a steering group (see Steering Committee draft Terms of Reference in Attachment 1) to lead the development and implementation of a plan for improving mental health and wellbeing in the Clarence Valley[4].

This document firstly presents the draft Our Healthy Clarence Mental Health and Wellbeing Plan, and then describes the community and local mental health and well-being data. The evidence regarding suicide prevention is then presented, followed by a description of the process used to develop the plan.

[1] NSW Mental Health Commission, 2015. *Proposed Suicide Prevention Framework for NSW: Systems Approach to Suicide Prevention,* [Online] Available at http://www.blackdoginstitute .org.au/public/research/suicideprevention.cfm [Accessed June 2016].
[2] For further information about the Framework, please see Section 3: Evidence
[3] For further information about the Clarence Valley, please see Section 2: Background
[4] For further information about the planning process, please see Section 4: Planning Process

2. Plan

Objective 1: Improve access to evidence-based treatment, crisis care and coordinated care after a suicide attempt

1.1 Develop and implement agreed guidelines and tools for treatment, crisis care and follow up of people who have self-harmed, including for case coordination and sharing of information between providers
1.2 Ensure availability of evidence-based group programs, where appropriate
1.3 Improve access to counselling, psychiatry and General Practitioners across the lifespan
1.4 Identify and communicate availability of health professionals in the region with expertise in the treatment of suicidal individuals
1.5 Develop local resource packs for people who have self-harmed and their families
1.6 Establish a Postvention[5] Planning Network and Guidelines, including communication protocols

Objective 2: Improve the capacity of the workforce and the community to respond to people at risk of suicide

2.1 Provide training opportunities to GPs and other health providers on screening for suicidality, immediate risk management, and identification of mental disorders such as depression, including utilisation of the peer workforce to provide training
2.2 Promote agreed guidelines and tools for crisis care and follow up of people who have self-harmed to all service providers
2.3 Deliver Mental Health First Aid, Youth Mental Health First Aid, Aboriginal Mental Health First Aid and ASIST training to frontline workers and community members
2.4 Develop and implement strategies to support those who have been trained
2.5 Provide broad community education for mental wellbeing and suicide prevention

Objective 3: Increase the availability of evidence-based mental health and wellbeing programs within schools

3.1 Support schools to adopt frameworks such as KidsMatter and MindMatters, and programs such as Youth Aware of Mental Health, Signs of Suicide, Sources of Strength and peer support programs
3.2 Work with local Aboriginal organisations and/or community members to identify and implement culturally safe and competent programs for Aboriginal young people in the school environment
3.3 Investigate the feasibility of screening school students for signs of mental health concerns
3.4 Support schools in ongoing implementation of existing staff training to support youth mental health
3.5 Offer training to parents and carers to enhance their capacity to identify and respond to depression and suicide risk

Objective 4: Improve community awareness of mental health and how to access information and services

4.1 Develop *Our Healthy Clarence* website
4.2 Provide workshops and support to local organisations to promote awareness and engagement with their services
4.3 Promote access to good quality health, well-being and service information
4.4 Engage local media organisations to establish a coordinated mental health and wellbeing campaign
4.5 Develop Our Healthy Clarence communication plan to enhance awareness of the initiative

Objective 5: Improve community engagement, early intervention and prevention

5.1 Develop and maintain a community engagement and planning framework to underpin implementation of the Our Healthy Clarence plan
5.2 Develop and implement non-clinical support services for young people and other groups with a focus on prevention and early intervention
5.3 Develop and promote community spaces to hold meetings and support groups, and provide opportunities for community members to come together formally and informally

[5] Postvention refers to action taken after a suicide attempt or a suicide death.

3. Background

The Clarence Valley mental health and wellbeing community consultation process was initiated in response to community concern regarding relatively high suicide rates since early 2015.

