Australian Government
Department of Health

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An Australian Government Initiative

Primary Health Network

Needs Assessment Reporting Template

This template must be used to submit the Primary Health Network's (PHN's) Needs Assessment report to the Department of Health (the Department) by **30 March 2016** as required under Item E.5 of the PHN Core Funding Schedule under the Standard Funding Agreement with the Commonwealth. This template should include the needs assessment of primary health care after hours services.

To streamline reporting requirements, the Initial Drug and Alcohol Treatment Needs Assessment Report and Initial Mental Health and Suicide Prevention Needs Assessment Report can be included in this template as long as they are discretely identified with clear headings.

Name of Primary Health Network

Western NSW

When submitting this Needs Assessment Report to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Report has been endorsed by the CEO.

Section 1 – Narrative

This section provides PHNs with the opportunity to provide brief narratives on the process and key issues relating to the Needs Assessment.

Needs Assessment process and issues

The timescale for this task was shortened in part due to the timing of Mental Health Reform Implementation Circular 2/2016and the need to clarify the precise dimensions of the task. The process was assisted by the appointment of the Centre for Rural and Remote Mental Health, University of Newcastle as a partner to obtain and process available information. A rapid review of available information (provided by the PHN, the Western NSW Health Intelligence Unit and drawn from other publicly available sources) was undertaken supported by key informant interviews (including the Mental Health Directors of both local health districts). A draft needs analysis was produced for the PHN which undertook an internal review and discussed the draft with its Board and its Clinical, Community and Aboriginal Health Councils. This was followed by revision and final submission.

The Research methods used for the rapid review of information for the mental health and drug and alcohol sections of the needs assessment differed due to the differing information base for each area.

Mental Health needs assessment

Due to lack of time rather than a systematic search being conducted a more targeted approach was used. Previous needs assessments in the region and documents that have gone some way to the mapping of health care services and needs were consulted. In addition, statistical data was collected from sources such as the Australian Bureau of Statistics and NSW Health Stats. Other documents and data sources suggested in the 'Needs assessment guide' were consulted and used where possible. In addition, the research team drew on their experience and knowledge in the area to help build a picture of the mental health needs and provision of services; using reference material wherever possible. The specific data sources, including sources specific to Aboriginal services and people, are cited within the tables.

Alcohol and other drug needs assessment

In addition to the sources investigated for the mental health search, a review of the following drug and alcohol organisations was conducted:

- Network of Alcohol and other Drugs Agencies (NADA)
- Community Mental Health and Drug and Alcohol Research Network (CMHDARN)
- NSW Users & Aids Association (NUAA)
- National Drug and Alcohol Research Centre, University of NSW (NDARC)
- Cancer Council NSW

The search terms 'Far West NSW, 'Western NSW and 'West NSW' were used to scan reports, newsletters, blogs and Facebook posts for relevant content.

Search of the websites for the Federal Member for Parkes, Mark Coulton, and State Member for Barwon, Kevin Humphries, was also conducted. The search terms 'drugs' and 'alcohol' were used to scan media releases and news articles. Searches of other MPs websites may have provided useful information but time constraints prevented more comprehensive coverage.

Section 4 – Opportunities, priorities and options

The approach to populating section 4 involved structuring the priorities (which have emerged via triangulation of tables in sections 2 and 3) within the six objectives outlined on p11 of the Mental Health Reform Implementation Circular 2/2016. The priorities extended beyond these objectives and are included in objectives of system redesign and workforce.

As indicated above, the short time scale has only permitted a snap-shot needs analysis and highlights the need for further consultation (with consumers, carers, community and health service providers) and facilitated discussion to build an adequate picture of both health demand and service supply needs, and the priorities and opportunities ahead.

Additional Data Needs and Gaps

The data was found from many sources and use multiple definitions of mental illness and mental health needs and different geographical boundaries and timescales. A number of the providers were engaged in restructuring and revising their strategies which were not available for this project. There was insufficient time or opportunity to analyse MBS and service data. Mental health services provided by GPs are highly variable and depend on the demand for services, GP interests and skills and the availability of specialist providers in public and private sectors. There is an absence of community data about unmet needs. Some of this data may be available in further analysis of the Australian Rural Mental Health Study which is cohort study conducted by the CRRMH.

We note that there was more data regarding health and service needs for the Far West area compared to Western NSW. This included a comprehensive Mental Health Atlas for Far West (not performed for Western NSW), more data from previous service mapping and needs analyses. Whilst some of this data may be available, it was not discerned during the time frame available.

Additional comments or feedback

There are a number of integrated care and stepped care opportunities including the integration of primary and secondary care, the integration of health and social care, and the integration of mental and physical health care. In remote communities the small population numbers imply considerable year-on-year variability in numbers, especially when considering suicide data. Additionally, staff turnover in rural and remote areas can change the supply of mental health services from year to year. There was insufficient time to

respectfully engage Aboriginal leaders and their communities and it would be inappropriate to impute needs without proper consultation. Likewise, this needs analysis does not address non-traditional pathways of mental health provision such as through occupational and work-based programs. Finally, insufficient attention is given to the delivery of programs through telehealth and online media. This is a key issue in the New South Wales Rural Health Plan: Towards 2021 in the subject of considerable investment in programs and infrastructure.

Section 2 – Outcomes of the health needs analysis

This section summarises the findings of the health needs analysis in the table below.

MENTAL HEALTH (INCLUDING SUICIDE PREVENTION) – HEALTH NEEDS ASSESSMENT

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
GEOGRAPHY AND DEMOGRAPHY		
Population density	Low population density	From HealthStats NSW, 4% of the state's population (2016 estimated resident population - ERP) is geographically distributed over more than half (55%) of the total land mass of New South Wales (NSW)
Transient population may not be included in estimations	Transient/migratory population in the West/North West of the PHN	From the Far West Medicare Local (FWML) Preliminary Primary Health Care Population Needs Investigation report, 2013: a transient/migratory population due to factors such as seasonal work, migration to warmer parts during winter, contract workers, drought affected migration and tourists
Population projections	Small population growth projections with sub-regional variations	From HealthStats NSW, population projections for 2013-2031 suggest that 7 of the Primary Health Network's (PHNs) 28 local government areas (LGAs) will have a positive population growth (Bathurst the highest 20.2%). However, the remaining 21 LGAs will show negative growth (Lachlan the lowest -23.2%
HEALTH DETERMINANTS		
Socio-economic factors	High levels of socio-economic disadvantage	The ABS SEIFA 2011 (Socio- Economic Indexes for Areas) - Index of Relative Socio-economic Disadvantage (IRSD is a general socio-economic index of disadvantage that summarises

