Western Victoria Primary Health Network

Needs Assessment

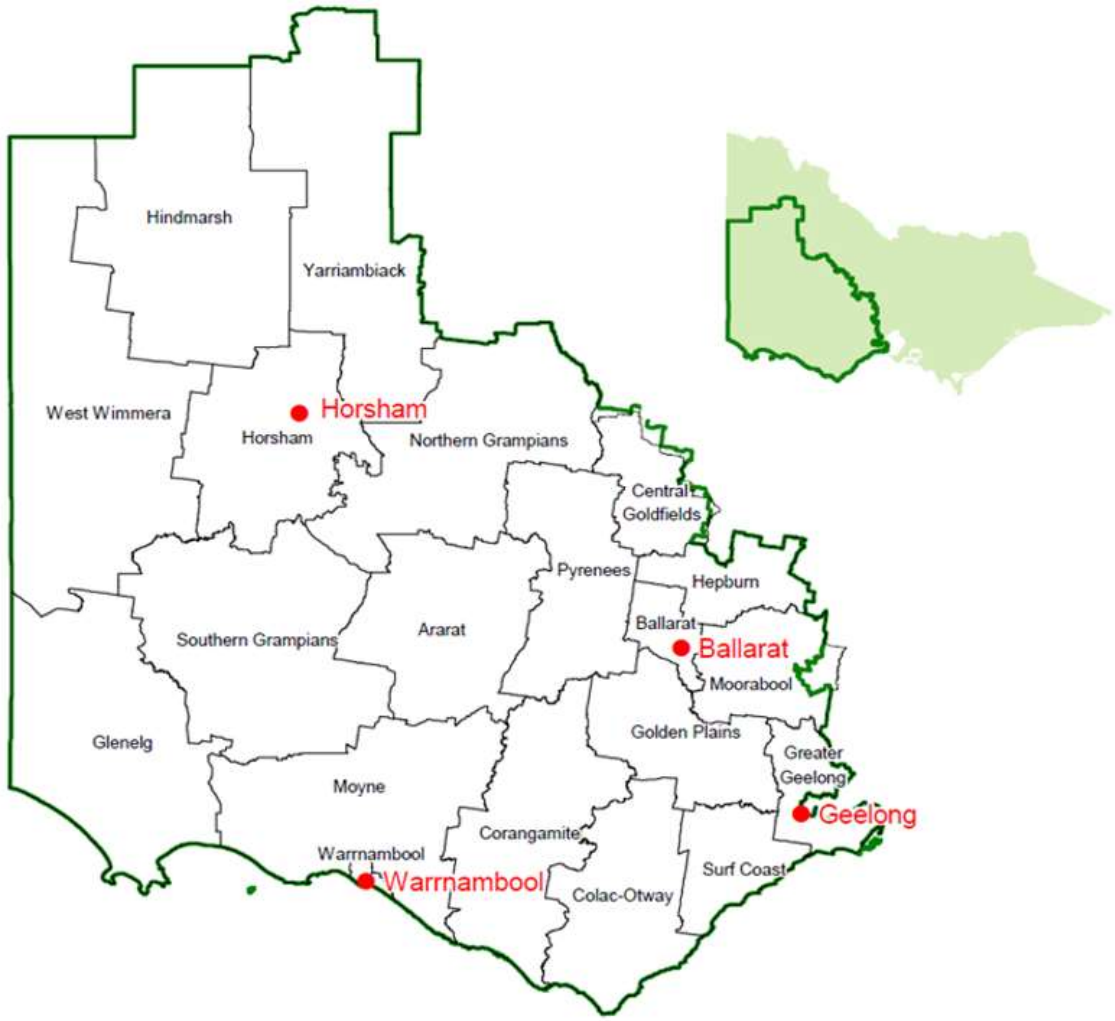
Mental Health 2017

phn WESTERN VICTORIA

An Australian Government Initiative

Together with our partners and communities, Western Victoria PHN identifies priority health care needs, improves access through government funding, and co-designs localised solutions to improve health care systems across western Victoria.

Western Victoria PHN Regional Map



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Section 1 – Narrative

Needs Assessment process and issues

Mental Health was an area of focus in the Western Victoria PHN needs assessment and the data in the general needs assessment underpins the data in this Mental Health specific needs assessment.

Work on the Mental Health Needs assessment has continued in accordance with the process outlined in the Mental Health Needs Assessment submitted in November 2016. Since the November submission, work has centred on:

1. Analysing statistics made available since the Mental Health Needs Assessment was submitted (e.g. additional data from the Victorian Population Health Survey 2014, updated suicide rates, mental health hospitalisations and Medicare Benefits Schedule (MBS) data).

2. Consultations with service providers, and people with a lived experience of mental illness, their families and carers will be undertaken as part of the commissioning of mental health services for those with severe and complex mental illness, youth severe and complex services and suicide prevention; and as part of the development of a Stepped Care Model for Western Victoria PHN. These consultations will be used to inform the next Mental Health Needs Assessment and will build on those conducted in 2016 in rural localities of the Western Victoria PHN region where mental health was identified as a key issue in many communities. A consultation was completed in the City of Ballarat for the Place Based Suicide Prevention Trial. Community members, service providers and those with lived experience of suicide participated in a forum, which included mapping the suicide prevention services in the City of Ballarat.

There is major change taking place in relation to mental health and suicide prevention services. These changes include reforms following the National Mental Health Commission's (NMHC) 2014 Review of Mental Health Programmes and Services; implementation of state based suicide prevention initiatives; the implementation of the National Disability Insurance Scheme (NDIS); and the commissioning of locally responsive mental health services by PHNs. Both Victoria's 10-year Mental Health Plan (2015) and the Commonwealth's Fifth National Mental Health and Suicide Prevention Plan (2017) highlight the need for person centred mental health services, including the co-production of mental health services, where service providers, consumers and carers all contribute to service planning and development. Integration is the pivotal theme underpinning the Fifth National Plan. This is in response to the NMHC 2014 Review of Mental Health Programmes and Services which concluded that 'mental health services are fragmented and delivered within a complex system that involve multiple providers and siloed funding streams and people having a poor experience of care and unmet need'. This was echoed in Victoria's 10 year Mental Health Plan, where mental health services were reported as 'fragmented, siloed, difficult to navigate and hard to access'.

In Victoria's 10 year Mental Health Plan Primary Health Networks along with Local Hospital Networks are identified as fundamental to the delivery of better planned and integrated mental health services, and the 'core architecture' to support regional integration in the Fifth National Plan.

To determine the mental health and service need priorities the identified issues were assessed against the impact that they will have on increasing the efficiency and effectiveness of mental health services for patients, particularly those at risk of poor health outcomes, and improvement in the coordination of care to ensure patients receive the right care in the right place at the right time. The priorities identified were also based on the guidance provided by the Commonwealth Government regarding the development of a stepped care model for mental health.

Additional Data Needs and Gaps

Much of the data available regarding mental health and service needs is at a national and state level; and when local data is available it is often for varying geographical boundaries, which makes it challenging to determine local needs. Additionally there is little data available on those aged 18 to 25 years making it difficult to plan mental health services for youth. The National Mental Health Service Planning Framework (NMHSPF) has been developed to strengthen regional planning and decision-making in a nationally consistent manner. Western Victoria PHN has three staff members licenced to use the NMHSPF. There are some challenges with the use of the NMHSPF. These include: the NMHSPF modelling will accurately assess service demand/need for populations under 300,000 people, but not the resources required (all 21 local government areas [LGAs] within the Western Victoria PHN region have populations less than 300,000 people); the model does not consider socio-demographic factors such as culturally and linguistically diverse populations, Aboriginal and Torres Strait Islander peoples and rural and remote communities (all of which are target populations for PHN commissioned mental health services); the NMHSPF does not assess service demand/need for youth aged 12-24 years; the NMHSPF models Commonwealth services at an LGA level but the data available on Medicare Benefits Schedule (MBS) Mental Health Services is available at Statistical Area Three (SA3) level not LGA level; and, the NMHSPF definition of severe is based on diagnoses and use of acute and specialised community mental health services but does not consider complexity. At this stage, due to the above challenges, the NMHSPF will be used to stimulate questions for activity planning. Further developments, including improving its applicability to rural communities will make it more useful for Western Victoria PHN in the future.

Additional sources of local data were identified for mental health and service needs however, this data, including statistics from the Victorian Child and Adolescent Monitoring System (VCAMS), when assessed against the ABS Data Quality Framework, were not always of a quality fit for the purpose of the mental health needs assessment.

Consultations with Aboriginal Community Controlled Organisations (ACCOs) identified strong interest they have in co-designing funded initiatives within their community. Western Victoria PHN will build on their current engagement and utilise the local knowledge and experience of ACCOs for particular commissioned projects into the future.

As indicated in the previous Needs Assessments, there is limited up-to-date, localised, and high quality health data available for Aboriginal and Torres Strait Islander peoples, persons from culturally and linguistically diverse backgrounds, and family and carers. These groups will be considered into the future through different engagement opportunities, including the already commenced ACCO consultations.