The Clarence Valley

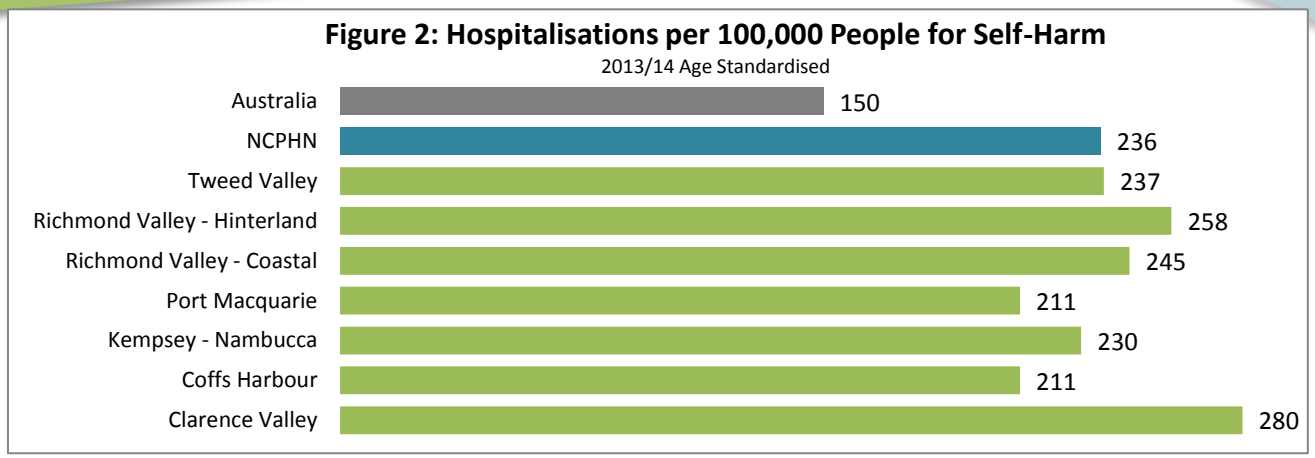
The Clarence Valley Local Government Area (LGA) is situated below the Richmond Valley LGA, and above the Coffs Harbour and Bellingen LGAs in Northern New South Wales (see Figure 1). The Clarence Valley is home to almost 50,000 people across almost 10,500km^2. The region is home to twice the proportion of Aboriginal and Torres Strait Islander residents (5.7%) compared to the NSW average (2.5%). The Valley is also home to a large proportion of older people (21.3%) in comparison to the NSW average (14.7%)[6].

Clarence Valley Mental Health & Wellbeing

In the 2016 North Coast Primary Health Network Needs Assessment Survey, more Clarence Valley residents rated mental health issues as the most serious local health concern than they did any other health concern[7]. Suicide was rated as a serious health concern by twice the proportion of Clarence Valley residents compared to the average proportion across the NCPHN region[8].

Compared to the NCPHN Region, the Clarence Valley has relatively high levels of socioeconomic disadvantage, unemployment, low-income households and lone parent families[9]. Figure 2 below shows that within the Clarence Valley, there are 280 self-harm hospitalisations per 100,000 people, compared to 150 in Australia and 236 in the NCPHN region[10].

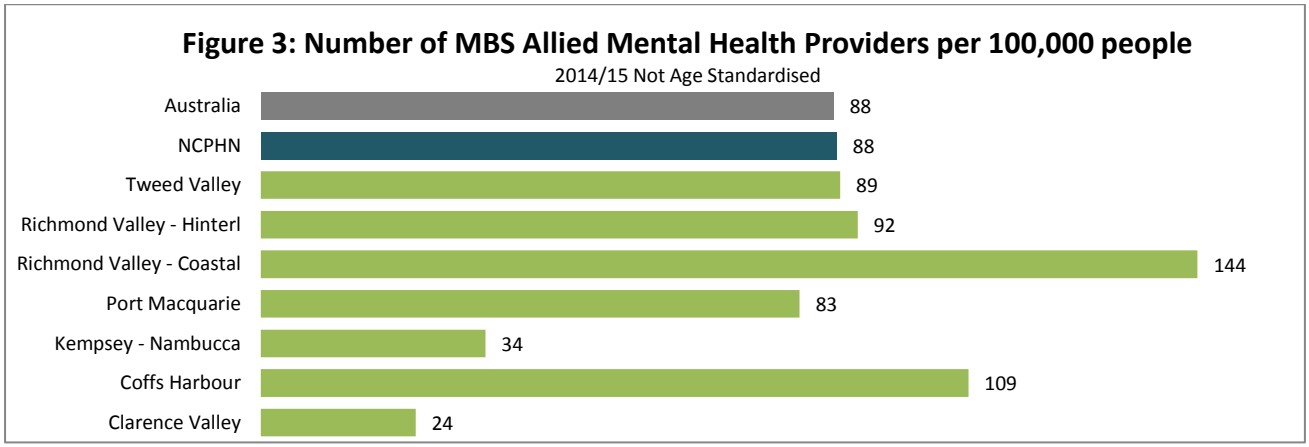
[6] Australian Bureau of Statistics, 2011. Census of Population and Housing: QuickStats, [Online] Available at http://www.abs.gov.au/websitedbs/censushome.nsf/home/quickstats?opendocument&navpos=220 [Accessed March 2016].
[7] North Coast Primary Health Network, 2016. *Clarence Valley Local Government Area Health Check*, [Online] Available at http://ncphn.org.au/needs-assessment-2016 [Accessed June 2016].
[8] The NCPHN region ranges from the Tweed Heads LGA in the North to the Port Macquarie LGA in the south, and its most western point is within the Kyogle LGA.
[9] University Centre for Rural Health North Coast, 2016. Population Health Maps using data from the Australian Bureau of Statistics, 2011. Census of Population and Housing, Not available online. [Accessed March 2016].
[10] Australian Institute of Health and Welfare, 2016. *Healthy Communities*
Hospitalisations for mental health conditions and intentional self-harm in 2013–14. [Online] Available at: http://www.myhealthycommunities.gov.au/Content/publications/downloads/AIHW_HC_Report_Mental_Health_September_2016.pdf?t=1475111127719, [Accessed September 2016]