Outcomes of the health needs analysis		
		information about the economic and social conditions of people and households in an area. More than 80% (85.7%) of the 28 LGAs within the PHN boundaries have a SEIFA IRSD in the 50% most disadvantaged deciles nationally. More than a third of the LGASs (35.7%) are classified in 1st and 2nd deciles for the most disadvantaged nationally.
Health literacy	Lower levels of health literacy	From the FW ML Preliminary Primary Health Care Population Needs Investigation report, 2013: low health literacy levels were evident in high risk groups such as Aboriginal people and older people reported from stakeholder consultations. The ABS reports that people aged 65 years and over had lowest levels of health literacy.
		A survey conducted in 2011, found that while mental health literacy in Australia had improved slightly in recent years there were still potential gains to be made in the area (Reavley, N. & Jorm, A. (2012), 2011 National Survey of Mental Health Literacy and Stigma, Commonwealth of Australia). No specific data found for mental health literacy in the PHN area.
Mental health linked to physical health	Rising levels of multi-morbidity and lower life expectancy in people with mental illness	People with severe mental illness have poorer physical health than the rest of the population. Moreover, treatment for physical conditions may be overlooked when treating those with a mental illness. This results in lower life expectancy and reduced quality of life. In addition, physical conditions may elicit or exacerbate mental health conditions (Mental Illness Fellowship of Australia Inc. (2011) Literature Review: The Physical Health of People Living with a Mental Illness). In 2007, 12% of Australians aged 16-85 had a physical disorder in addition to a mental illness (National Survey of Mental Health and Wellbeing (2008) Australian Bureau of Statistics). The occurrence of multi-morbidity (including chronic mental illnesses) is understood to be rising in Australia (Harris, M., Dennis, S. & Pillay, M. (2013) Multi-morbidity: negotiating priorities and making progress. *Australian Family Physician*, 42: 850-854). Also as part of a 2014 Medicare Local Health Needs Analysis, aggregated patient data was interrogated for 15,528 general practice and AMS patients living in 348 rural North West

Outcomes of the health needs analysis		
		NSW postcodes (2829, 2877, 2821, 2831, 2828, 2396, 2825, 2669, 2830 etc.) and found for the mental health patients with a schizophrenia, anxiety or depression profile (1,191 patients or 7.6% of the total group), the top four areas of multi-morbidities were: diabetes (135 diabetics or 19.4% of the total 861 sub-group), asthma (219 asthmatics or 18.4% of the total 1,191 sub-group), hypertension (394 hypertensive patients or 17.3% of the total 2,276 sub-group) and osteoarthritis (198 osteoarthritic patients or 16.6% of the total 932 sub-group).
Accessing health care	Travelling long distances to access health care	Over a third of LGAs have an Accessibility/Remoteness Index (ARIA 2011+) classification of remote or very remote: only 3 were classified as 'Accessible'.
	Difficulty accessing healthcare when needed	According to the 2012 NSW Adult Population Health Survey, respondents living in Far West (FW) and Western NSW Local Health Districts (WNSW LHDs) reported the highest levels of difficulty accessing health care when needed of all NSW LHDs (30.4% and 27.0% (smoothed estimates), respectively)
	Stigmatization of mental health problems and privacy issues may act as barriers to service access in small communities	Stakeholders interviewed for the Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report considered being seen entering a health service, particularly in relation to mental health, or where the clinician was known to the patient was a barrier to accessing services. In some locations, services are offered in alternative sites to help overcome the barrier. Secondly, when a service user's family is in conflict with another family or clan some may be reluctant to attend services where member of that family works (mostly but not exclusively an issue for ACCHOs).
Social determinants	Living alone	In the Far West 12.3% of people live alone (highest rates in Far West were: 13.6% in Broken Hill and 13.4% in Central Darling LGAs) (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney).

Outcomes of the health needs analysis		
		Being married or in de facto relationship is protective against mental illness (Australian Rural Mental Health Survey , Kelly various)
	Sense of trust and belonging in the community	Stakeholders interviewed for the Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report considered there was a strong sense of community and a willingness to help others in the Far West. However, there was concern that people living outside towns and villages did not have sufficient social networks for support. NSW Health Statistics suggest there may be some evidence that the social connection is stronger in the Western and Far West NSW compared to Sydney. People living in the Western NSW PHN area were more likely than people in Sydney LHD to run into friends while shopping, visit neighbours, considered most people can be trusted and feel sad about leaving their neighbourhood. However, people in Sydney felt safer walking after dark and were more likely than people in the Far West NSW LHD to feel able to ask a neighbour to look after a child (people in the Western NSW LHD were the most likely to feel they could ask the neighbour) (NSW Health Stats).
	Lone parent	In the Far West LHD, 5% of households are lone parent families (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney).
Risk factors	High prevalence of risk factors	From the NSW Adult Population Health Survey for WNSW PHN residents, with the exception of overweight or obesity, the prevalence of risk factors is showing decreasing trends. However, for 2013-14, PHN adults reported higher proportions than the state average for: overweight, physical inactivity, adults smoking, consumption at lifetime risk levels of alcohol.
	Higher rates of alcohol-attributable hospitalisations and deaths	From HealthStats NSW, alcohol attributable hospitalisations in 2013-14 were higher for PHN males than the state average for the same. For all persons, rates increased with remoteness.

Outcomes of the health needs analysis		
		From HealthStats NSW, alcohol attributable deaths in 2013-14 were higher for PHN males than the state average. For all persons, rates increased with remoteness, particularly for North West LGAs.
	Methamphetamine-related hospitalisations have increased significantly since 2009-10	From HealthStats NSW, the numbers of methamphetamine-related hospitalisations have increased in the PHN from 6 in 2009-10 to 87 in 2013-14. Trends reflect those seen at a state level. Methamphetamine use seen as a bigger problem in WNSW than in FWNSW (personal communication)
	Problem gambling	Problem gambling has been associated with some mental health problems (Beyond Blue, Fact sheet 45: Problem gambling and depression). A 2011 survey classified 0.8% of the NSW population as problem gamblers and 2.9% as moderate risk gamblers. Problem gambling was associated with being male, partnered, unemployed and having a low level of education attainment (Sproston, K., Hing, N. & Palankay, C. (2012) Prevalence of gambling in New South Wales).
MENTAL HEALTH STATUS AND BEHAVIOURS		
Mental and behavioural problems	High estimated rates of mental and behavioural problems in some communities (Including Broken Hill, Central Darling, Cowra, Forbes, Peak Hill, Wellington, Wilcannia).	In 2011-13 the estimated rates of mental and behavioural problems in the PHN is consistent with other parts of NSW outside of Sydney and other major urban centres. However, in Broken Hill (17.9%), the Central Darling (17.9%), Cowra (16.4%), Forbes (16.1%), Peak Hill (16.2%) and Wellington (17.1%) the female rates are high (compared to 15.6% in NSW excluding major urban centres). For males the highest rates were estimated to be in the same communities (Broken Hill (13.6%), Central Darling (13.6%), Cowra (13.5%), Forbes (13.8%), Wellington (13.8%) (compared to 13.3% in NSW excluding major urban centres) (Social Health Atlas of Australia – data by PHN, 2014).
		Stakeholders interviewed for the Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report considered mental illness was widespread across the Far West LHD and that depression, drug induced psychosis, grief and