Mental Health Service Mapping was undertaken in early 2016 and will be built upon through the development of the Stepped Care Model for Western Victoria PHN and Place Based Suicide Prevention Initiative in the Great South Coast and City of Ballarat. As the National Health Service Directory develops, it is anticipated that this will provide a resource that will allow for ease in mapping of services and provide clarity around service gaps and changes over time.

The Department of Health, National Mental Health Report, 2013, recommends caution when interpreting data related to mental health treatment rates. This is for several reasons including: those who meet the diagnostic criteria for mental illness do not always experience a need for professional assistance; health service use may be related to perceived need rather than availability of services and perceived need can be influenced by a lack of recognition by the person that they have an illness, lack of awareness of available effective treatments, previous negative experience of service use and stigma regarding mental illness.

Additional comments or feedback

Consistent with feedback we have received from the Department of Health, we have named areas, which may be above or below a particular indicator relative to elsewhere in the Western Victoria PHN region, (rural) Victoria and/or Australia. However, we add the caveat that such comparisons should be viewed with caution, and that we do not place undue emphasis upon where the Western Victoria PHN or localities therein sit in relation to one-another in assessing and setting our priorities and activities. It is simply one element we consider, given such comparisons can disguise as much as they reveal.

For example, the rate of deaths from suicide between 2010 and 2014 was highest in Yarriambiack Shire at an age-standardised rate of 26.3 per 100,000 people, compared to 14.3 per 100,000 people in the City of Ballarat. However, in absolute numbers, there were 8 deaths from suicide in Yarriambiack in this period and 63 deaths from suicide in the City of Ballarat.

Western Victoria Primary Health Network commissioned the provision of Psychological Therapy Services for people experiencing mild to moderate mental health conditions. The delivery of these services commenced on November 1, 2016. The commissioning of these services has resulted in increased access to these services across the PHN region. At a minimum, there is at least two-service providers in each of the 21 Local Government Areas with the capacity to provide services to children and adults increasing choice and at least one provider who can provide Suicide Prevention services. Lead agencies have been commissioned for headspace Geelong, Ballarat, Warrnambool and Horsham. In recognition of the significant recommissioning activities over the past twelve months for headspace and Psychological Therapy Services, these services will be reviewed and Western Victoria PHN will work with current service providers to improve services and refine the contracts in line with review findings. Western Victoria PHN also receive funding targeting mental health initiatives for Aboriginal and Torres Strait Islander Peoples, this has been bundled with Alcohol and Other Drugs funding to provide a more holistic approach to meet the health needs of this vulnerable population. This funding is currently being reviewed to improve the co-design of these services.

Section 2 – Outcomes of the health needs analysis

Mental health

Key Issue	Description of Evidence
Mental health identified as an issue within communities throughout the Western Victoria PHN region.	At the majority of consultations held with service providers and communities across Western Victoria PHN region, in 2016, mental health was prioritised as one of the top issues in the community. This is supported by the National Survey of Mental Health and Wellbeing 2007, which reported each year about 1 in 5 people aged 16 to 85 years will experience mental ill health; and over a lifetime, nearly half of the Australian adult population will experience mental illness at some point. The National Mental Health Strategic Planning Framework tool estimates the number of people in Western Victoria PHN region in 2017 with mild mental illness as 55,600, moderate mental illness 28,327, and severe mental illness 19,145.

Psychological distress

Key Issue	Description of Evidence
Higher prevalence of adults with high or very high levels of psychological distress in some local government areas in the Western Victoria PHN catchment, relative to Victoria and rural Victoria. At a state level, the proportions of people with high or very high psychological distress has remained unchanged from 2003 to 2014.	In six local government areas in the Western Victoria PHN region, the estimated proportion of adults reporting to have high or very high levels of psychological distress was higher than that reported in rural Victoria as a whole (13.1 per cent) and, in seven local government areas, higher than Victoria (12.6 per cent). These local government areas included Central Goldfields Shire (20.3 per cent), Northern Grampians Shire (19 per cent), Pyrenees Shire (17.8 per cent), City of Greater Geelong (15.8 per cent), Hepburn Shire (15 per cent), and Warrnambool City Council (14.7 per cent) (Victorian Population Health Survey 2014). No update is required.

Psychological distress

Key Issue	Description of Evidence
The proportion of the population reporting that they were unable to work, study or manage day-to-day activities due to psychological distress for one day or more in the previous 4 weeks exceeds that seen across rural Victoria as a whole in several local government areas.	In six local government areas in the Western Victoria PHN region, the estimated proportion of adults reporting that they were unable to work, study or manage day to day activities due to psychological distress for one day or more in the previous four weeks was higher than that reported for rural Victoria as a whole (11.4 per cent). These local government areas are Hepburn Shire (17.8 per cent), Pyrenees Shire (17.4 per cent), Glenelg Shire (16.6 per cent), Golden Plains Shire (15.9 per cent), Yarriambiack Shire (15.3 per cent) and City of Greater Geelong (14.3 per cent) (Victorian Population Health Survey 2011-12). No update is required.

Anxiety and depression

Key Issue	Description of Evidence
Higher prevalence of depression or anxiety in most local government areas in the Western Victoria PHN catchment.	In eight local government areas in the Western Victoria PHN region, the estimated proportion of the population reporting a lifetime diagnosis of depression or anxiety was higher than that reported for rural Victoria as a whole (28.7 per cent) and, in twelve local government areas, higher than Victoria (24.2 per cent). These local government areas include the City of Ballarat (35.7 per cent, statistically significant difference relative to Victoria), Shire of Central Goldfields (33.7 per cent), Northern Grampians Shire Council (33.1 per cent), City of Greater Geelong (32.3 per cent), Golden Plains Shire Council (31.6 per cent), Warrnambool City Council (31.3 per cent), Pyrenees Shire (30.3 per cent) and Moorabool Shire Council (29.3 per cent) (Victorian Population Health Survey 2014).
At a state level, a significantly higher percentage of females had ever been diagnosed with depression or anxiety by a doctor. In the majority of local government areas in the Western Victoria PHN region a greater proportion of women than men reported having ever been diagnosed with depression or anxiety.	In seventeen of the 21 local government areas in the Western Victoria PHN region the estimated proportion of women, reporting having ever been diagnosed with anxiety and depression was higher than men (Victorian Population Health Survey 2011). This is consistent with Victoria where 18.1 per cent of men and 30.1 per cent of women reported having ever been diagnosed with depression or anxiety (Victorian Population Health Survey 2014).

Anxiety and depression

Key Issue	Description of Evidence
An increase in the lifetime prevalence of depression or anxiety in the majority of local government areas in the Western Victoria PHN region from 2011-12 to 2014.	In eighteen local government areas in the Western Victoria PHN region, the estimated proportion of the population reporting a lifetime diagnosis of depression or anxiety, increased between 2011-12 and 2014. This increase was significant in three local government areas. These local government areas were City of Ballarat (15.6 per cent to 35.7 per cent), Northern Grampians Shire Council (15.1 per cent to 33.1 per cent), and Warrnambool City Council (17.8 per cent to 31.3 per cent) (Victorian Population Health Survey 2014).
At a state level, between 2003 and 2014, the lifetime prevalence of self-reported doctor diagnosed depression or anxiety increased significantly for both men and women.	The age-standardised lifetime prevalence of depression or anxiety in Victoria significantly increased from 2003 to 2014 for both women and men, from 18.6 per cent to 28.6 per cent and from 10.9 per cent to 18.1 per cent, respectively (Victorian Population Health Survey 2014).
Mental and substance use disorders are the leading cause of the non-fatal disease burden in Australia.	Mental and substance use disorders were responsible for almost 12 per cent of the total disease burden in Australia, making it third behind cancer and cardiovascular disease. It was also the leading cause of non-fatal burden, accounting for almost one-quarter (24 per cent) of all years lived with disability nationally and 25.9 per cent in Victoria. Just over a quarter (26 per cent) of the burden due to mental and substance use disorders was attributed to anxiety disorders, and a similar proportion (24 per cent) to depressive disorders (AIHW, 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011). No update is required.

Mental health and social determinants

Key Issue	Description of Evidence
There are a number of localities in the Western Victoria PHN region, which are disadvantaged on one or more indicators of the social determinants of health relative to other localities in the region and/or state and national benchmarks. These determinants influence the health experiences of individuals, population	As with physical health, mental health and many common mental disorders are shaped by various social, economic and physical environments (World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva, World Health Organization, 2014). People with a mental health condition were almost twice as likely as those without to have experienced some form of discrimination, 29 per cent compared with 16 per cent (ABS, 2015. 4159.0 – General Social Survey: Summary Results, Australia, 2014).