Access to Services

The 2016 NCPHN Needs Assessment survey results[11] reveal that Clarence Valley residents report finding it more difficult to get a GP appointment, and experience long waits for GP appointments more often than the average across the NCPHN region. Psychiatrists were rated as hard or very hard to access by more than twice the proportion of Clarence Valley residents than the proportion across the NCPHN region. The most commonly reported barriers to accessing specialists in the Clarence Valley were 'distance of travel' and 'lack of specialists in the area'. These barriers were reported more frequently in the Clarence Valley than across the NPCHN region. 'Lack of services' was the challenge most often identified by Clarence Valley residents as a barrier to accessing mental health services.

The Needs Assessment survey results are supported by Medicare Benefits Schedule data. Figure 3 shows that there are only slightly more than a quarter of the number of Allied Mental Health Providers per 100,000 people providing services in the Clarence Valley compared to the NCPHN and national averages. Similarly, Figure 4 shows that around 70% more Allied Mental Health services are delivered per 100,000 people in Australia than are provided in the Clarence Valley.



[11] North Coast Primary Health Network, 2016. *Clarence Valley Local Government Area Health Check*, [Online] Available at http://ncphn.org.au/needs-assessment-2016 [Accessed June 2016].

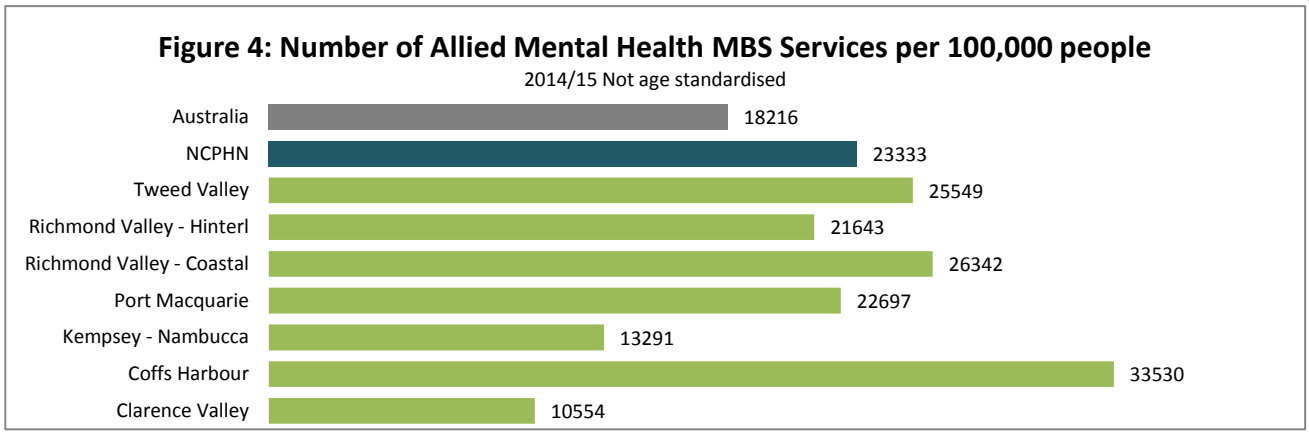
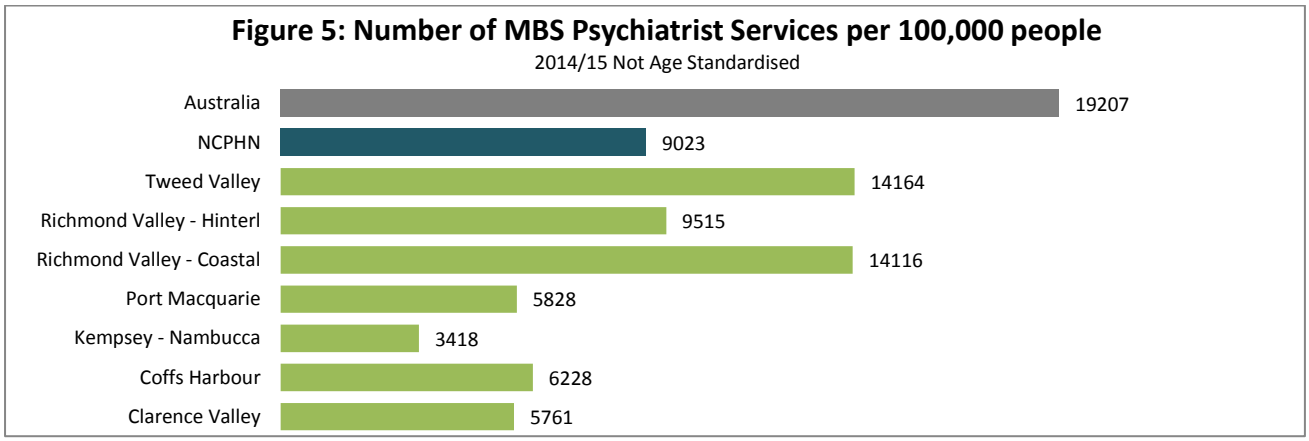
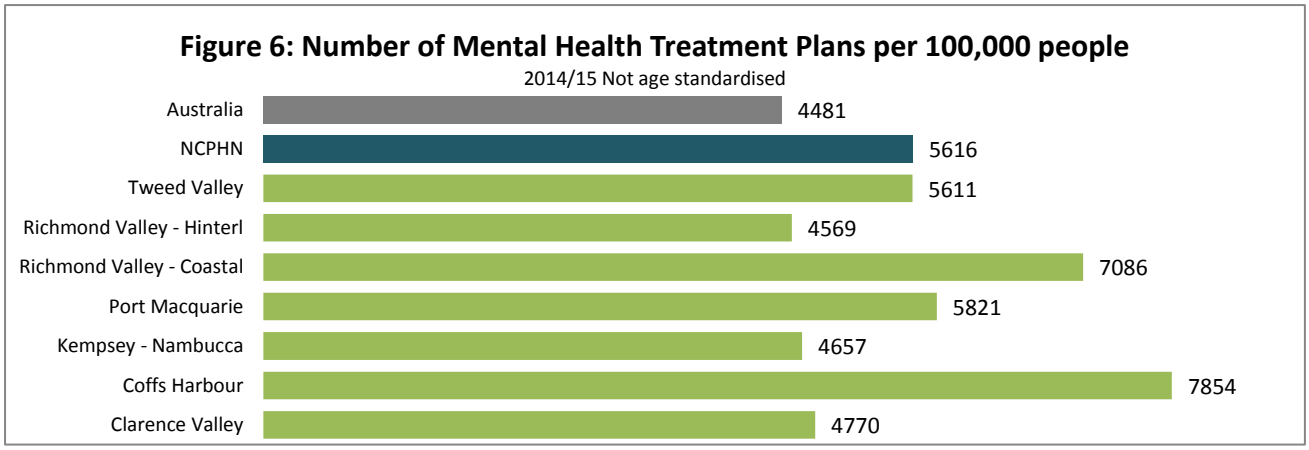


Figure 5 below shows access to psychiatry in the Clarence Valley, and demonstrates that on average, Australians access over 230% more psychiatry services than people living in the Clarence Valley. However, this lack of access to psychiatry and psychology does not appear to be due to lack of access to GP Mental Health Treatment Plans. Figure 6 shows that Clarence Valley residents have more GP Mental Health Treatment Plans per 100,000 people than the national average.