Outcomes of the health needs analysis		
		trauma (especially in Wilcannia), schizophrenia (especially in Broken Hill) and post-traumatic stress disorders were particular concerns.
	Large proportion of adults with high or very high levels psychological distress (K10) adults in Far West	In 2013, the proportion of the population (16 years and over) with high or very high psychological distress was substantially greater in the Far West than all other parts of NSW. Western NSW LHD was similar to other parts of NSW. Moreover, the proportion of the population with high or very high K10 levels in Western NSW LHD gradually decreased between 2002 (12.8%) and 2013 (10.4%). Whereas in Far West NSW LHD the proportion Increased from 7% in 2007 to 18.1% in 2013. This higher than average prevalence may be associated with the relatively high Indigenous population. The prevalence among the Indigenous population of NSW is roughly double that of the non-Indigenous community despite a decrease between 2003 (24.2%) and 2013 (19.7%) (NSW Health Stats). Data does not appear to be available for the Indigenous community by LHD. (Time constraints prevented Aboriginal controlled health organisations (including Maari Ma and Bila Muuji), who may have local data, from being contacted in this round)
Suicide and self-harm	Mental and behavioural disorders relatively more prominent (to a small degree) cause of deaths compared to NSW as a whole	In the Far West, Mental and behavioural disorders were the 4th cause of death, compared to 5th in the rest of NSW. (Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report: Appendix 3, Epidemiological Profile).
	People in north-west of PHN more likely to be on anti-depressant or antipsychotic medication	Prescriptions for antidepressant medicines for people of all age groups and for antipsychotic medicines for adults 18 to 64 years were relatively high in the north-west compared to other parts of the PHN (use of anxiolytic medicines in all age groups and antipsychotic medicines for other age groups more consistent across the area) (Australian Atlas of healthcare variation 2015, Australian Commission on Safety and Quality in Health).

Outcomes of the health needs analysis		
	Comparatively high rates of hospitalisations due to intentional self-harm	In 2013-14, the rates of hospitalisation due to intentional self-harm among 15 to 24 year old males in the Far West LHD (181.2/100,000) was close to average but in the Western LHD the rate (250.2/100,000) was greater (4th highest). For females the rate was higher than that for males but less than average in Western (396.2/100,000) and Far West LHDs (403.1/100,000) compared to other areas in NSW. Further, the rates in NSW amongst Indigenous community were about double that of the non-Indigenous community: • Indigenous females 1040.6/100,000 compared to 473.3/100,000 for non-indigenous females • Indigenous males 375.5/100,000 compared to 165.8/100,000 for Non-Indigenous males (NSW Health Stats). Findings may be influenced by differences in access to hospitals.
	High rates of suicide and very high rates of suicide or deaths caused by self-inflicted injury in some communities (particularly Bourke, Oberon and Walgett)	In 2013, the suicide rate in the Western NSW LHD was 11.2/100,000 population higher than average (8.9/100,000 for all LHDs) and 5th highest in NSW (NSW Health Stats). No figures are available for Far West LHD, however, ABS data shows that there are generally higher rates of suicide occurring in rural areas, especially in relation to young men and among the Indigenous population (around twice the rate of the non-Indigenous population) (Australian Bureau of Statistics (2012) Suicides Australia, catalogue no. 3309.0). Hence it is expected that rates in the Far West are likely to be high.
		Suicide thought to be underreported in WNSW LHD (stakeholder interview 17/3/2016).
		According to the Social Health Atlas of Australia, 2014 in 2008-2012 there were extremely high rates of deaths from suicide or self-inflicted injury in some communities: Bourke 36.5/100,000; Narromine, 23.5/100,000; Oberon, 37.4/100,000; Peak Hill, 23.5/100,000; Walgett, 34.3; Wellington 22.3/100,000 (compared to 15.1 for non-metropolitan parts of Australia as a whole).
POPULATIONS WITH SPECIAL NEEDS		

Outcomes of the health needs analysis		
Aboriginal and Torres Strait Islander people	High Indigenous presence with a younger population profile than the non-Indigenous community	From HealthStats NSW, for 2015 (latest NSW ERPs available), WNSW PHN had the highest proportion of Aboriginal people (11.8%) of all NSW PHNs.
		From HealthStats NSW, for 2015, almost half (45.6%) of the PHN Aboriginal population are aged under 20 compared to a quarter (24.7%) for the same for the non-Aboriginal population. This is most likely due to a higher fertility rate and a lower life expectancy for the Aboriginal population.
	High rates of psychological distress and suicide	As outlined above the rates of high or very high psychological distress and suicide in the Indigenous population are roughly double that of the non-Indigenous population.
	Mental illness important in regard to fatal burden of disease	In 2010, mental illness and behavioural disorders were amongst the top 5 causes of fatal burden of disease for 35-44 year old Indigenous women. Injuries were also among the top five (which may be related to mental health issues). Mental illness and behavioural disorders are amongst the top 5 causes of fatal burden of disease for 25-34 year old Indigenous males and 35-44 year old Indigenous females. Injuries were also among the top 5 causes for both of these groups (Australian Institute of Health and Welfare (2015) Fatal burden of disease in Aboriginal and Torres Strait Islander people 2010. Australian Burden of Disease Study series Cat. no. BOD 2. Australian Government, Canberra).
	Higher suicide rates amongst Indigenous people	The age-standardised suicide deaths rates (deaths per 100,000) for NSW are higher for Indigenous people at 10.3 than non-Indigenous 8.9. Data source: Australian Bureau of Statistics (2016) Causes of Death, Australia 2014. Cat. no. 3303.0.
	Social determinants of mental health problems	A huge range of social determinants need to be addressed (including: alcohol, domestic violence and housing) (stakeholder interview, 17/3/2016).
Children and young people	Highest prevalence rates of mental health disorders found among 16 to 24 year olds	In 2007, the National Mental Health and Wellbeing Survey (ABS, cat no. 4326.0) found people aged 16 to 24 had higher annual prevalence rates of mental health disorders than any other age group.

Outcomes of the health needs analysis		
	Mental health disorders and psychological distress is common in children	In 2014, based on the reports of parents, about 14% of children, 4 to 17 years old, were assessed as having a mental health disorder in the previous year. Based on self-reporting, 20% of 11 to 17 year olds were found to have high or very high levels of psychological distress, while only around half (51%) were found to have low levels of psychological distress. High levels of psychological distress were found to be similar across states and when comparing capital cities with other parts of the state (Lawrence, D, Johnson, S, Hafekost, J, Boterhoven de Haan, K, Sawyer, M, Ainley, J and Zubrick SR (2015) The mental health of children and adolescents: report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra).
	Mental illness may disrupt schooling which can have long-term implications	Symptoms of major depressive disorder, on average, stopped students with the disorder attending school on 20 days in the previous year. In addition, while at school a third of students (34%) with major depressive disorder were severely affected by the symptoms and a further third was moderately affected (Lawrence, D, Johnson, S, Hafekost, J, Boterhoven de Haan, K, Sawyer, M, Ainley, J and Zubrick SR (2015) The mental health of children and adolescents: report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra).
	Self-harm particularly a problem in adolescent females	Adolescent Australian females self-harm at around twice the rate of their male counterparts (Lawrence, D, Johnson, S, Hafekost, J, Boterhoven de Haan, K, Sawyer, M, Ainley, J and Zubrick SR (2015) The mental health of children and adolescents: report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra; Harrison, JE and Henley, G (2014) Suicide and hospitalised self-harm in Australia: trends and analysis. Injury research and statistics series no. 93. Cat no. INJCAT 169, Australian Institute of Health and Welfare, Canberra).
	Suicide main cause of death in adolescents	Suicide was the main cause of death for Australians 15 to 24 years of age (Australian Bureau of Statistics (2015) Causes of death, catalogue no. 3303.0).