Mental health and social determinants

Key Issue	Description of Evidence
health outcomes, and important equity issues such as access to health care.	When compared with all Victorian men and women there were a significantly higher estimated proportion of men and women with high psychological distress who had the following characteristics: did not complete high school, unemployed, not in the labour force and total annual household income less than $40,000 (Victorian Population Health Survey 2014). No update is required. Nationally, the lowest socioeconomic quintile experienced greater burden compared with the highest quintile in every disease group including mental and substance use disorders. The difference in disability adjusted life years (DALY) rate per 1,000 people between the lowest and highest socioeconomic quintiles were highest for mental and substance use disorders (16 DALYs per 1,000 people). The rate of burden due to mental and substance use disorders in the lowest socioeconomic group (31.6 DALYs per 1,000 people) was double that in the highest socioeconomic group (16 DALYs per 1,000 people). There was also a clear pattern of decreasing rate of burden from suicide and self-inflicted injuries with increasing socioeconomic position (AIHW, 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011). Nationally, the proportion of people, aged 15-64 years, with a self-reported mental health condition who were employed (59 per cent) was less than that of those without a mental health condition (78 per cent). There was a higher proportion of people with a mental health condition who were unemployed (7.4 per cent compared with 4.5 per cent) and who were not in the labour force (32 per cent compared with 17.6 per cent) in comparison to people who did not report a mental health condition (ABS, 2015. 4159.0 – General Social Survey: Summary Results, Australia, 2014). These statistics were supported by community and service provider consultations held across the Western Victoria PHN region, during 2016, where the connection between low socioeconomic status and social isolation and mental health issues was raised. No update required.

Children and youth

Key Issue	Description of Evidence
The Victorian Department of Education Area, Central Highlands, had a greater proportion of young people with high levels of	The Victorian Department of Education Area, Central Highlands (which includes the Western Victoria PHN local government areas [LGAs] of Rural City of Ararat, Ballarat, Golden Plains Shire, Hepburn Shire, Moorabool Shire Council and Pyrenees Shire) had a greater proportion (17.5 per cent) of young people

Children and youth	
Key Issue	**Description of Evidence**
depressive symptoms, who report experiencing bullying recently and are experiencing cyber bullying, than Victoria as a whole.	who showed high levels of depressive symptoms on the International Youth Development Study Short Version Moods and Feelings scale than Victoria as a whole (15.5 per cent); a greater proportion of young people who report experiencing bullying recently, 48.7 per cent, compared to Victoria as a whole, 45.1 per cent; and a greater proportion of young people who are experiencing cyber bullying, 32.2 per cent, compared to Victoria as a whole, 29.3 per cent. The Western District Department of Education Area (which includes 10 of the 21 local government areas in the Western Victoria PHN region) had a greater proportion of young people who are bullied most days 17.0 per cent, compared to Victoria as a whole, 15.3 per cent (2014 Victorian Student Health and Wellbeing Survey. State of Victoria Department of Education and Training. VCAMS Indicator data spreadsheets, Indicator 10.3b, 10.3b1 and 10.3b2). No update required.
Mental health identified as an important issue for youth in Victoria.	A headspace youth consultation, including youth from both Ballarat and Geelong, identified mental health as an important issue for young people, especially for those from disadvantaged or marginalised groups such as LGBTIQA+, transgender young people and young people with a disability (Headspace Youth Consultations: Report for the Office for Youth, October 2015). In the Mission Australia Youth Survey 2016, mental health was one of the top three issues that youth considered most important in Australia today. These issues were alcohol and drugs (28.7 per cent of respondents), equity and discrimination (27 per cent) and mental health (20.6 per cent).
Nationally, children and adolescents living outside capital cities have significantly higher rates of mental disorders.	At a national level an estimated 13.9 per cent of 4-17 year olds in Australia were assessed as having mental disorders in the previous 12 months; 12.6 per cent in Greater capital cities and 16.2 per cent in rest of state (Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, 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, Canberra). No update required. These statistics were supported by community and service provider consultations held across the rural communities of Western Victoria PHN region, in 2016, where the issue of mental health problems amongst youth in their communities was raised. No update required.

Risk of poor mental health outcomes for rural and remote, under-serviced and/or hard to reach groups	
Key Issue	**Description of Evidence**
Mental health needs vary across population groups.	Mental health experiences are influenced by age, gender, sexuality, family situation and cultural background (National Mental Health Commission. Contributing Lives, thriving communities, 2014). The following population groups were identified by the Fifth National Mental Health and Suicide Prevention Plan and Victoria's 10-year Mental Health Plan as needing specific consideration. Research suggests the mental health of LGBTIQA+ people is worse than that of the general population. Rates of major depressive episodes can be four to six times higher in the LGBTIQA+ community than the general population, psychological distress rates are reported as twice as high and suicidality rates are higher than any other group in Australia (Rosenstreich, 2011. LGBTI people mental health and suicide, Private Lives 2, 2012 and Tranznation Report, 2007). Australian Defence Force personnel have higher rates of affective and anxiety disorders and higher rates of suicidality than those in the general community (McFarlane et al, 2011. Mental health in the Australian Defence Force). Trauma is widespread amongst those who use mental health services and it often has lasting adverse effects (Commonwealth of Australia, 2017. The Fifth National Mental Health and Suicide Prevention Plan). The experience of childhood trauma, particularly sexual abuse, greatly increases the risk of mental illness (Australian Institute of Family Studies, 2013. The long term effects of child sexual abuse). People with an intellectual disability experience higher rates of mental health problems and mental illness. They are at least two to three times more likely to have a mental disorder than the general population (Department of Developmental Disability Neuropsychiatry, 2014. Accessible mental health services for people with an intellectual disability). People with mental illness are over represented in the justice system, as offenders, victims and people in need of assistance (Department of Health and Human Services, 2015. Victoria's 10-year Mental Health Plan). In a study of mental illness prevalence in Australia's criminal justice system, almost half of the detainees sampled, 49 per cent, were experiencing a diagnosable mental disorder. This is 2.5 times the 12-month prevalence rate of mental disorder than in the Australian population (20 per cent) (Forsythe and Gaffney, 2012. Mental disorder prevalence at the gateway to the criminal justice system. Australian Institute of Criminology). N.B. 12- month prevalence is the proportion of the population that has the specified condition during a 12 month period.

Risk of poor mental health outcomes for rural and remote, under-serviced and/or hard to reach groups

Key Issue	Description of Evidence
The lifetime prevalence of depression or anxiety is significantly higher in rural Victoria than in metropolitan areas.	Rural Victoria had a higher estimated lifetime prevalence of depression or anxiety than in metropolitan areas, 28.7 per cent and 22.8 per cent respectively (Victorian Population Health Survey 2014). N.B. Lifetime prevalence is the proportion of the population who had ever had the specified condition.
Nationally, the age standardised rate of burden for mental and substance use did not increase with remoteness. However, the age standardised rate of burden of disease for suicide increased with remoteness.	For most disease groups, the age standardised rate (ASR) of burden increased with remoteness. However, interestingly the ASR of burden for mental and substance use did not increase with remoteness. Nationally, anxiety and depressive disorders were amongst the top ten causes for total burden in major cities and inner regional areas but not for outer regional and remote areas. Suicide showed a clear trend of greater rates of burden in more remote areas (AIHW, 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011). No update required.

People with severe and complex mental illness

Key Issue	Description of Evidence
Approximately 3 per cent of the population have a severe mental illness.	The National Mental Health Strategic Planning Framework (NMHSPF) tool estimates the number of people in the Western Victoria PHN region in 2017 with severe mental illness as 19,145. The definition of severe in the NMHSPF is based on diagnoses and the use of acute and specialist community mental health services. However, severe and complex mental illness is a broader concept than severe mental illness. It incorporates severely disabled people; those with complexities such as comorbid chronic physical illness; those whose illness is adversely impacted on by complex social factors; people with multiple recurrent acute episodes that require frequent hospital care; people with a high suicide risk; or those with a need for coordinated assistance across a range of health and disability support agencies (Commonwealth of Australia, 2017. The Fifth National Mental Health and Suicide Prevention Plan). Thus the number of people with severe mental illness, as estimated by the NMHSPF, may be a conservative estimate.

People with severe and complex mental illness

Key Issue	Description of Evidence
The Geelong Employment Service Area has the third highest proportion of Disability Management Services caseloads with a primary disability category of Psychiatric in Australia.	In the Geelong Employment Service Area, the proportion of the caseload of Disability Management Services with a primary disability category of psychiatric was third highest of all Employment Service Areas in Australia at 51 per cent (Disability Employment Services Historical Commencement and Caseload Data, 30 June 2017).
National proportions of high prevalence disorders and severity.	In terms of the total Australian population, 4.1 per cent had severe mental disorders in the previous 12 months; and of the one in five (20.0 per cent) Australians aged 16-85 years who experienced mental disorders in the previous 12 months, one-fifth (20.5 per cent) were classified as severe (this excludes those with low prevalence disorders) (Slade et al, 2009. The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra). No update required.
Amongst the low prevalence psychotic disorders schizophrenia is most common.	Nationally, an estimated 4.5 cases per 1,000 population aged 18-64 have a psychotic illness and are in contact with public specialised mental health services each year, 47 per cent of this population are diagnosed with schizophrenia (Morgan et al, People Living with a psychotic illness 2010. Report on the second Australian National Survey. Department of Health and Ageing, Canberra). No update required.