4. Evidence

The National Health and Medical Research Council (NHMRC) Centre for Research Excellence in Suicide Prevention and Black Dog Institute prepared a proposed *Suicide Prevention Framework for NSW*[12] for the NSW Mental Health Commission in August 2015. The Framework recommends a 'Systems' approach to suicide prevention which involves:

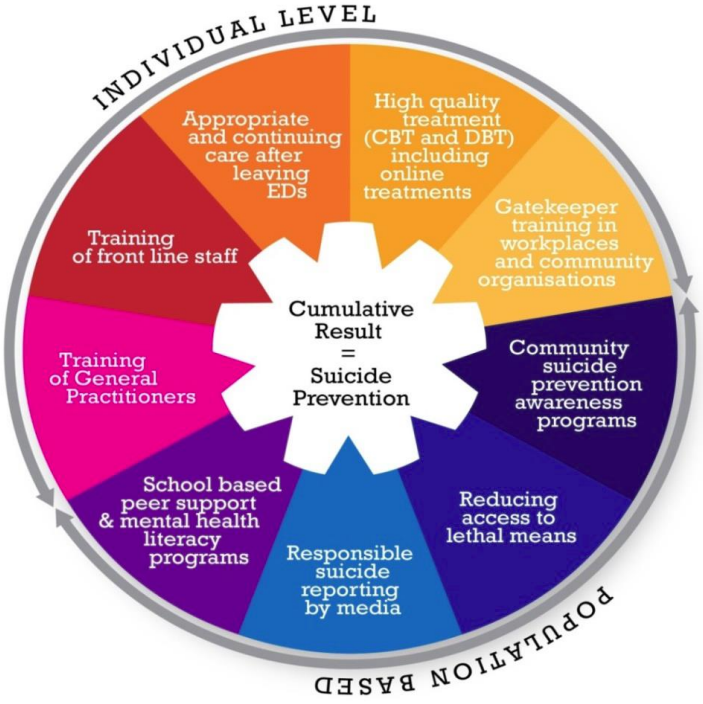
- Multi-sectorial involvement by all government, non-government, health, business, education, research and community agencies and organisations
- Within a localised area
- Implementing evidence-based strategies at the same time
- Demonstrating sustainability and long-term commitment.

Four major actions make up the Systems Approach:

1. Implement evidence-based suicide prevention strategies in local areas, using existing community structures and initiatives where possible.
2. Adopt a common evaluation framework across local areas.
3. Engage local communities, such as health services, schools, community agencies, worksites, rural and remote services, and the police in suicide prevention, and build capacity and readiness across these organisations within the community.
4. Establish good implementation, governance, resources and processes at central and local areas.

In relation to the first component of the Framework, the following are considered to be the nine evidence-based strategies:

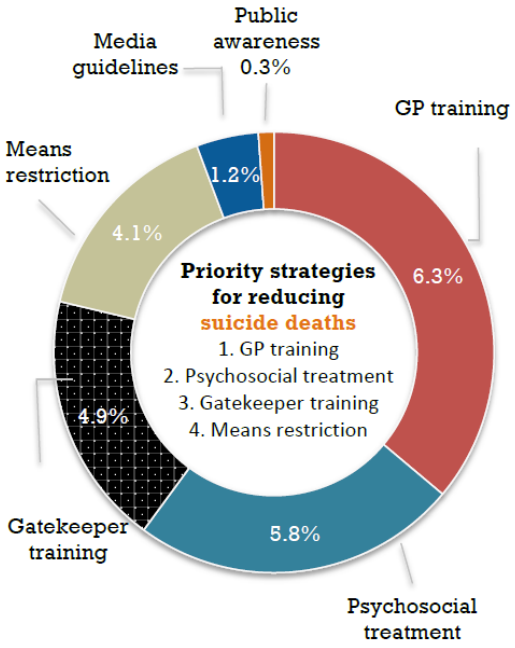
1. Appropriate and continuing care once people leave Emergency Departments (ED), and for those at risk in the community at any one time:
   a. 24/7 call out emergency teams experienced in adult/child/adolescent suicide prevention;
   b. Crisis-call lines and chat services for emergency callers;
   c. Assertive outreach for those in the ED and discharged including those hard to engage with;
   d. E-health services or web programs through the Internet.
2. High quality treatment, such as Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT) for those with mental health problems (including online treatments).
3. Training of GPs in detecting depression and dealing with suicide risk.
4. Suicide prevention training of front line staff every three years, including police, ambulance and other first responders.



[12] NSW Mental Health Commission, 2015. *Proposed Suicide Prevention Framework for NSW: Systems Approach to Suicide Prevention,* [Online] Available at http://www.blackdoginstitute .org.au/public/research/suicideprevention.cfm [Accessed June 2016].

5. Gatekeeper training for persons who are likely to come into contact with at risk individuals (teachers, youth workers, friends and family, clergy, counsellors). Provision of training in appropriate workplaces, in particular communities (Aboriginal communities) and across other services targeting particular populations, such as people who interact with those with a disability, or unemployed, or in financial crisis, people dealing with child trauma, rape, violence, etc.
6. School-based peer support and mental health literacy programs.
7. Community awareness programs about suicide.
8. Responsible suicide reporting by the media.
9. Reducing access to lethal means of suicide.