Outcomes of the health needs analysis		
Older people	Ageing population	From HealthStats NSW, population projections suggest that for the PHN, the proportion of the population aged 65 years and over will rise from 18.5% in 2016 to 24.1% in 2031.
	Psychological disability rises with age	In 2007, the National survey of Mental Health and Wellbeing assessed people aged 75 to 85 years as having the lowest annual prevalence rate of mental health disorders (6%) compared to other age groups (14% for 55 to 64 year olds and 9% for 65 to 74 year olds) (Australian Bureau of Statistics (2008) National Survey of Mental Health and Wellbeing 2007, cat no. 4326.0). However, generally the rates of psychological disability have been found to increase with age in both men and women and to rise steeply at 75 years (7.3% of people 75 to 84 and 18% of people over 85 reported a psychological disability). In older age, the rates of psychological disability tend to be a little higher in women compared to men and the level of disability tends to be greater for women (Australian Bureau of Statistics (2015) Psychological disability, 2012, cat no. 4433.0.55.004).
	Mood disorders particularly associated with residential aged-care facilities	In 2012, around half of older people living permanently in aged-care facilities were found to be depressed and the rates for men and women were similar (51% and 53% respectively) (Australian Institute of Health and Welfare (2013) Depression in residential aged care 2008-2012. Aged care statistics series no. 39, cat no. AGE 73, AIHW, Canberra).
	High rates of suicide amongst older aged males	In 2014, suicide rates were highest for men aged 85 and over (37.6 deaths per 100,000) (Australian Bureau of Statistics (2016) Causes of death, catalogue no. 3303.0).
	Poor mental health literacy amongst older people	Older people tend to have poorer mental health literacy, hold stigmatising attitudes and show greater reluctance to seek help with mental health issues compared to people in other age groups (Haralambous, B., Lin, X., Dow, Briony, Jones, C., Tinney, J. & Bryant, C. (2009) Depression in older age: a scoping study. Final report – National Ageing Research Institute).
Rural and remote populations	Prevalence of mental health appears to fairly consistent across geographical location	There appear to be only minor variations overall when comparing prevalence rates of mental health disorders within capital cities, urban areas and other areas of a state or territory. But prevalence rates are slightly higher in capital cities and major urban areas

Outcomes of the health needs analysis		
		compared to other parts of the state or territory (20.5% for state capital, 20.4% for major urban, 19.1% for other urban and 19.2% for balance of the state) (Australian Bureau of Statistics (2008) National Survey of Mental Health and Wellbeing 2007, cat no. 4326.0).
	Farming communities are at particular risk of mental health problems	Climate related catastrophic events (drought, fire and flood) is understood to increase farming communities' risk of developing mental ill-health (Berry, H., Hogan., Owen, J., Rickwood, D. & Fragar, L. (2011) Climate change and farmers' mental health: risks and responses. *Asia-Pacific Journal of Public Health*, 23: 119S-132S).
		One study has suggested that farmers have been found to be more likely to engage in risky alcohol consumption patterns than their city counterparts which has been associated with higher levels of psychological distress (Brumby, S., Kennedy, A. & Chandrasekara, A. (2013) Alcohol consumption, obesity, and psychological distress in farming communities. The Journal of Rural Health, 29: 311-319).
	Farmers are a high risk of suicide	Rates of suicide amongst NSW farmers are much less than Queensland. Nevertheless, the standardised suicide rate from 2000 to 2009 for NSW farmers was 13.5/100,000. Australian farmers are in a high risk group due to a complex set of factors. Including climate change, economic downtowns and changing government regulations, additional unique stressors, being male and access to firearms. Younger unmarried males at higher risk (Urska Arnautovska, S. McPhedran, B. Kelly, P. Reddy & D. De Leo (2016): Geographic variation in suicide rates in Australian farmers: Why is the problem more Frequent in Queensland than in New South Wales? *Death Studies*, DOI: 10.1080/07481187.2016.1153007).
	Suicide rates increase with remoteness	In Australia, greater rates of death by suicide have been associated with increasing remoteness; the rate in very remote areas (18.1 deaths per 100,000) was found to be close to double that in major cities (9.4 deaths per 100,000) from 2010 to 2011 (Harrison, JE and Henley, G (2014) Suicide and hospitalized.
		Self-harm in Australia: trends and analysis. Injury research and statistics series no. 93. Cat no. INJCAT 169, Australian Institute of Health and Welfare, Canberra). Moreover, as

Outcomes of the health needs analysis		
		outlined above some communities have very high rates of suicide and hospitalisation due to intentional self-harm.
Culturally and Linguistically Diverse people (CALD)	Some communities have a high proportion of people that speak a language other than English	According to 2011 Australian Bureau of Statistics (ABS) census data the Walgett LGA has a higher proportion of people speaking language other than English (5.5%) and 10.6% were born overseas. Overall, however, CALD people make up less than 1% of the Far West population (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney). No data found on proportion of CALD people in the Western NSW LHD.
People with complex needs	People with a mental health disorder often have complex needs	It is common for people to have more than one condition including physical health problems (see above), intellectual disability, problem gambling (see above), drug use issues, homelessness etc. The extent of needs often goes unrecognised, however, having a complex variety of needs has implications for service provision and the delivery of effective care. General practitioners and community health teams are considered as best placed to orchestrate the care of people with complex needs (Department of Health, Australian Government. People with coexisting conditions and complex care needs. http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc~mental-pubs-n-recovgde-10~mental-pubs-n-recovgde-10-com).
		The physical health of mental health consumers was seen as critical (stakeholder interview, 17/3/2016).
	People With a Dual Diagnosis of an Alcohol and/or Other Drug Problems and a Mental Health Disorder	It is estimated that 35% of people with a drug and/or other drug problem also have a mental health disorder (Mills, K., Deady, M., Proudfoot, H., Sannibale, C., Teesson, M., Mattick, R. & Burns, L. Co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. Australian Government).

Outcomes of the health needs analysis		
		These comorbidities must be taken into account for effective treatment (Mills, K., Deady, M., Proudfoot, H., Sannibale, C., Teesson, M., Mattick, R. & Burns, L. Co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. Australian Government; NSW Health (2015) Effective models of care for comorbid mental illness and illicit substance use: evidence check review.

D & A – HEALTH NEEDS ASSESSMENT

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
General substance dependence	No publicly available data related to local demand for services was identified meaning estimating need is difficult.	Statistics suggest that about 4% of the population have substance dependence and 10% have a problem that could do with intervention. In rural areas, major issue is access and community stigma to seeking help for substance issues (Ritter, A, Chalmers, J. & Sunderland , M (2013) *Planning for drug treatment services: estimating population need and demand for treatment* . Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW).
Accessing health care	Travelling long distances to access health care	Over a third of LGAs have an Accessibility/Remoteness Index (ARIA 2011+) classification of remote or very remote: only 3 were classified as Accessible
	Difficulty accessing healthcare when needed	According to the 2012 NSW Adult Population Health Survey, respondents living in Far West (FW) and Western NSW Local Health Districts (WNSW LHDs) reported the highest levels of difficulty accessing health care when needed of all NSW LHDs (30.4% and 27.0% respectively). This is especially the case with D&A services, where it has been noted that participants in Opioid Treatment Programs can be required to travel as much as 350 kilometres (Allan, J (2015) Prescription Opioids and Treatment in Rural Australia: A Failure of Policy for Indigenous Australians, Substance Abuse, 36:2, 135-137). Problems of access to services are compounded in smaller towns by stigmatization of substance abuse problems. Stakeholders interviewed for the Far West Medicare Local (2013) *Preliminary Primary Health Care Population Needs Investigation: draft report* considered being seen entering a health service, particularly in relation to mental health, or where the clinician was known to the patient, was a barrier to accessing services.