Suicide

Key Issue	Description of Evidence
High number of deaths from suicide across the Western Victoria PHN region and in certain Statistical Area Level 3 regions, relative to Australia.	Between 2010 and 2014, on an age-standardised basis, there were more deaths from suicide per 100,000 persons in the Western Victoria PHN region (12.5 deaths) compared with Australia as a whole (11.2) (Australian Institute of Health and Welfare 2016. Mortality Over Regions and Time books: Primary Health Network, 2009–2013. Canberra: AIHW). Across the Western Victoria PHN region, there were more deaths from suicide amongst males than females. On an age-standardised basis, the Statistical Area Level 3 regions with the highest number of male suicides per 100,000 persons were Warrnambool-Otway Ranges (27.4 deaths), Ballarat (24.5), and Grampians (20.6). In contrast, there were 17.1 male suicides per 100,000 persons across Australia between 2010 and 2014 (Australian Institute of Health and Welfare 2016. Mortality Over Regions and Time books: Primary Health Network, 2010-2014. Canberra: AIHW).

Suicide

Key Issue	Description of Evidence
Higher rates of suicide within some local government areas in the Western Victoria PHN region compared to the Victorian rate.	Between 2010 and 2014, over half of the local government areas (LGAs) within the Western Victoria PHN region had higher rates of deaths from suicide and self-inflicted injuries compared to the Victorian rate (9.6 age standardised rate (ASR) per 100,000). These local government areas included Yarriambiack Shire (26.5 ASR per 100,000), Colac Otway Shire (17.1 ASR per 100,000), Southern Grampians Shire (16.4 ASR per 100,000), Shire of Central Goldfields (16.0 ASR per 100,000) and Moyne Shire Council (15.3 ASR per 100,000 (Data compiled by PHIDU from deaths data based on the 2010 to 2014 Cause of Death Unit Record Files supplied by the Australian Coordinating Registry and the Victorian Department of Justice, on behalf of the Registries of Births, Deaths and Marriages and the National Coronial Information System. The population at the small area level (Statistical Area Level 2) is the ABS Estimated Resident Population (ERP), 30 June 2010 to 30 June 2014).
Suicide reported as an issue at community and service provider consultations held across the Western Victoria PHN region.	These statistics are supported by community and service provider consultations where suicide was reported as a health issue in the community. These consultations were in all four administrative regions of the Western Victoria PHN Great South Cost, Wimmera Grampians, Geelong Otway and Ballarat Goldfields, in 2016. No update required.
Greater rates of burden from suicide with increasing remoteness nationally.	For most disease groups, the age standardised rate (ASR) of burden increased with remoteness. Suicide showed a clear trend of greater rates of burden in more remote areas (AIHW, 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011). No update required.
A higher proportion of those living with a psychotic illness in Australia have attempted suicide than the general population.	In the national survey on psychosis, just under half the participants, 49.5 per cent reported that they had attempted suicide at some point in their life. This is much higher than the proportion of the general population, 3.7 per cent, who have attempted suicide in their lifetime (Morgan et al. People Living with a psychotic illness 2010. Report on the second Australian National Survey. Department of Health and Ageing, Canberra). No update required.

Prevalence of mental health conditions within the Aboriginal and Torres Strait Islander population

Key Issue	Description of Evidence
At a national and state level, Aboriginal and Torres	At a national and state level, Aboriginal and Torres Strait Islander persons experience poorer mental health compared to the

Prevalence of mental health conditions within the Aboriginal and Torres Strait Islander population	
Key Issue	**Description of Evidence**
Strait Islander persons experience poorer mental health compared to the population as a whole.	population as a whole. For example, this is evident in the higher rates of psychological distress (nationally it is 2.7 times that of non-Aboriginal and/or Torres Strait Islander Australians for high/very high psychological distress based on K5 scale and age standardised rates, 29.4 per cent compared to 10.8 per cent; and in Victoria the Aboriginal and/or Torres Strait Islander rate of persons reporting high/very high levels of psychological distress is 2.8 times that of non-Aboriginal and/or Torres Strait Islander Australians, 31.6 per cent compared to 11.3 per cent) (ABS and AIHW analysis of 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey and 2011-12 Australian Health Survey). No update required.
The mortality rate from suicide for Aboriginal and/or Torres Strait Islander persons is greater than that of non-Aboriginal and/or Torres Strait Islander persons.	The age standardised national mortality rate from suicide was 24.0 per 100,000 Aboriginal and/or Torres Strait Islander Australians, which is 2.1 times the rate of non-Aboriginal and/or Torres Strait Islander Australians, 11.2 per 100,000 (AIHW, 2017. Aboriginal and Torres Strait Islander Health Performance Framework 2017. Online data tables. AIHW analysis of National Morbidity Database).
The impact of trauma on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples.	Consultations with some Aboriginal Community Controlled Organisations (ACCOs) in the Western Victoria PHN region identified the adverse impact of trauma on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. National reports support this by recognising trauma can compound across generations leading to physical, mental, emotional, spiritual and social distress (Dudgeon et al, 2014. Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice).

Comorbidity with alcohol and other drugs	
Key Issue	**Description of Evidence**
Alcohol and other drugs can mask, trigger or increase the risk of mental health conditions. Alcohol and other drugs can also be used by individuals to alleviate their mental health condition(s).	There is a strong association between illicit drug use and mental health issues. Nationally, the proportion of people aged 18 years or over who report being diagnosed with or treated for a mental illness was greater for people who reported using an illicit drug in the previous 12 months, 26.5 per cent compared to 13.9 per cent of the non-illicit drug using population. People using meth/amphetamines in the past 12 months were more likely than any other drug user to report being diagnosed with or treated for a mental illness, 42 per cent, followed by 28 per cent of recent cannabis users, 26 per of recent ecstasy users and 25 per cent of recent cocaine users (AIHW, 2017. National Drug Strategy

Comorbidity with alcohol and other drugs

Key Issue	Description of Evidence
	Household Survey 2016: detailed findings. Drug Statistics series No. 31. Cat. No. PHE 214. Canberra: AIHW). Mental illness among individuals in AOD treatment programs range from 51-84 per cent (Comorbidity Guidelines developed by Turning Point, 2014). Nationally almost a third (32 per cent) of those who identified as a current smoker had a 12-month mental disorder. This is twice the prevalence of 12-month mental disorders than people who had never smoked. Of those people that reported drinking alcohol nearly every day, 21 per cent had a 12-month mental disorder. This is slightly more than those who reported they drank less than once a month, of which 18 per cent had a 12-month mental disorder. Almost two thirds, 63 per cent, of those who reported misusing drugs (use of illicit drugs and/or misuse of prescription drugs) had a 12-month mental disorder (Slade et al, 2009. The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra). N.B. Prevalence of 12-month mental disorder is the proportion of the population that had a mental disorder during the 12 month period prior to the survey. No update required. Two thirds, 66.1 per cent, of people with psychotic illness smoke. A large proportion of those with psychosis had a lifetime history of alcohol abuse or dependence, 58.3 per cent of males and 38.9 per cent of females. The proportion with a lifetime history of cannabis or other illicit drug abuse or dependence was also high, 63.2 per cent of males and 41.7 per cent of females (Morgan et al, People Living with a psychotic illness 2010. Report on the second Australian National Survey. Department of Health and Ageing, Canberra). No update required. Among adolescents with major depressive disorder almost a third (31.5 per cent) smoked cigarettes or used alcohol or drugs to help manage their problems compared with 4.6 per cent of those with no mental disorder (Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, 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, Canberra). No update required. These statistics were supported locally during consultations with community and service providers across the Western Victoria PHN region during 2016, where the link between mental health and substance abuse was raised as an issue in communities.

Long-term health conditions in people with mental illness	
Key Issue	**Description of Evidence**
Nationally, the majority of people with a mental and behavioural condition reported having another long-term health condition.	Nationally, 94.1 per cent of people with a mental health and behavioural condition reported having another long-term health condition. People with a mental and behavioural condition were almost twice as likely than those without a mental and behavioural condition to report having diabetes (8.1% compared with 4.5%), almost three times as likely to report chronic obstructive pulmonary disease (COPD) (5.7% compared with 2.0%) and around twice as likely to report osteoporosis (6.3% compared with 2.9%). (ABS, 2015. National Health Survey: Mental Health and co-existing physical health conditions, 2014-15 Australia). An Australian study found the overall gap in life expectancy for people with mental illness was 15.9 years for men and 12 years for women. The majority of excess mortality was attributed to physical health conditions, such as cardiovascular disease, respiratory disease, and cancer (Lawrence, 2013. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ 2013;346:f2539).