The Framework anticipates simultaneous implementation of the nine strategies will result in a 21% reduction in suicide deaths, and a 30% reduction in attempts[13]. Figure 7 below shows the extent to which each of the nine strategies are expected to contribute to reduction in deaths.



cted to Reduce Deaths[13]

[13] Blackdog Institute, 2016. *The Systems Approach to Suicide Prevention: Site Selection Information*, [Online] Available at http://www.blackdoginstitute .org.au/public/research/suicideprevention.cfm [Accessed June 2016].

5. Planning Process

Community Meetings

The process for developing this plan commenced with concerns raised by people in the Clarence Valley in relation to the number of suicide deaths of young people. Community members initiated a series of community meetings in March to June 2016 to advocate for services and the community to combine to generate a response. These meetings resulted in the convening of multi-agency meetings which were aimed to form a coordinated response and implement a whole of community mental health strategy within the Clarence Valley. This process led to the commissioning of Robyn Considine to conduct community interviews.

Community Interviews

In May 2016, the Northern NSW Local Health District commissioned Robyn Considine, Associate with the School of Medicine and Public Health in the University of Newcastle's Centre for Rural and Remote Mental Health to undertake community interviews in the Clarence Valley in order to:

- Identify factors associated with mental health problems
- Identify strategies, capacity and resources to promote mental health and wellbeing across the community.

Interviewees were identified using two key strategies: Newspaper articles promoting the opportunity to be interviewed; and a snowballing technique which involved asking each interviewee to identify others who should be approached for interview. Ninety-seven individuals were interviewed, and 32 services were represented through the interview process.

The community interviews resulted in the following outcomes:

- Identification of key local mental health issues
- Identification of individual, community and structural risk and protective factors
- Mapping of existing strategies
- Identification of gaps in existing strategies

The community interview process identified the following as commonly identified local mental health concerns:

- Depression
- Anxiety
- Substance abuse (alcohol, marijuana, methamphetamines)
- Eating disorders
- Self-harm
- Schizophrenia

The risk and protective factors identified for mental health and wellbeing across the community are summarised in Table 1 overleaf.

Table 1: Risk & Protective Factors Identified By Community Interviews

	Risk Factors	Protective Factors
Individual & Family	• Knowledge and understanding of mental health signs, symptoms, ways to provide support and services • Family breakdown • Stigma about mental health problems • Numbers of parents with mental illness • Chronic illness in older people • Families struggling with family members with mental illness • Recognition of role of family and carers in care for family members with mental illness • Domestic violence • Sexual abuse • Impact of social media and IT on relationships, sleep and behaviour	• Commitment to address mental health problems • Commitment of family and community • Increasing knowledge and awareness of mental health problems • Strong generational family ties • Commitment among young people to address issue
Community-level	• Culture of denial in some groups regarding mental health problems, domestic violence and sexual abuse • Conservatism • Generational trauma in Indigenous communities • Community trauma (suicides and other deaths) • Bullying (social media, workplace, community, sporting clubs) • Stigma, racism and social disconnect for some groups • Focus on sport and alcohol (binge drinking) • One-off nature of community events rather than systematic approach to participation • Lack of proactive approach to social and economic development • Leadership on social issues • Capacity of service providers in mental health • Community resilience • Community social efficacy • Sensationalist reporting by media	• Community commitment to address mental health • Strong volunteering and participation (crisis response, sporting clubs, diverse range of seniors groups, strong cultural groups) • Cultural groups (Indigenous, LGBTIQ) • Range of activities (sporting, cultural) • Community events • Range of initiatives to address mental health (community action groups, youth suicide prevention committee) • Community resilience • Community social efficacy • Improved media reporting
Structural	• High unemployment (youth, Indigenous) • Few employment opportunities (sense of hopelessness) • Homelessness and lack of housing stock • Lack of knowledge of range of service options and referral pathways (service providers and community, gaps, duplication) • Poor transport access across Valley and between other centres • Tertiary education opportunities outside Valley • Poor access to acute mental health services across Valley (attitudinal and quality barriers, cost, specialist services, lack of Aboriginal staff) • Capacity in primary health care to address mental health (GP skills, support staff, focus on medication, GPs as gatekeepers) • Access to drug & alcohol services (general community, youth) • Lack of responsiveness to mental health in institutions (education, health, council) • Lack of focus on early intervention	• Range of secondary education options • Training providers responding to employment opportunities • Local employment opportunities (targeted schemes) • Range of NGOs focussing on support and employment • TAFE responsive to employment needs • Recent developments in primary care (GP Superclinic) • Recognition that services are now trying to address mental health