Outcomes of the health needs analysis		
Tobacco use	High smoking rates (compared to National population rates) identified in several sectors of the current PHN	Reviewing AIHW and PHIDU Social Atlas data identifies generally an increased likelihood to smoke for individuals living in a rural area. Far West Medicare local has the highest ratio of smokers than any other ML (*Far West NSW Medicare Local Preliminary Health Care Population Needs Investigation*, Draft Report, June 2013). Western Medicare Local also reports high rates of smoking (*Western Medicare Local Comprehensive Needs Assessment Report* 2014-15).
	Higher smoking attributable hospitalisations and deaths within the PHN with rates increasing with remoteness of residence	From HealthStats NSW, for 2013-14, LGAs located within the PHN had higher rates of smoking attributable **hospitalisations** that increased with remoteness
		From HealthStats NSW, for 2013, LGAs located within the PHN had higher rates of smoking attributable **deaths** that increased with remoteness, particularly those LGAs located in the north west
	Higher prevalence of smoking in pregnancy overall in PHN, higher again amongst Aboriginal mothers and increasing with remoteness	From HealthStats NSW, the proportion of mothers smoking in pregnancy is higher for FW and WNSW LHD residents compared to the state average, and higher still for Aboriginal mothers with more than half smoking during pregnancy in 2014. For the years 2012-14, the prevalence ratio for smoking in pregnancy was higher among LGAs within the PHN, than for the state, increasing with remoteness.
Alcohol use	Higher use of alcohol in sectors of the PHN than the State population	Reviewing AIHW and PHIDU Social Atlas data identifies adults as more likely to drink alcohol in risky quantities that would be harmful in the short term and long term (*Far West NSW Medicare Local Preliminary Health Care Population Needs Investigation*)
		• The SR for high risk alcohol consumption is 120 (20% higher than the Australian rate) and is ranked 14th of the 61 MLs. • People who live in remote areas are more likely to drink at risky levels at least once a week compared to people who live in major cities (26% compared to 15% respectively). • While Aboriginal people are less likely than non-Aboriginal people to consume alcohol those that do drink generally consume at much more harmful levels.

Outcomes of the health needs analysis		
	Higher alcohol attributable hospitalisations and deaths for men and for all persons increasing with remoteness. Higher levels for Aboriginal people.	From HealthStats NSW, alcohol attributable hospitalisations in 2013-14 were higher for PHN males than the state average for the same. For all persons, rates increased with remoteness. • The rate of alcohol attributable hospitalisation in remote areas in NSW is significantly higher than NSW as a whole.
		From HealthStats NSW, alcohol attributable deaths in 2013-14 were higher for PHN males in all LGAs than the state average for the same. For all persons, rates increased with remoteness, particularly for North West LGAs. • Less Aboriginal people drink, but when they do it is at far riskier levels. Therefore, higher risk of Alcohol-related brain damage, FASD, suicide/self-harm, incarceration and domestic violence. Can be very complex - so need a whole of community response and a range of options for support (Allan, J. & Campbell, M. (2011): Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities, Social Work in Health Care, 50:6, 443-465) • Aboriginal people die from mental and behavioural disorders due to alcohol use at 7 times the rate of non-Aboriginal people, and from alcoholic liver disease and poisoning by alcohol at 6 times the rate non-Aboriginal people (Far West Medicare Local (2013) *Preliminary Primary Health Care Population Needs Investigation: draft report)*.
Use of other substances	Methamphetamine-related hospitalisations are increasing dramatically	From HealthStats NSW, the numbers of methamphetamine-related hospitalisations have increase in the PHN from 6 in 2009-10 to 87 in 2013-14. Trends reflect those seen at a state level.
	Methamphetamine, as the primary drug, is responsible for more referrals to the MERIT (court avoidance) Program than	There are particular problems in the small committees and the northwest corridor of the Western LHD and NGOs are reporting methamphetamine use in people as young as 10 to 12 years and three generation use in some families (Stakeholder consultation 17/3/16 with Director, Mental Health Drug and Alcohol Services, Western Local Health District).

Outcomes of the health needs analysis		
	alcohol according to recent data.	
	Overdose deaths from opioids are higher in rural Australia than urban locations.	In New South Wales (NSW), the accidental overdose death rate outside of Sydney has doubled since 2008, from 2.25 to 4.72 per 100,000 people. A national survey of Indigenous health and wellbeing found that 5.6% of Indigenous respondents had used opiate painkillers or sedatives for nonmedical purposes. The rate is higher in remote areas and in locations of high Aboriginal population concentration (Allan, J (2015) Prescription Opioids and Treatment in Rural Australia: A Failure of Policy for Indigenous Australians, Substance Abuse, 36:2, 135-137).
	Opioid treatment programs in many PHN rural & remote towns inaccessible.	Due to high caseload of service hubs to support users of heroin and prescription opioids; need for prescribers and dispensers within the community to reduce caseload (http://onlinelibrary.wiley.com/doi/10.1111/ajr.12217/abstract).
Early intervention and prevention (health promotion)	Drug and alcohol education programs required to lower levels of high risk health factors including smoking levels, obesity and alcohol and drug misuse.	*Far West NSW Medicare Local Comprehensive Health Needs Assessment* May 2014
	More is needed in prevention, health promotion, and brief interventions.	Stakeholder consultation 17/3/16 with Director, Mental Health Drug and Alcohol Services, Far West Local Health District
	Health promotion addressing smoking and smoking cessation services required	*Western Medicare Local Comprehensive Needs Assessment Report* 2014-15

Outcomes of the health needs analysis		
Co-morbidity of D&A problems with other health needs	People With a Dual Diagnosis of an Alcohol and/or Other Drug Problems and a Mental Health Disorder	It is estimated that 35% of people with a drug and/or other drug problem also have a mental health disorder (Mills, K., et al. *Co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Australian Government). These comorbidities must be taken into account for effective treatment. No local data found in the timeframe on the prevalence of people with dual diagnosis or multiple morbidity in the PHN.

Section 3 – Outcomes of the service needs analysis

This section summarises the findings of the service needs analysis in the table below.

MENTAL HEALTH (INCLUDING SUICIDE PREVENTION) – SERVICE NEEDS ASSESSMENT

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
GEOGRAPHY		
Population geographically dispersed over more than half of the total area of the state of NSW.	Challenges providing, or facilitating access to, a wide range of primary and community health services to over 60 towns and communities and surrounding properties.	The population of Western NSW Primary Health Network (WNSW PHN) reside in 28 local government areas (LGAs). Health services are provided to more than 60 towns ranging from large regional centres (e.g. Broken Hill and Orange), smaller rural towns (e.g. Bourke and Parkes) to remotely located small communities (Tibooburra and Goodooga).
Cross-border flows and access to services in adjacent regions	Complex array of cross-border flow arrangements with three states, multiple PHNs and multiple local health districts.	The PHN shares borders with 3 states: Queensland, South Australia and Victoria. Further, within NSW alone, the PHN shares boundaries with 5 other PHNs and associated local health districts. States have different Mental Health Acts.
		People in the south of the Far West LHD may access mental health services in Mildura Victoria due to an agreement with Ramsay Health (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney).