Section 3 – Outcomes of the service needs analysis

Primary mental health services

Key Issue	Description of Evidence
Estimated demand for mental health services.	The National Mental Health Strategic Planning Framework (NMHSPF) tool estimates the number of people in the Western Victoria PHN region in 2017 with a demand for treatment for mild mental illness as 27,800; for moderate mental illness 22,589; and for severe mental illness 19,145 (The NMHSPF is based on the following service demand rates: 100% of people with severe mental illness will seek and/or receive treatment; 80% of people with moderate mental illness; and 50% of people with mild mental illness).
Higher proportions of adults not accessing health services for their psychological distress in some local government areas in the Western Victoria PHN region compared to rural Victoria.	In 11 local government areas of the Western Victoria PHN region, there were higher estimated proportions of adults who had not visited a health professional about their psychological distress than the rural Victorian average of 88.2 per cent. These local government areas included Golden Plains Shire (92.4 per cent), Hepburn Shire (92.1 per cent), Moorabool Shire Council (91.9 per cent), and Warrnambool City Council, Northern Grampians Shire and Corangamite Shire Council (all 90.9 per cent). It is interesting to note that in 2011-12, the local government areas of Moorabool Shire Council and Golden Plains Shire both had the second and third highest proportion of people with high or very high psychological distress, 11.9 per cent and 11.6 per cent respectively, within the Western Victoria PHN region (Victorian Population Health Survey 2011-12). No update is required.
In contrast to 2011 where there were lower proportions of the population seeking professional help for mental health related problems in the majority of local government areas in the Western Victoria PHN region relative to rural Victoria; in 2014 there were 9 local government areas where the proportion of the population seeking professional help for mental health related problems was higher than rural Victoria and 12 local government areas where	In 12 local government areas in the Western Victoria PHN region the estimated proportion of the population who had sought professional help for a mental health related problem in the previous 12 months was lower than the rural Victorian average of 18.1 per cent and, in nine local government areas, lower than Victoria (16 per cent). These local government areas included Moyne Shire Council (9.3 per cent), West Wimmera Shire Council (10.1 per cent), Glenelg Shire Council (11 per cent), Hindmarsh Shire Council (11.4 per cent), Southern Grampians Shire (12.1 per cent) and Colac Otway Shire (12.3 per cent). There was a significantly higher estimated proportion of people who had sought professional help for a mental health problem in the 12 months before the survey in the Shire of Central Goldfields (28.2 per cent) compared with all Victorians (16 per cent) (Victorian Population Health Survey 2014).

Primary mental health services	
Key Issue	**Description of Evidence**
the proportion was lower than rural Victoria.	
At a state level, more females than males sought professional help for mental health related problems; and more rural females sought help compared to metropolitan females.	At a state level, a significantly higher estimated proportion of females sought professional help for a mental health problem in the year before the survey (19.9 per cent) compared to males (12.1 per cent). While there was no difference between rural and metropolitan males, a significantly higher percentage of rural females sought professional help compared with metropolitan females, 23.6 per cent and 19.0 per cent respectively (Victorian Population Health Survey, 2014).
Higher proportions of the population, in some SA3s of the Western Victoria PHN region, accessing MBS subsidised mental health services relative to that of Victoria.	In 2013-14 the number of MBS-funded services for the preparation of mental health treatment plans by general practitioners per 100,000 population (age-standardised) was higher than the Victorian rate, 4,769, and the Australian rate, 4,260 in two thirds of the SA3s in the Western Victoria PHN region. These SA3s included Ballarat, 5,469; Creswick-Daylesford-Ballan, 5,391; Geelong, 5,348; Surf Coast-Bellarine Peninsula, 5,343; Maryborough- Pyrenees, 5,151; and Warrnambool-Otway Ranges, 4,843 (Australian Commission on Safety and Quality in Health Care, 2015. The First Australian Atlas of Healthcare Variation. Local area data tables). The number of MBS-funded services under the MBS reporting group of GP mental health has continued to grow in the Western Victoria PHN region. In the Western Victoria PHN region, the average annual growth for the number of providers providing services under the MBS reporting group of mental health between 2012-13 to 2015-16 was 5.33 per cent; the average annual growth for the number of patients receiving services was 12.67 per cent; and the average annual growth for the number of services provided was 13.67 per cent (MBS data by PHN and MBS Reporting Group, for 2012-13 to 2015-16. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-MBS_Data).
Lower proportions of men accessing MBS subsidised mental health services.	The proportion of females accessing MBS subsidised mental health services in 2011, 8.7 per cent, was greater than the proportion of males 5.5 per cent, in the Western Victoria PHN region. A similar pattern to that seen Australia wide (ABS, The characteristics of people using mental health services and prescription medication. The Mental Health Services-Census Integrated Dataset, 2011).
The number of MBS services accessed decreases by remoteness in the Western Victoria PHN region.	As seen in the Australian statistics, the proportion of the population accessing MBS subsidised services decreased by remoteness area in the Western Victoria PHN region: major city 8.0 per cent, inner regional 7.1 per cent, outer regional 5.5 per cent and remote 2.7 per cent (ABS, The characteristics of

Primary mental health services

Key Issue	Description of Evidence
	people using mental health services and prescription medication. The Mental Health Services-Census Integrated Dataset, 2011). In 2013-14, the two outer regional SA3s in the Western Victoria PHN region, Grampians and Glenelg-Southern Grampians had the lowest number of MBS-funded services for the preparation of mental health treatment plans by general practitioners per 100,000 population (age-standardised), 3,657 and 4,318, respectively (Australian Commission on Safety and Quality in Health Care, 2015. The First Australian Atlas of Healthcare Variation. Local area data tables).
General practitioners are the health professional most likely to be consulted regarding mental health problems.	Nationally, of those persons who reported they had been told by a doctor or nurse they had a mental or behavioural problem 15.7 per cent had consulted a GP in the previous 2 weeks, 6.4 per cent had consulted a specialist, 4.9 per cent had consulted other health professionals and 77.1 per cent had taken no action. Of those who had taken no action in relation to mental and behavioural problems in the previous 2 weeks, 68.1 per cent had consulted a GP in the previous 12 months and 26.6 per cent and 29.3 per cent had consulted a specialist or other health professional respectively. Over half of those persons with mental health and behavioural problems, 58.7 per cent, took at least one medication in the previous two weeks for their mental health condition, with 43.2 per cent taking antidepressants (Australian Health Survey: Health Service Usage and Health Related Actions, 2011- 12). No update required. Nationally, the proportion of people with a 12-month mental disorder that accessed services for mental health problems was 35 per cent, with women (41 per cent) more likely than men (28 per cent) to access mental health services. Of the 35 per cent of people with 12-month mental disorders who accessed health services, 70.8 per cent consulted general practitioners, with 28.9 per cent receiving mental health services from their general practitioner only and 64.2 per cent received services from mental health professionals (including psychiatrists, psychologists and mental health nurses), either alone or in combination with services provided by GPs or other health professionals (Slade et al, 2009. The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra). No update required. This was confirmed at service provider and community consultations across the Western Victoria PHN region. General practitioners were identified as being the first point of contact for many people experiencing mental health issues and in smaller rural areas where there is a lack of general practitioners, nurses at health services were often the first point of contact. Consultations in rural areas of the Western Victoria PHN region during 2016, also identified GPs and nurses may need additional skills and support to assist in the management of mental health

Primary mental health services

Key Issue	Description of Evidence
	issues. A need was identified for increased knowledge of local referral pathways to mental health professionals; and there was concern amongst service providers that the lack of availability of mental health services for mild to moderate illness may lead to crisis situations, which often have to be managed by GPs. This is confirmed in the findings of the National Review of Mental Health Programmes and Services, Contributing Lives, Thriving Communities where it was identified it is unlikely all rural communities will have regular access to specialist mental health services and instead primary health service providers should be 'supported to enhance their knowledge and expertise'.
Prescribing for mental illness.	NB: the following data refers to prescriptions dispensed; it is not possible to determine from this data the number of individuals for whom the prescriptions were dispensed. In 2013-14 the number of psychotropic PBS prescriptions dispensed per 100,000 people (age standardised) was greater than the rate for Victoria and Australia in many SA3s in the Western Victoria PHN region. Of particular note are the number of PBS prescriptions dispensed for antidepressant medications per 100,000 people aged 18 to 64 years (age standardised), which was greater than the rate for Victoria (99,774) and Australia (101,239) in all of the SA3s in the Western Victoria PHN region. The highest rate, 150,178 for Maryborough-Pyrenees SA3, was approximately 1.5 times that of Victoria and Australia. Ballarat SA3 and Grampians SA3 were 10th and 11th highest in Australia for the rate of prescriptions dispensed for anxiolytic medicines, 32,107 and 32,092 per 100,000 people aged 18 to 64 years, respectively. Geelong SA3 had the highest rate of prescriptions dispensed for antipsychotic medicines per 100,000 people aged 17 years and under in Victoria. The rate of 4,205 per 100,000 was more than double the rate of Victoria and Australia, 1,774 and 2,070, respectively. Geelong SA3 also had the highest rate in Victoria, and 7th highest in Australia, for the number of PBS prescriptions dispensed for ADHD medicines per 100,000 people aged 17 years and under. The rate of 23,546 per 100,000 people for Geelong SA3 was more than three times the rate of Victoria, 7,367, and more than double that of Australia, 10,780 (Australian Commission on Safety and Quality in Health Care, 2015. The First Australian Atlas of Healthcare Variation. Local area data tables).
Nationally, the majority of unmet needs, for the	The majority of those people with a 12-month mental disorder that accessed services in the previous 12 months felt that their

Primary mental health services

Key Issue	Description of Evidence
population with a 12-month disorder, were for skills training and social intervention.	needs had been met for medication (86.7 per cent) and talking therapy (cognitive behaviour therapy, psychotherapy and counselling) (68.2 per cent). However, the majority felt that their needs were not met in regards to skills training (to improve the ability to work, self-care or manage time effectively) (66 per cent) and social intervention (such as help to meet people and sort out accommodation or finances) (68.7 per cent). 85.7 per cent of those who did not use services reported that they did not have any need for help (Slade et al, 2009. The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra). No update required.
A lack of preventive support for mental health identified at service provider and community consultations in the Western Victoria PHN region.	Through rural service provider consultations and service mapping (conducted early 2016) service providers raised the issue that the number of funded sessions under the Better Access Scheme do not always meet the needs of more complex patients and that there is a lack of preventive support for mental health.

