NSW GOVERNMENT | Health

Supplementary Questions

INQUIRY INTO THE PREVENTION OF YOUTH SUICIDE

QUESTION 1

For the purposes of the Key Performance Indicator, what does the follow-up within seven days involve for a child and young person discharged?

ANSWER

This indicator measures whether a person has contact with a public mental health service in the seven days after discharge from a NSW public mental health unit. NSW uses the national specifications for this KPI. Contact with mental health teams anywhere in NSW is included, not just teams in the same LHD. Telephone or video-conference contacts are included when the consumer is directly involved, but purely administrative contacts (such as phone calls to a community case manager) are not. Contacts on the day of discharge are not included, because most occur while the person is still in hospital, during discharge planning. Contacts with private practitioners, GPs or NGO services are not included because data is not available from those services.

The national specifications are at (http://meteor.aihw.gov.au/content/index.phtml/itemId/663838.

QUESTION 2

Please provide statistics on the performance for this indicator for children and young people for each Local Health District over the past three years?

ANSWER

The table below (Table 1) shows the follow-up rate for people less than 18 years from any NSW acute mental health unit (including CAMHS Units, PECCs, Adult general units) for the last three years.

Table 1: Rate of post-discharge community care, by percentage, by local health district, for people under 18 years of age

Local Health District	2015-2016	2016-2017	2017-2018
Central Coast	82%	65%	79%
Far West	100%	67%	100%
Hunter New England	64%	86%	89%
Illawarra Shoalhaven	64%	80%	86%
Murrumbidgee	60%	77%	84%
Mid North Coast	82%	90%	80%
Nepean Blue Mountains	58%	66%	73%
Northern NSW	69%	64%	81%
North Sydney	87%	84%	86%
Sydney Children’s Hospitals Network	54%	70%	87%
South Eastern Sydney	85%	86%	91%

Local Health District	2015-2016	2016-2017	2017-2018
Sydney	63%	75%	65%
Southern NSW	56%	77%	81%
St Vincent's Hospital Network	20%	70%	53%
South Western Sydney	56%	65%	66%
Western NSW	66%	57%	58%
Western Sydney	65%	66%	79%
NSW	**67%**	**73%**	**80%**

QUESTION 3

In the current 2017-18 Service Agreement between the Secretary and the Local Health Districts the target for performance of the Acute Post-Discharge Community Care KPI is 70%. What are the reasons given for not meeting this target in each of the LHDs which have not met the target of 70%?

ANSWER

Through the NSW Health System Performance Framework, the Ministry of Health monitors the performance of each LHD against the Key Performance Indicators (KPIs) in the Service Agreements. In its role as system manager, the Ministry uses this framework to monitor statewide performance and work towards statewide improvements. The focus of this framework is on LHD performance recovery and on identifying opportunities for improvement and collaboration to restore and improve performance. Since 2010-11, the statewide acute post-discharge community care performance has improved from 47.6% in 2010-11 to 72.8% in 2016-17.

The seven day follow up measure is a KPI that Chief Executives are required to report on and address in terms of operational standards. The reasons proffered by a small number of local health districts for performing under the benchmark include the challenges posed by young people being admitted outside their LHD of residence as well as contact refusal within the timeframe of the measure, particularly in areas with high mobility of the population.

Services are required (Transfer of Care from Mental Health Inpatient Services, PD2016_056) to conduct a risk assessment prior to discharge and as part of the Transfer of Care Plan package, to contact the person's primary health provider including private counsellors, psychiatrist or GP as part of local discharge arrangements. However contact with the transferred healthcare provider is not counted as a contact for the purposes of this indicator.

QUESTION 4

The Committee is concerned as to whether the 70% target for this KPI is too modest.

(i) Why is 70% the target set by NSW Health?

(ii) What would be needed to achieve a target of 90% Acute Post-Discharge Community Care follow-up?

ANSWER

The target for this KPI was established by consultation with clinical leaders and service managers.

The target is not set to 100% because:

(i) Follow up care with private psychiatrists, psychologists, General Practitioners or Community Managed Organisations such as headspace cannot be measured because the data is unavailable to the health system. For many young people these services may be the most appropriate or preferred form of follow-up.

(ii) Apart from people on specific treatment orders, the majority of people being discharged from hospital are voluntary patients at the time of discharge. As in other areas of health care, some young people and their families refuse follow-up care from NSW Health services;

(iii) follow up can't be measured for interstate or overseas residents who return home after discharge.

All Local Health Districts have been working hard to improve their performance against this indicator and most currently exceed the 70% target, while several are approaching or have exceeded 90%. Any consideration in adjusting this KPI should be done in consultation with consumers and services.