Outcomes of the service needs analysis		
	Need for improved communication and collaboration across PHN boundaries to ensure patient access to services close to home.	Several community forums discussed cross-border flows and the need to understand services across boundaries. Funding silos and lack of joint planning limit ability to provide joined-up services.
Networking of services within the region	Complex network of transfers and referrals for patients across the region to access higher levels of care and specialist services in larger centres. Need to understand the picture and impact on primary care. Further, funding arrangements and inadequate collaborative planning impact on effective and efficient service distribution and cross-border networking.	From the WNSW LHD The Clinical Services Framework 2015: the WNSW LHD is organised into southern and northern network systems. Referral networks, both informal and formal, for intra-district and tertiary services for WNSW LHD follow the southern and northern network system. These are based on usual flows from smaller towns to larger towns and cities for generalist and specialist services. Flow patterns for certain speciality services e.g. acute coronary syndrome, stroke and severe trauma are influenced at a state level according to state-wide pathways. Some of these patients will have comorbid mental health problems. Funding arrangements and lack of collaborative planning can be a barrier to effective and efficient service distribution and cross-border working.
		WNSW LHD Southern Sector Referral Network: the majority of southern sector residents access their local hospitals for most of their community, ambulatory and in-patient services. Those requiring higher levels of care attend Bathurst, Dubbo, Mudgee and/or Orange. Children requiring tertiary level care are generally transferred to Westmead's Children's Hospital.
		WNSW LHD Northern Sector Referral Network: Residents access their local hospitals and health services for the majority of their community, ambulatory and inpatient services. People requiring higher levels of generalist or specialist care are generally referred to health services at Orange or Dubbo. Adults requiring services not available at Dubbo are frequently referred to Royal Prince Alfred Hospital and a small number to Westmead and

Outcomes of the service needs analysis		
		Nepean hospitals - located in Sydney. Children requiring tertiary level care are generally transferred to Westmead's Children's Hospital.
SERVICE ACCESS		
Access to mental health professionals	Location of mental health professionals mainly in regional centres, creates challenges for access to more remote communities	The majority of mental health services are located in Bathurst, Orange, Dubbo and Broken Hill. In the Far West, 85% of services Including all residential services) are located within Broken Hill. Western LHD is engaged in restructuring its mental health services to match population need. Outreach services to rural and remote areas are mostly provided by the Royal Flying Doctor Service (RFDS) and other NGOs. However, access to psychiatrists and clinical psychologists is limited and some communities have no access to acute or specialised services when needed. In the north of the Far-West, people may travel anything from 3 to 5.5 hours to reach residential care services in Broken Hill (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney).
	High rates of care provision by General Practitioners and General psychologists	In Broken Hill, general psychologist's services are used at a rate double that of NSW overall and in other parts of the Far West the rate of access of general psychologists was found to be about 12.5% of that in NSW as a whole (Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report). There are high levels of GP mental health plans in the north-west of the area (5,000/100,000 population compared to around 3,000/100,000 population in other parts of NSW) (Australian Atlas of healthcare variation 2015, Australian Commission on Safety and Quality in Health).
Transport	Access to affordable transport	From the Australian Bureau of Statistics (ABS) Census 2011, almost a third of Aboriginal households (28.9%) do not have a motor vehicle and only Broken Hill has a regular passenger bus service -this creates problems when trying to access services. From

Outcomes of the service needs analysis		
		community consultations financial support available through Isolated Patient Transport and Accommodation Assistance Scheme (IPTAAS) was considered inadequate.
Heavy reliance on NGOs to provide services in small communities	Diverse and complex array of outreach services from multiple providers and funding sources without any clear mapping of services	In addition to the LHDs, Aboriginal Community Controlled Health Organisations (ACCHOs), Marathon Health, General Practice and the RFDS which provide the core base of services, there are a number of other NGOs involved in providing mental health services or services to support people with mental illness. In addition, there is a complex array of funding sources and programs (State and Commonwealth) and an absence of any clear understanding of which organisations are providing what services.
		Funding sources include: Access to Allied Psychological Services, Mental Health Services in Rural and Remote Areas, and the Better Access initiative
		The PHN subcontracts service provision to: Dowdy's Wellbeing Centre (MHSSRA), The Baudinet Centre (MHSRRA), Maari Ma (ATAPS-ATSI), Outback Division of General Practice (ATAPS (various)), MHSRRA and flexible funds), Desert Healing (ATAPS (various)) and Marathon Health.
		Some of the NGOs providing mental health services in the area include: Aftercare, Benevolent Society, Carers NSW, CareWest, Catholic Health Care Limited, Centacare, Grow NSW, House with No Steps, Interrelate Family Centres, Lifeline, Mission Australia, NEAMI, Richmond PRA, Salvation Army, Schizophrenia Fellowship of NSW, and Uniting Care.
		Programs provided by NGOs include: Partners-in-Recovery (PIR), Personal Helpers and Mentors Service (PHaMS), Recovery and Resource Services Program, Mental Health Nurse Incentive Program, Housing and Accommodation Support Initiative (HASI), Family Wellbeing Program (FWB), Targeted Community Care Program, Arts in the Dust, Brighter Futures
		Other services provided by NGOs include: respite and support for carers, help with independent living skills, counselling, employment assistance, housing, advocacy,

Outcomes of the service needs analysis		
		information, referral, support/self-help groups, residential and day care, suicide prevention
Heavy reliance on outreach/visiting/telehealth services	Lack of any locally based services in some communities such as Walgett and Wilcannia. Many other communities have only basic nursing and community mental health services	The RFDS provides visiting mental health clinics to Hungerford, Ivanhoe, Menindee, Tilpa, Monolon, Pooncarie, Wanaaring, White Cliffs, Wilcannia, Innaminka, Louth, Packsaddle, Tibooburra, Wiawera, Yunta) either weekly, fortnightly to monthly (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney). The consistency of support in mental health treatment is important and while the RFDS aims to provide regular clinics this may not be the case when planes are diverted to attend to an emergency. Frequency depends on size of community to some extent. (stakeholder interview, 16/3/2016).
	Telehealth	Telehealth Psychiatric service (Mental Health Emergency Care Rural Access Program (MHEC-RAP): telephone and video link to Bloomfield Hosptial, Orange to provide emergency care and advice across the PHN area. The service also provides mental health information and specialist assistance (Saurman, E., Lyle, D., Perkins, D. & Roberts, R. (2014) Successful provision of emergency mental health care to rural and remote New South Wales: An evaluation of the Mental Health Emergency Care-Rural Access Program. *Australian Health Review*, 38: 58-64). Service awareness in the Far West was found to be inconsistent (Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report).
		Other telehealth services include: • The RFDS based in Broken Hill to support their non-acute visiting services. • The Royal Far West Kids delivers cognitive-behavioural therapy via Skype (service offered throughout rural NSW)

Outcomes of the service needs analysis		
		• The GP Super Clinic in Broken Hill have a non-acute outpatient care psychiatric telehealth program • Lifeline (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney)
Limited access to primary care and related services in the communities	Lack of GP services in majority of WNSWPHN region	The shortage of General Practitioners in the region, apart from in Broken Hill, Dubbo and Orange (Australian Government Doctor Connect website accessed 24/02/2016) is problematical for accessing mental health services. GPs are pivotal in the construction of mental health plans and the referral to psychiatric and psychology services under the Better Access and ATAPS schemes. Medicare Benefit claims for the 'Better Access' program for the 2009-10 period were similar for the average for rural NSW, both significantly less than the same for all of NSW. Within WNSW, the rate of utilisation of this program decreased with remoteness (WNSW Health Needs Assessment 2013).
		Even when GPs are available they may have insufficient time available to provide properly addressed mental health issues and some GPs will not provide counselling services (Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report). This may be insufficient training as well as due to time pressures.
	Gaps in mental health community-based services, increasing with remoteness.	Stakeholder consultation conducted by FWML and WML identified a need to improve community-based mental health services including after-hours services, community-living support and mental health promotion. From the WNSW LHD Health Partners' Mental Health Review 2014 higher unmet need was noted for Aboriginal, children, adolescents and older people. Stakeholders identified after-hours services as a critical gap in FW NSW.