Workshops

Community members and service providers were invited to an initial half-day Workshop held on the 23rd of May at the Grafton Community Centre. The event was attended by 75 people, representing community members, government agencies, non-government agencies and community groups and representatives. The following outcomes were achieved at the Workshop:

- Familiarisation with the outcomes of the community interviews
- Identification of local strategies not identified during the community interview process
- Identification of opportunities for building on or improving existing strategies
- Identification of new strategies which could be implemented to address protective and risk factors
- Nomination of levels of continued involvement by participants in the consultation and planning process
- Voting on potential logos to be used in promoting local mental health and wellbeing (with the most popular logo used in this report)
- Agreement that a further Workshop would be held to develop a local mental health and well-being plan

A second Workshop was held on the 29th of June 2016. This workshop introduced the Systems Approach to suicide prevention, and used information from the previous workshop, as well as recommendations from the Black Dog Institute regarding the Systems Approach to identify actions which could be taken to reduce suicide and improve mental health and wellbeing in the Clarence Valley. The workshop outcomes are presented in Table 2 below.

This workshop also identified that the North Coast Primary Health Network would become responsible for leading the Our Healthy Clarence initiative, and that a Steering Committee would be formed to guide the development and implementation of a plan for improving mental health and wellbeing in the Valley.

Table 2: Summary of Workshop 2 Outcomes

Evidence-Based Strategy	Priorities	Organisation Responsible	Possible Progress in 2016/17
Aftercare, Crisis Care and Treatment	• Local coordination for Aftercare, Crisis Care and Treatment	Primary Health Network	• Develop local coordination including shared intake, clear roles and responsibilities, follow-up response and mechanism for sharing information • Develop Service Agreement / Accord between relevant agencies
	• Postvention	Primary Health Network	• Establish Postvention Planning Network
GP Capacity-Building & Support, Frontline Staff & Gatekeeper Training	• ASIST training for Gatekeepers	Lifeline	• Deliver ASIST training to Clarence community quarterly
	• GP Capacity Building (including use of peer workforce)	TAFE & Primary Health Network	• Continue to develop Mental Health Peer Support Certificate IV, and utilise the peer support workforce to engage with GPs via Primary Health Network • Ensure GPs have access to evidence-based guidelines (e.g Biochem)
	• Mental Health First Aid (MHFA) or ASIST training for police	Health & Lifeline	• Deliver MHFA or ASIST training to Police Officers
	• Community-wide training	Cranes	• Deliver MHFA, Youth MHFA & Aboriginal MHFA to Clarence community quarterly
School Programs	• Embed wellbeing framework	Schools	• Embed wellbeing framework within schools (e.g. Mindmatters) – all staff, every classroom, every teacher, every student. Whole school delivery; whole school training.
	• Screening for suicide risk	To be identified	• Investigate practical ways to implement screening
	• Training for parents	To be identified	• To be identified
Community Campaigns	• Our Healthy Clarence Website	To be identified	• Establish Our Healthy Clarence website that provides information, links to current services, updates, themes, events calendar (consider linking to www.directory.wayahead.org.au) ▪ Establish a committee ▪ Develop website ▪ Gather information
	• Marketing of local services	To be identified	• Provide marketing workshops to local service organisations to enhance their ability to market their services
	• Engagement of Media Organisations	To be identified	• Implement 'Media Without Borders' strategy to encourage cooperation and active campaigning by local media organisations
Broader Well-Being Strategies	• Non-clinical support services	Council, New School of Arts, Cranes, Sporting Clubs, Service Groups, Land Councils, Gurelgham	• Develop non-clinical support services for youth and other groups to enhance prevention and early intervention
	• SMART recovery groups	CHESS, NSOA	• To be identified
	• Community engagement and planning	Council, New School of Arts, Cranes, CHESS	• Harwood community conversations • #askclarencevalley
	• Volunteer recruitment and support	New School of Arts, Council, Cranes, Sporting Clubs & Service Groups	• To be identified
	• Interagency coordination	Council, New School of Arts, Cranes, Interagency Groups	• Improve interagency communication • Develop case coordination service integration models

A third workshop was held on 12 December 2016, and was attended by more than 70 people. At this workshop, participants reviewed and provided feedback on the draft plan, commenced identifying how the strategies within the plan may be achieved, and nominated for working groups to progress implementation of the plan.