Child and youth mental health services

Key Issue	Description of Evidence
Limited access to child specific counsellors, family therapy and support services across the Western Victoria PHN region.	At service provider and community consultations during 2016, in the rural regions of the Western Victoria PHN, it was identified that there were gaps in services for youth with mental health issues, in particular acute mental health services.
Child and Adolescent Mental Health Service (CAMHS) Reports	In 2016-17, in the Western Victoria PHN region, of the three Community Child and Adolescent Mental Health Services, Barwon Health and South West Health, both had a higher average length of case, 339.1 days and 326.1 days respectively, relative to rural Victoria, 245.4 days, and Victoria 209.8. The average length of case for Ballarat Health was 222.7 days. The percentage of all CAMHS (aged 0-18) clients receiving a community or inpatient service who were aged under 12 was similar to rural Victoria, 33% and Victoria, 29% for the three Community Child and Adolescent Mental Health Services in the Western Victoria PHN region, Ballarat Health 31%, Barwon Health 33% and South West Health 31% (Department of Health and Human Services, State Government of Victoria, 2017. Child and Adolescent Mental Health Services Performance Indicator Report 2016-17).

Child and youth mental health services

Key Issue	Description of Evidence
	In the Western Victoria PHN region, of the three Community Child and Adolescent Mental Health Services, Barwon Health did not reach the pre-admission contact rate target of 60 per cent for Child and Adolescent Mental Health Services (CAMHS) for 2016-17 (percentage of admissions to inpatient unit for which a community ambulatory service contact was recorded in the seven days before an admission. This reflects a planned approach to admission rather than a crisis response). The pre-admission contact rate for Barwon Health was 44 per cent, lower than both the rural and state rates of 61 per cent and 51 per cent respectively. For both Ballarat Health and Barwon Health, the post-discharge follow up rate for CAMHS was lower than the target of 75 per cent (Ballarat Health 70 per cent and Barwon Health 43 per cent) (Department of Health and Human Services, State Government of Victoria, 2017. Child and Adolescent Mental Health Services Performance Indicator Report 2016-17). The National Mental Health Service Planning Framework (NMHSPF) estimates the expected demand for treatment of mild and moderate mental illness and early intervention for young people aged 0-4, 5-11 and 12-17 in the Western Victoria PHN region as 5,579; 9,183; and, 7678 young people respectively in 2016 (22,440 in total). The number of young people aged 12-17 that received treatment at the four headspace centres in the Western Victoria PHN region, Ballarat, Geelong, Warrnambool and Horsham, for the primary service of mental health treatment in 2016-17 was 2165, which is 28 per cent of the expected NMHSPF treated population (Report on headspace centres Western Victoria PHN. Financial Year 2016-17).
A smaller proportion of young people, with an identified need for mental health services, in the Department of Education and Training Western District area, were able to access mental health services when needed relative to Victoria as a whole.	In the Department of Education and Training Western District area (which includes 10 of the 21 local government areas in the Western Victoria PHN region) 32.6 per cent of young people reporting an identified need for mental health services were able to access mental health services when needed compared to 41.6 per cent in Victoria as a whole (2014 Victorian Student Health and Wellbeing Survey. State of Victoria Department of Education and Training. VCAMS Indicator data spreadsheets, Indicator 35.2). No update required.
Barriers to accessing youth mental health services and support in Ballarat and Geelong.	Youth from Ballarat and Geelong identified long waiting lists for youth mental health services and lack of transport options as barriers to accessing youth mental health services. Youth also recommended the provision of information for other mental health conditions beyond anxiety and depression such as psychotic illnesses and personality disorders (Headspace Youth Consultations: Report for the Office for Youth, October 2015).

Child and youth mental health services

Key Issue	Description of Evidence
	This is confirmed by the reported waiting time for headspace services in Ballarat, where 35.4 per cent of young people had to wait greater than 3 weeks for their first appointment in 2016/17 compared to 20.3 per cent nationally. The proportion of young people who reported waiting greater than 3 weeks for their first appointment was lower than that nationally in Geelong (10.9 per cent) and Warrnambool (9.8 per cent) (headspace centres Western Victoria PHN. Financial Year 2016/17).
At a state level, younger Victorians were more likely to have sought professional help for mental health problems compared with those aged 35 years and over.	A significantly higher estimated proportion of younger Victorians, aged 18- 34 years, sought professional help for mental health problems in the year before the survey compared with Victorians aged 35 years and over (Victorian Population Health Survey, 2014).
Nationally, approximately one fifth of 4-17 year olds with mental disorders did not have their needs met.	Approximately one fifth (20.6 per cent) of 4-17 year olds with mental disorders were reported as not having their need for help met. Counselling was the service most needed (68.1 per cent) and 73.8 per cent of those with a need for counselling had their needs met. Of the 36 per cent of children and adolescents that had a need for life skills training the majority 60.9 per cent did not have their needs met. The main barriers to seeking help or receiving more help that were identified by parents and carers of 4-17 year olds with mental disorders were mental health literacy (36.4 per cent) including being unsure whether their child needed help, where to get help or that the problem would get better by itself; and accessibility of services (30.9 per cent) such as problems in getting to a service, not being able to afford it or not being able to get an appointment (Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, 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, Canberra). No update required.

Psychological therapies for rural and remote, under-serviced and/or hard to reach groups

Key Issue	Description of Evidence
There is limited access to mental health services in some localities.	In the Western Victoria PHN region, the estimated proportion of respondents that rated their access to mental health services (e.g. psychologist, psychiatrist) as poor was greater than that for rural and regional Victoria, 39.30 per cent, and rural and regional Australia, 42.2 per cent, in the following local government areas

Psychological therapies for rural and remote, under-serviced and/or hard to reach groups	
Key Issue	**Description of Evidence**
	or groups of local government areas: Southern Grampians Shire 58.6 per cent; West Wimmera Shire , Hindmarsh Shire Council and Yarriambiack Shire combined 57.2 per cent; Ararat Rural City Council, Horsham Rural City Council, Northern Grampians Shire Council and Pyrenees Shire combined 46.6 per cent; and Colac Otway Shire 42.6 per cent (2016 Regional Wellbeing Survey, Barwon South West, Loddon Mallee and Grampians VIC region data tables, version 1.01, July 2017). This was confirmed through service provider consultations and mental health service mapping (conducted early 2016) where gaps in service provision were identified.
Fewer full-time equivalent psychologists per 100,000 persons in the Western Victoria PHN catchment compared with Victoria, and an uneven distribution of psychologists across Statistical Area Level 3 regions.	In 2014, there were 72 full-time equivalent (FTE) psychologists per 100,000 persons in the Western Victoria PHN region, compared to 81.4 across Victoria. Amongst the eight Statistical Area Level 3 regions in the Western Victoria PHN region for which data is published, Surf Coast-Bellarine Peninsula (18.3), Grampians (24.7), and Maryborough-Pyrenees (20.8) had the fewest FTE psychologists per 100,000 persons (Australian Institute of Health and Welfare National Health Workforce Dataset). Access to mental health services (high acuity services in particular) were highlighted as a key issue of concern in the 2016 rural service provider and community consultations. The Great South Coast and Wimmera Grampians Community Advisory Councils advised in 2016 consultations that it is difficult to recruit and/or access psychiatrists in the western regions of the Western Victoria PHN catchment. Consultation with the Great South Coast Clinical Advisory Council in 2017 reaffirmed that limited access to mental health services is an issue in that region. Other health professional gaps identified included mental health services for children and youth and counselling services. Reasons given for the difficulty of recruiting and retaining mental health professionals included lack of clinical supervision and professionals not willing to relocate for a part time position. In rural areas, where there are mental health services available, long waitlists for these services were an issue raised in various rural communities.
Barriers to accessing mental health services in rural areas of Western Victoria PHN.	Barriers to accessing mental health services in rural communities identified at service provider and community consultations across the Western Victoria PHN region in 2016, included: a lack of after-hours support for mental health in rural communities; concerns about privacy and not wanting to be seen accessing mental health services; and that the crisis assessment and treatment teams from the major regional hospitals are not always available due to high demand and there is a lack of capacity at the local level to deal with mental health crises. This is supported by the Fifth National Mental Health and Suicide

Psychological therapies for rural and remote, under-serviced and/or hard to reach groups

Key Issue	Description of Evidence
	Prevention Plan which reported the lack of available early intervention and primary mental health services in regional and rural areas results in people presenting later, being diagnosed at a later stage and being at a more advanced stage of illness.
A lack of mental health system literacy in rural areas of Western Victoria PHN.	A lack of mental health system literacy, for both community and service providers, was raised at consultations in rural communities across the Western Victoria PHN region, during 2016. The issues identified included providers and communities having limited knowledge of the full complement of mental health services available and limited connections between mental health service providers. This can mean that appropriate referrals to available mental health services may not be made.
Challenges in delivering mental health.	Service provider consultations, in 2016, identified a lack of outreach models for hard to reach vulnerable populations (e.g. Aboriginal and Torres Strait Islander population, GLBTQIA+ and children and families with complex and chronic needs). Cost of transport and limited transport options can be a barrier to accessing mental health services. Delivering services to CALD clients is challenging when using interpreters.
Barriers to accessing mental health services for people from refugee backgrounds.	A study on the health experiences of people from refugee backgrounds, which involved a small number of participants with refugee backgrounds from Geelong, identified the following barriers to accessing mental health services: stigma, taboos, denial and reticence to acknowledge mental health issues. Melbourne service providers reported that a barrier to accessing mental health services for those with a refugee background is the lack of culturally appropriate mental health services that can accommodate different cultural perspectives of mental health (Tyrrell, L., Duell-Piening, P., Morris, M., & Casey, S., 2016, Talking about health and experiences of using health services with people from refugee backgrounds, Victorian Refugee Health Network: Melbourne). No update required.