Outcomes of the service needs analysis		
		The Western Local Health District have community mental health teams based in Bourke and providing outreach to nearby communities but they do not provide counselling services. Services are limited to health promotion, assessment care coordination and support (Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report).
		Note: Aboriginal controlled services are covered below
SYSTEM ISSUES		
Coordination and Integration	Disconnected care and poor communication and collaboration between providers across the WNSWPHN region vital for stepped care model.	The lack of integration and coordination of services has been a strong theme in previous needs assessments conducted in the region and was raised as a key issue to be addressed the National Review of Mental Health Services (2014) and the NSW Mental Health Commission's report (2014).
		In the Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report Mental health services were identified as "fragmented", as well as "insufficient and inaccessible".
		At best, coordination has been seen as patchy (Hallwright & Chiplin (2014) Mental health review – key service – related findings and recommendations, Health Partners Consulting Group Limited).
		The Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report observed little evidence of integration between mainstream and NGO services.
	Service providers lack knowledge of other services	The Far West Medicare Local (2014) Comprehensive Health Needs Assessment 2014-15 considered that service providers lacked of knowledge about referral pathways.
	Lack of a coordinated approach to care	Some service providers have been seen as resistant to collaborating with other services and many to do not engage in a coordinated approach to care (The Far West Medicare

Outcomes of the service needs analysis		
		Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report).
	The full range of services need to be integrated	Treatment of mental illness, especially for those severely affected, needs to take into account their full range of needs including physical health care, housing and employment assistance and independent living skills. Integration therefore, needs to go beyond coordination of mental health services. Fragmentation of physical and mental health was identified as key issue in the Mental Health Commission of NSW (2014) Living Well: a strategic plan for mental health in NSW 2014-2024.
	Domestic violence, police and emergency services	There are arrangements for information sharing and collaboration between police, emergency and other services which include safety action meetings. These might be of value across the mental health system (stakeholder interview, 17/3/2016).
Workforce	Staffing shortages	Lack of staffing and funding resources was identified as an impediment to providing the services required. Funding wasn't considered the only issue, shortages were considered to occur due to difficulty in attracting and retaining appropriately skilled and experienced professionals (Far West Medicare Local (2014) Comprehensive Health Needs Assessment 2014-15).
		Due to lack of support staff in rural and remote areas often experience burn-out (Hallwright & Chiplin (2014) Mental health review – key service – related findings and recommendations, Health Partners Consulting Group Limited).
		In the health sector mental health services are mostly provided by mental health nurses. There are few clinical professionals in the Far West compared to other areas. The NGO
		sector mostly employs non-professional mental health staff and no psychiatrists
		The only psychiatrist employed by the acute unit in Broken Hill spilt their time with the community mental health service. Hence a psychiatrist wasn't always available in the acute unit when needed (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West –

Outcomes of the service needs analysis		
		version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney).
	Lack of ongoing relationships between mental health professionals and the wider community	As so many services are provided on a visiting basis providers tend not to have an ongoing relationship with the community they serve (Hallwright & Chiplin (2014) Mental health review – key service – related findings and recommendations, Health Partners Consulting Group Limited).
	Maintaining a mixed age workforce with opportunities for succession over time.	Both the FWML and WML CNAs 2014 mentioned the ageing medical workforce. Data shows the nursing workforce in the region is also ageing. Related comments were about the need for better succession planning, currency of professional knowledge and skills and introducing new models of care, and the challenges of providing adequate supervision for young clinicians.
	Professional development	Skills of CMHTs need to be developed (stakeholder interview, 17/3/2016).
		PHN consultation forums, particularly in smaller and more remote communities, discussed the difficulties of offering staff regular opportunities to participate in professional development. Some of the issues raised included the extra time commitment if long distance travel is required, the lack of (and cost of) providing backfill, and a desire to have more opportunities available locally.
Data and information and technology	Availability of effective information technology that	The FWML C.N.A. 2014 identified poor availability of fast and reliable internet and associated technology as a barrier to effective service delivery. Similar issues were raised in
	enables effective use of contemporary data and related systems	2016 consultation forums in a number of locations in the region.
		Importantly this issue particularly affects the regions ability to effectively employ and expand telehealth services
SPECIFIC CHALLENGES AND GAPS IN RELATION TO GROUPS WITH SPECIAL NEEDS		

Outcomes of the service needs analysis		
Services for children and young people	Few mental health services specifically for child and young people	There are very few services identified as being specifically for children and young people. In the Far West 2% of services are specifically for children. There is: One non-acute, non-mobile out-patient care service with two psychologists, a social worker and an Aboriginal Mental Health worker in Broken Hill. In addition, the Royal Far West provides short stays (3-5 days) in Sydney for children under 12 with non-acute behavioural problems and their families for assessment, guidance and education – and telecare program to deliver CBT via Skype (for all of rural NSW). There are no residential or day care services specifically for children (no residential care within FW and no day care services specifically for children) (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney).
	Lack of appropriate crisis intervention services	The Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report said: "It appears impossible to obtain appropriate crisis intervention quickly, even in Broken Hill, and especially for young Aboriginal people."
	Lack of drop-in centres for young people in small communities	Headspace centres are only in Bathurst, Dubbo and Orange. One is opening in Broken Hill in early 2017. Young people living outside of these regional cities may have trouble accessing these services especially if they do not have transport (stakeholder interview, 17/3/16). There are no drop-in centres in the Far West LHD catchment (Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report).
	Children under 15 years not catered for by Headspace or by low intensity services	Access to services top priority – particularly an issue for under 15 year olds in small communities (stakeholder interview, 17/3/16).
	Family intervention services	Seen as key gap by a stakeholder (interview, 17/3/2016).