QUESTION 5

Is there a follow-up care plan for children and young people who present to emergency departments after an attempted suicide or acts of self-harm but who are not admitted as patients? If so, what does this follow-up involve?

ANSWER

Planning for follow-up occurs as part of determining whether a person is ready for departure from NSW Emergency Departments (EDs) once the ED phase of their care is complete. The NSW Ministry of Health *Policy Directive: PD2014_025 Departure of Emergency Department Patients* directs that prior to discharge, referral to appropriate services occurs to manage identified risks and should occur as early as possible.

This policy also specifies that departure from the ED must not take place if significant risk has been identified and these risks cannot be managed after ED Departure, or if the patient requires the supervision of a responsible adult for appropriate ED Departure and this cannot be ensured.

A number of services and supports are in place for children and young people and their carers after a presentation to emergency departments with an attempted suicide or acts of self-harm but who are not admitted as patients, including:

- The 24 hour state-wide NSW Mental Health Line (1800 011 511) to provide universal access to mental health services through triage, referral and advice.
- NSW Specialist Community Child and Adolescent Mental Health Services and Youth Mental Health Services to provide assertive outreach and follow-up care for children and young people with moderate-severe mental health problems and their families/carers, particularly those with the greatest clinical need related to severe and acute problems and increased risk of harm to themselves or others.
- The continued roll-out of the Project Air Strategy for Personality Disorders across NSW. This initiative involves training clinicians to respond to people in distress who have self-harmed, and developing local follow-up support services and pathways to specialist care.
- The Black Dog Institute is piloting LifeSpan in four areas of NSW: Murrumbidgee, Central Coast, Illawarra Shoalhaven and the Newcastle Local Government Area. LifeSpan involves

the implementation of nine evidence-based strategies including improving emergency and follow-up care for suicidal crisis. Activities under this strategy include:

- Improved crisis care with new guidelines and training in EDs, education and resource packs distributed to individuals and families in crisis.
- Dedicated aftercare services for people who attempt suicide.
- Better networks and information sharing between care providers and families.

The LifeSpan trial sites work alongside service providers funded under the Suicide Prevention Fund.

- Direct aftercare services funded through the NSW Suicide Prevention Fund include:
  - ACON Suicide Prevention Initiative: ACON provides counselling services and care co-ordination for individuals identified at risk of suicide, or who have been hospitalised for attempted suicide. Support includes brief interventions, referrals and assisting clients navigate the mental health system with LGBTI-responsive options. This aftercare service is located in the Sydney and South Eastern Sydney Local Health Districts (LHD) and St Vincent's Health Network.
  - The Bright Minds, Connected Communities Suicide Prevention Project: Tailored to address the needs of young people at risk of suicide in the Lake Macquarie region of the Hunter New England LHD. The aftercare support service works with the Lake Macquarie Suicide Prevention network to update existing suicide prevention information packs, as well as develop new packs tailored to Aboriginal and young people.
  - Delivery of the Clarence Coordinated Aftercare Service in the Northern NSW LHD. This service provides non-clinical support for the three months following a suicide attempt. Support workers assist individuals by developing safety plans, providing support coaching and motivation to encourage the person to build skills and motivation to stay alive, and building networks to promote recovery. Families and carers are also provided with information and resources on how to support their loved ones and their own wellbeing.
  - Grand Pacific Health - Next Steps Suicide Attempt Response Team: Located in the Illawarra Shoalhaven LHD, the service supports people who have presented to Shellharbour, Shoalhaven or Wollongong hospitals following a suicide attempt. The service provides intensive psycho-social clinical services and peer-work support including assessment, planning, and care co-ordination. Families and carers are also offered support and resources to help them cope and assist their loved one.
  - HealthWISE Suicide Prevention Initiative: HealthWISE provides clinical mental health aftercare and care co-ordination to people in the New England North West region, Hunter New England LHD.
  - Hunter Primary Care - Way Back Support Service: The service supports individuals in the Hunter New England region who have presented to Calvary Mater Newcastle hospital following a suicide attempt. The service provides non-clinical care and practical support for the three months following a suicide attempt. Individuals are supported through tailored case management and linkages to appropriate existing health, clinical and community-based services.
- The Way Back Support Service developed and delivered by beyondblue since 2014 is currently available in three NSW locations; the Hunter, Murrumbidgee and North Coast regions. This service delivers one-on-one, non-clinical care and practical support to help people stay safe and connected with their support networks and existing health and community services. In May 2018 the Commonwealth Government announced $37.5M to expand this service nationally and beyondblue is contributing a further $5M.