Steering Committee

A Steering Committee was formed and first met on 25 August 2016, and met again in October and November 2016. Membership of the Committee currently consists of:

- Bulgarr Ngaru Aboriginal Medical Corporation
- CHESS
- Clarence Valley Council
- Clarence Valley Private School Representative/s
- headspace School Support
- Lifeline North Coast
- New School of Arts
- North Coast Primary Health Network (Chair)
- Northern NSW Local Health District

- Carer representative
- Community members (x2)
- CRANES
- Department of Education
- NSW Police
- Partners in Recovery
- StandBy Response Service

The purpose of the Steering Committee is to play a communication, coordination, advocacy and leadership role to drive the finalisation of the Our Healthy Clarence Mental Health and Wellbeing Plan, and to drive its implementation and evaluation. Draft Terms of Reference can be found in Attachment 1

6. Attachment 1

Draft Steering Committee Terms of Reference

Purpose

The Our Healthy Clarence Steering Committee plays a communication, coordination, advocacy and leadership role to drive the finalisation of the Our Healthy Clarence Mental Health and Wellbeing Plan, and to drive its implementation and evaluation.

Objectives

Our Healthy Clarence Steering Committee member organisations will:

- Participate in the finalisation, implementation and evaluation of the Our Healthy Clarence Mental Health and Wellbeing Plan
- Lead achievement of the Our Healthy Clarence Plan by contributing knowledge, skills, staff and resources to achieve the outcomes outlined in the plan
- Actively engage, communicate with and report to the community
- Provide advocacy on behalf of the Our Healthy Clarence initiative, to funding bodies, policy makers and other influential stakeholders to address identified gaps, and collectively attract resources to address these gaps
- Respond to emerging issues identified during implementation of the plan, and remove barriers to advancement
- Identify individuals and agencies who can contribute to achievement of the Plan, and actively seek their participation
- Identify risks and probity issues, and advise on managing these
- Avoid duplication by acknowledging the work undertaken as part of the Our Healthy Clarence plan

Membership

Bulgarr Ngaru Aboriginal Medical Corporation
CHESS
Clarence Valley Council
Clarence Valley Private School Representative/s
Carer representative
Community members (x6, including 2 young people)
Cranes
Department of Education or other Clarence Valley Public School Representative/s
Department of Prime Minister & Cabinet
headspace school support
Lifeline North Coast
New School of Arts
North Coast Primary Health Network
Northern NSW Local Health District
NSW Police
Partners In Recovery
Standby Response Service

Membership will be determined by assessing a prospective member's capacity to contribute to the objectives of the Committee. Applications will be assessed by all Committee Members, and approved when

more than half of the members approve the new membership. To request membership of the Steering Committee, please contact mentalhealth@ncphn.org.au.

Chair

Current: North Coast Primary Health Network (NCPHN).

An annual process to express interest in the roles of Steering Committee Co-Chairs will be held at the first meeting of the calendar year. At least one of the Co-Chair roles will be filled by a community member.

- Expressions of Interest will be called for by email at least 4 weeks prior to the first Steering Committee meeting of the calendar year
- Expressions of Interest will be sent to the Secretariat support role via email (mentalhealth@ncphn.org.au)
- At least 2 weeks prior to the first Steering Committee meeting of the calendar year, details of those who expressed interest in Co-Chair roles will be sent to the Steering Committee membership
- Steering Committee members will nominate their preferred Co-Chairs at least 2 days prior to the first meeting of the calendar year by communicating their preference by email to mentalhealth@ncphn.org.au. One nomination will be accepted per member organisation, and one per community member.
- The organisational nominee with the highest number of votes, and the community nominee with the highest number of votes will be offered the Co-Chair roles
- Those who expressed interest in the Co-Chair roles will be contacted by the Secretariat role prior to the first meeting of the calendar year to inform them of the outcome
- The outcome will be officially announced at the first Steering Committee meeting of the calendar year

The Chair is authorised to represent the Our Healthy Clarence initiative publically. Other members may share information about and advocate for Our Healthy Clarence, but not make statements or commitments on behalf of the Committee without agreement of the Committee.

Quorum

No requirements

Meeting Frequency

Commencing 6-weekly with review at each meeting

Group Support

Secretariat function will be provided by NCPHN

Distribution of Minutes

Within one week of meetings. An update from the meeting is to be sent to all community members and service providers who have expressed interest in receiving information about progress of Our Healthy Clarence.