Mental health services for people with severe and complex illness

Key Issue	Description of Evidence
In certain SA3s in the Western Victoria PHN region, the rate of hospitalisations (private and public hospital admissions) for particular	While the rate of overnight hospitalisations for mental health conditions per 100,000 for the Western Victoria PHN region was the second lowest of all PHNs in Australia, 786 per 100,000 people (age standardised), there was variation amongst the SA3s within the Western Victoria PHN region for the six groups of mental health conditions: schizophrenia and delusional

Key Issue	Description of Evidence
mental health conditions was higher than the rate for Australia.	disorders, anxiety and stress disorders, bipolar and mood disorders, depressive disorders, drug and alcohol use and dementia (AIHW 2016. Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014-15. Cat. No. HSE 177. Canberra: AIHW). The two most common groups of mental health conditions requiring overnight treatment in a hospital in 2014-15 were schizophrenia and delusional disorders and drug and alcohol use. The number of overnight hospitalisations per 100,000 people (age standardised) for schizophrenia and delusional disorders in Warrnambool-Otway Ranges SA3, 170; and Geelong SA3, 166, was higher than the rate for regional Australia, 159 per 100,000 people. The number of bed days per 100,000 people (age-standardised) for schizophrenia and delusional disorders was higher than the regional Australia average 3,133, and the National average, 3,615, in the SA3s of Ballarat, Glenelg-Southern Grampians and Grampians, 4,656, 4,453 and 4,037 respectively (AIHW 2017. Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014-15. Cat. No. HSE 177. Canberra: AIHW). The number of overnight hospitalisations per 100,000 people (age standardised) for drug and alcohol use was higher than both the National (180) and Regional (196) rates in the Maryborough-Pyrenees SA3, 240 per 100,000 people; and higher than the National rate in Geelong SA3, 193 per 100,000 people. The number of bed days per 100,000 people for drug and alcohol use was higher than the National (1,369) and Regional (1,334) rate in the following SA3s: Surf Coast-Bellarine Peninsula, 2,141; Geelong 2,021; Maryborough-Pyrenees, 1,754; and Warrnambool-Otway Ranges, 1,421 (AIHW 2017. Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014-15. Cat. No. HSE 177. Canberra: AIHW). The Grampians SA3 had higher rates of hospitalisations and bed days than the Regional rates, for both anxiety and stress disorders and depressive episodes. There were 180 overnight hospitalisations per 100,000 people for anxiety and stress disorders in the Grampians SA3 in comparison to the National rate of 142 and the Regional rate of 165. The number of bed days per 100,000 people for anxiety and stress disorders was 1,300 in the Grampians SA3, which was greater than the National rate (1,239) and the Regional rate (1,263). The number of hospitalisations per 100,000 people for depressive episodes in Grampians SA3 was 142 in comparison to 118 Nationally and 132 Regionally. The number of bed days per 100,000 people for depressive episodes in Grampians SA3 was 1,617 in comparison to 1,556 Regionally (AIHW 2017. Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014-15. Cat. No. HSE 177. Canberra: AIHW).

Mental health services for people with severe and complex illness	
Key Issue	**Description of Evidence**
	Overnight hospitalisations and bed days per 100,000 people for bipolar and mood disorders were both greater than the National and Regional rates in Barwon-West SA3 and Grampians SA3. The number of overnight hospitalisations was 128 per 100,000 people in Barwon-West SA3 and 124 per 100,000 people in Grampians SA3 compared to 101 Nationally and 104 Regionally. The number of bed days per 100,000 people was 2,205 in Barwon-West SA3 and 1,878 in Grampians SA3 compared to 1,781 Nationally and 1,713 Regionally (AIHW 2017. Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014-15. Cat. No. HSE 177. Canberra: AIHW). Overnight hospitalisations and bed days per 100,000 people for dementia was greater than the National and Regional rates in Creswick-Daylesford- Ballan SA3 and Grampians SA3. The number of overnight hospitalisations was 76 per 100,000 people in Creswick-Daylesford-Ballan SA3 and 58 per 100,000 people in Grampians SA3 compared to 50 Nationally and 47 Regionally. The number of bed days per 100,000 people was 1,673 in Creswick-Daylesford-Ballan SA3 and 1,066 in Grampians SA3 compared to 820 Nationally and 738 Regionally (AIHW 2017. Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2014-15. Cat. No. HSE 177. Canberra: AIHW).
Area Mental Health Services Reports.	In the Western Victoria PHN region, of the three Area Mental Health Services (Ballarat Health, Barwon Health and South West Health), Barwon Health did not reach the 28 day readmission rate target (number of discharges from an inpatient unit where client was readmitted within 28 days of discharge) of 14 per cent for 2016-17 for Adult Mental Health Services. The 28 day readmission rate was 17 per cent, higher than the rural and state rate, 12 per cent and 13 per cent respectively. For both Ballarat Health and Barwon Health, the post-discharge follow up rate (percentage of client discharges for which a contact was recorded in the seven days immediately after discharge) was lower than the target of 75 per cent (Ballarat Health 58 per cent and Barwon Health 52 per cent). These rates can reflect quality of care and indicate effective discharge management (Department of Health and Human Services, State Government of Victoria, 2017. Adult Mental Health Performance Indicator Report 2016-17).
Mental Health Nurse Incentive Program.	In the financial year of 2016-17, 1, 738 people in Western Victoria received services through the Mental Health Nurse Incentive Program (MHNIP). This is 0.28 per cent of the population of the Western Victoria PHN region and 9 per cent of the treated population with severe illness as estimated by the National Mental Health Services Planning Framework.

Mental health services for people with severe and complex illness

Key Issue	Description of Evidence
Nationally, the proportion of people living with a psychotic illness that had unmet treatment needs was 55.5 per cent.	In the national psychosis report, just over a quarter of survey respondents with psychotic illness (27.5 per cent) had a need in the past year for one or more services that they had wanted and had not received. These unmet needs were treatment (55.5 per cent) or treating services (26.9 per cent) that were primarily but not wholly mental health related. 30.5 per cent of respondents identified the following areas where needs were not met: housing, finances, employment, legal assistance and practical assistance. The top reasons given for not receiving the service they needed were: it was not available 37.9 per cent; they could not afford it 31.3 per cent; and did not know how to access the service 20.0 per cent. However, concerns around mental illness treatment were not reported as the main challenge for those with psychosis, the top challenges identified were financial matters (42.7 per cent), loneliness/social isolation 37.2 per cent and lack of employment (35.1 per cent) (Morgan et al, People Living with a psychotic illness 2010. Report on the second Australian National Survey. Department of Health and Ageing, Canberra). No update required.
Limited support and treatment options for rural people with severe and complex illness in the Western Victoria PHN region.	From community and service provider consultations in rural communities across the Western Victoria PHN region, during 2016, it was identified that there are limited support and treatment options for those with severe and complex mental illness. Therefore, treatment is often accessed outside the community.

Suicide prevention services

Key Issue	Description of Evidence
Nationally, over a quarter of those who made a suicide attempt did not access services for mental health problems.	Over half (58.6 per cent) of people who reported any form of suicidality (suicidal ideation, suicide plans or suicide attempts) accessed health services to help with their mental health problems in the previous 12 months. Of those who made a suicide attempt about a quarter (26.6 per cent) did not use any services for mental health problems (Slade et al, 2009. The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra). No update required.
Hospitalisations for intentional self-harm were lower than Australia for the majority of SA3s in Western Victoria PHN.	In 2014-15, the number of hospitalisations per 100,000 people for intentional self-harm was lower than the National and Regional rate, 161 and 202 respectively, in all SA3s within Western Victoria PHN except for Maryborough-Pyrenees SA3, 163 per 100,000 people; and, Grampians SA3, 175 per 100,000 people (AIHW 2017. Healthy Communities: Hospitalisations for mental

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	health conditions and intentional self-harm in 2014-15. Cat. No. HSE 177. Canberra: AIHW). Nationally, from 1999 to 2012, in contrast to suicide deaths, where male rates were generally markedly higher than female rates, females' recorded higher age-adjusted rates of hospitalisation due to intentional self-harm than males. In 2011-12 the age adjusted rate of hospitalisation due to intentional self-harm for females was approximately 1.75 times that of males, 156.6 per 100,000 compared to 89.4 per 100,000 people (AIHW, 2014. Suicide and hospitalised self-harm in Australia: trends and analysis. Injury research and statistics series no. 93. Cat. No. INJCAT 169. Canberra: AIHW).
Ambulance attendances for suicide attempt and suicidal ideation.	In 2013, the ambulance attendance rates per 100,000 people for suicide attempt in the Western Victoria PHN region were highest in the following local government areas: Horsham Rural City Council, 150-179 attendances per 100,000 people; Moorabool Shire Council, 130-149; and Yarriambiack Shire Council, 110-129 attendances per 100,000 people. The ambulance attendance rates for suicidal ideation were highest in the following local government areas: Warrnambool City Council, 150-199 attendances per 100,000 people; Borough of Queenscliffe, Horsham Rural City Council, City of Ballarat and Ararat Rural City Council each had 120-149 attendances per 100,000 population (Turning Point, 2015. Self-harm and mental health related ambulance attendances in Australia 2013).
Lack of integration and coordination across the suicide prevention system impacts the effectiveness of services.	As part of the Western Victoria PHN Ballarat Place Based Suicide Prevention Mapping Project, consultations were conducted with service providers, those with lived experience of suicide and community members. The consultations identified that, in the City of Ballarat, there are a range of strategies and activities being undertaken to reduce suicide attempts and deaths. However, the effect of this work is being impacted by the following: lack of integration across the suicide prevention system; lack of coordination of resources to ensure greatest effect and impact; and, knowledge gaps around service availability and service access. This is supported by the Fifth National Mental Health and Suicide Prevention Plan where the current approach to suicide prevention is described as fragmented, leading to duplication and gaps in services and a lack of clarity about which services are most effective or efficient.

Aboriginal and Torres Strait Islander mental health services

Key Issue	Description of Evidence
Difficulties for Aboriginal and Torres Strait Islander peoples in accessing mental health services.	Consultations with some Aboriginal Community Controlled Organisations (ACCOs) in the Western Victoria PHN region identified the cost of psychological therapy services, lack of transport and lack of culturally safe services as barriers for Aboriginal and Torres Strait Islander peoples accessing mental health services. The transfer of care between ACCOs and mainstream mental health services is adversely impacted by a lack of communication between providers and a lack of recognition of the knowledge and expertise of ACCO staff. At consultations with non-Aboriginal and/or Torres Strait Islander mental health service providers, during 2016, it was reported that only a limited number of sessions were being delivered to Aboriginal and Torres Strait Islander clients despite trying different strategies to engage the local Aboriginal and Torres Strait Islander population. Similar barriers in accessing mental health care were identified in the Fifth National Mental Health and Suicide Prevention Plan. The barriers faced by Aboriginal and Torres Strait Islander peoples included the cost of services, the cultural competence of the service, remoteness and availability of transport, and the attitudes of staff. The plan recommended that the skills, knowledge and behaviour of non-Aboriginal and/or Torres Strait Islander mental health staff should be enhanced through training encouraging cultural capability. These observations are supported by the following data, which shows despite having greater need, Aboriginal and Torres Strait peoples have lower than expected access to some mental health services. The national rate of the Aboriginal and/or Torres Strait Islander population accessing MBS services is lower relative to the Non-Aboriginal and/or Torres Strait Islander population. In 2014-15, the age-standardised rate per 1,000 people of MBS services claimed for psychologists and psychiatrists, was 133 and 52 respectively; in contrast to the rate for the Non-Aboriginal and/or Torres Strait Islander population of 200 services claimed per 1,000 people for psychologists and 97 services claimed per 1,000 people for psychiatrists (AIHW 2017. Aboriginal and Torres Strait Islander health performance framework 2017: supplementary online tables. Cat. No. WEB 170. Canberra: AIHW). In contrast, the rate of state-based specialised community mental health service contacts per 1,000 population for 2014-15, were three times higher for the Aboriginal and/or Torres Strait Islander population in Victoria compared to the Non-Aboriginal and/or Torres Strait Islander population, 865.1 and 283, respectively (AIHW 2017. Aboriginal and Torres Strait Islander health performance framework 2017: supplementary online tables. Cat. no. WEB 170. Canberra: AIHW).

Aboriginal and Torres Strait Islander mental health services

Key Issue	Description of Evidence
For the Indigenous Areas within the Western Victoria PHN where hospitalisation data was available, the Warrnambool Indigenous Area had a higher rate of hospital admissions for mental health related conditions relative to that of Victoria (excluding Melbourne).	In the Indigenous Area of Warrnambool, within Western Victoria PHN, the aged standardised hospital admissions rate for mental health related conditions, 2,804 per 100,000, was greater than the rate for Victoria (excluding Melbourne) 1219.1 per 100,000 (Compiled by PHIDU using data from the Australian Institute of Health and Welfare, supplied on behalf of State and Territory health departments for 2012/13; and the estimated resident population (non-ABS), average of 30 June 2012 and 2013, compiled by PHIDU based on data developed by Prometheus Information Pty Ltd, under a contract with the Australian Government Department of Health). No update required.
In Victoria and Australia, higher proportions of the Aboriginal and/or Torres Strait Islander population are admitted to hospital for mental and behavioural disorders compared to the non- Aboriginal and/or Torres Strait Islander population.	For 2014-15, the age-standardised hospitalisation rate for a principle diagnosis of mental health related conditions for the Aboriginal and/or Torres Strait Islander population, Victoria 24.4 and Australia 29.1 per 1,000 population, was almost double that of the non-Aboriginal and/or Torres Strait Islander population, Victoria 15.5 and Australia 15.9 per 1,000 population. The percentage change between 2004-5 and 2014-15 for age-standardised hospitalisations with a principle diagnosis of mental health related conditions in Victoria is 22 per cent for the Aboriginal and/or Torres Strait Islander population and -23.5 for the Non-Aboriginal and/or Torres Strait Islander population (AIHW 2017. Aboriginal and Torres Strait Islander health performance framework 2017: supplementary online tables. Cat. No. WEB 170. Canberra: AIHW). Western Victoria PHN combined AOD and mental health funding, to commission nearly all of the ACCOs within the region for screening, assessment and brief interventions for AOD and mental health.

Stepped care approach

Key Issue	Description of Evidence
Lack of flexibility in the service models to meet client needs.	Service provider consultations and the mental health mapping process (conducted early 2016) identified that service models for mild to moderate mental illness do not always meet the needs of clients. The delivery of Psychological Therapy Services, for people experiencing mild to moderate mental health conditions commenced on November 1, 2016, across all 21 local government areas in the Western Victoria PHN region.

Stepped care approach

Key Issue	Description of Evidence
	The impact of these newly commissioned services will be monitored. For the financial year of 2016-17 in the Western Victoria PHN region, 2,563 people accessed Psychological Therapy Services. This is 0.41 per cent of the population of the Western Victoria PHN region and 4 per cent of the treated population with mild and moderate illness as estimated by the National Mental Health Services Planning Framework. The mental health reform in Victoria has resulted in changes in the way community mental health services are delivered. For example, a discontinuation of drop-in services and group services. Additionally, a lack of focus on early intervention was identified in relation to Mental Health Community Support Services (MHCSS) (Aspex Consulting, 2015. Independent Review of MHCSS and Drug Treatment Services. Commissioned by DHHS).

Comorbidity (including AOD)

Key Issue	Description of Evidence
Complexities in treating people with comorbidity.	Both the National Drug Strategy 2017-26 and the Fifth National Mental Health and Suicide Prevention Plan recognise the comorbidity of substance use disorder and mental illness complicates treatment and services for both conditions. Both reports recommend collaboration and coordination between services to ensure the most appropriate treatment and support for individuals. Insufficient focus on clients with multiple service needs, including dual diagnosis clients and homeless clients and lack of a funding structure for dual diagnosis clients. This leads to silos between drug treatment and MHCSS. (Aspex Consulting, 2015. Independent Review of MHCSS and Drug Treatment Services, Commissioned by DHHS, service provider and consumer group consultations). The proportion of people with comorbid mental health conditions and substance abuse that sought help for mental health in the previous 12 months was highest for those with affective, anxiety and substance use disorders (65.4 per cent) compared to affective and substance use disorders only (27.8 per cent) and anxiety and substance use disorders only (30.0 per cent) (Slade et al, 2009. The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra). No update required.

Comorbidity (including AOD)	
Key Issue	**Description of Evidence**
	Despite the high prevalence of substance use disorders in people living with a psychotic illness, a small proportion, 12.9 per cent, had accessed drug and alcohol services and programs in the previous year (Morgan et al, People Living with a psychotic illness 2010. Report on the second Australian National Survey. Department of Health and Ageing, Canberra). No update required.