Outcomes of the service needs analysis		
	Coordination/communication between GPs and schools	Connection between school and general practice (including school counselling and out-of-school counselling) needs to be improved (stakeholder interview).
	Specialised grief and trauma services for children needed especially in Wilcannia	Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report
	Need to improve service provision by Headspace in Dubbo	The need to improve the effectiveness of the services provided by Headspace, Dubbo was identified. This included a proposal to appoint a suicide prevention counsellor (Western NSW Medicare Local (2014) Comprehensive Needs Assessment Report 2014-15).
Mental health services for older people	Few mental health services specifically for older people	Some residential care for older people is provided in Orange (12 acute beds and 16 non-acute beds) (Hallwright & Chiplin (2014) Mental health review – key service – related findings and recommendations, Health Partners Consulting Group Limited). No services specifically for older people identified in the Far West (Far West Medicare Local (2014) Comprehensive Health Needs Assessment 2014-15; Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney).
Appropriate services for Aboriginal People, including youth	Lack of mental health, drug and alcohol service gaps for Aboriginal people.	From the WNSW LHD Health Partners' Mental Health Review 2014; and, FWML and WML community consultations, mental health, drug and alcohol service gaps were identified by stakeholders. In particular, key stakeholders concern that drug and alcohol service delivery is one of the greatest unmet needs for the WNSW LHD population, in particular for Aboriginal people and youth.
	Some services specifically for Aboriginal people are available	Example, of services specifically for Aboriginal people in the region include: Aboriginal Services managed by Maari Ma Health Aboriginal Corporation in Broken Hill provide pscyhcological services and deliver services under the ATAPS program (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015)

Outcomes of the service needs analysis		
		The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney). Murdi Paaki (ACCHS partnered with Lyndon Health Community) provides OATSIH funded services to 8 communities in the Far West with located in Bourke, Broken Hill and Walgett ((Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report) Bila Muuji provides community based Social and Emotional support services in Bourke, Dareton and Wellington (http://www.bilamuujihealthservices.org.au/our-services.htm). ACCHOS are in many communities and the regional centres but also in smaller communities such as Bourke, Brewarrina and Walgett (Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report).
	Lack of culturally specific, appropriate and safe mental health and crisis intervention services.	Far West NSW Medicare Local Preliminary Health Care Population Needs Investigation, Draft Report, June 2013
	Need for a regional Aboriginal health plan	A regional Aboriginal health plan developed in consultation with Indigenous stakeholders is considered necessary (Hallwright & Chiplin (2014) Mental health review – key service – related findings and recommendations, Health Partners Consulting Group Limited).
	The appropriateness of telehealth for ATSI people	Stakeholders interviewed for the Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report questioned whether MHEC-RAP was culturally safe for Indigneous people.
	Communication and respect	The top priority is to build new respectful and transparent relationships for a process of deliberate and careful engagement and it is critical to build on what is happening at the moment (Stakeholder interview, 17/3/16). Service planning needs to acknowledge and

Outcomes of the service needs analysis		
		respect the concepts and values outlined in "The Gayaa Dhuwi (Proud Spirit) Declaration".
	Long-term commitment	Long-term commitment to solutions needed (stakeholder interview)
	Targeted response	Different localities have differing needs, it is critical to build on what is happening at the moment (e.g. Wilcannia needs a place-based solution) (stakeholder interview, 17/3/2016).
Farmers	Some programs are directed towards the mental health needs of the farming community	The Targeted Community Care Program has been delivered by some NGOs in the region to address mental health issues arising due to prolonged drought. Farm-Link operated by the Centre for Rural and Remote Mental
		Health aims to respond to the needs of the farming community. Undertaking mental health promotion and suicide prevention activities (particularly the Suicide Prevention Workshop (SCARF)).
Culturally and Linguistically Diverse people (CALD)	No services were identified that specifically cater for the needs of CALD people	Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney
People with a dual diagnosis of an alcohol and/or other drug problems and a mental health disorder	No services were identified that specifically cater for the needs of people with a dual diagnosis.	Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney
People with complex needs in addition to mental health care (such as assistance with housing and employment)	Services enabling social integration (employment and housing)	The PIR, PHaMs, HASI, Recovery and Resource Services, and Family Well-Being Programs along with other services provided in the main by NGOs are operating to support people with complex mental health needs. No data has been identified which would shed light on how well these programs and services are addressing the needs of people with complex needs.

Outcomes of the service needs analysis		
	Help with employment	No services that specifically focus on employment for people with mental illness were identified in the Far West (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney).
	No long term accommodation for people with ongoing mental health problems was identified in the Far West	Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney
	Lack of integration of care	Lack of case conferencing in regard to MH patients with complex needs. Services are not coordinated but rather operate in isolation (stakeholder interview 17/3/2016).
Rural and remote Populations	Primary prevention services	Little data indicating what prevention services are being provided and whether or not they are meeting needs has been found. Nevertheless, they are not entirely absent, however. The Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report considers there is a "paucity of primary prevention
		services". However, these services are not entirely absent. For example, the Rural Adversity Mental Health Program (RAMHP) (operated by the Centre for Rural and Remote Mental Health throughout NSW in collaboration with LHDs) primary activities include mental health literacy, develop community resilience and link people to mental health services.
		Mental Health apps may address mild and moderate problems allowing LHD staff to better address more serious and complex conditions (applies to young people as well) (stakeholder, interview, 17/3/2016).

Outcomes of the service needs analysis		
	Inadequate non-acute care	The Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report considered often services were not accessible unless a person was acutely ill.
	Inadequate community mental health	Hallwright & Chiplin (2014) Mental health review – key service – related findings and recommendations, Health Partners Consulting Group Limited; Western NSW Medicare Local (2014) Comprehensive Needs Assessment Report 2014-15 Stakeholder interview (17/3/16) identified lack of CMHTs in smaller communities (including Molong) as a major issue.
	Lack of locally based services in some communities particularly: Brewarrina, Cobar, Menindee, Walgett and Wilcannia	Visiting services considered inadequate as unable to address emergency situations and GP services are not filling the gap (Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report).
	Support for GPs	GPs as non-mental health specialists need good support which may include a telephone link to specialist help (stakeholder interview, 17/3/2016).
	Lack of day care	Few day care services identified in the Far West. In Broken Hill: NEAMI - day program (life skills, social and cultural needs) (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney).
	Telehealth for non-acute and ongoing problems needed	Hallwright & Chiplin (2014) Mental health review – key service – related findings and recommendations, Health Partners Consulting Group Limited.
	Residential care mostly based in Orange	Residential care for mental health patients is located in: Bathurst (10 non-acute beds) Broken Hill (6 acute beds, NEAMI provide 10 beds for pre- and

Outcomes of the service needs analysis		
		post-acute residential care) Dubbo (18 acute beds and 10 non-acute (rehabilitation and recovery) Orange (42 Rehabilitation, 26 medium secure and forensic, 8 involuntary D&A, 20 adult long stay, 56 acute or sub-acute and 26 non-acute) (Hallwright & Chiplin (2014) Mental health review – key service – related findings and recommendations, Health Partners Consulting Group Limited; Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney). In addition, an agreement with Ramsey Health in Mildura, Victoria which has 12 beds gives closer access to residential care to communities in the south of the Far West (Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, & T., Salinas-Perez, J.A. (2015) The Integrated Mental Health Atlas of the Far West – version for public comments. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney). As discussed above some communities have long distances to travel to residential care.
	Lack of acute care	A lack of after-hours care identified in some communities (Far West Medicare Local (2014) Comprehensive Health Needs Assessment 2014-15; Hallwright & Chiplin (2014) Mental health review – key service – related findings and recommendations, Health Partners Consulting Group Limited). After-hours support within the community which might include helping people with medication, preventing loneliness and homelessness (stakeholder interview, 17/3/2016).
		Emergencies are often dealt with by the police and ambulance officers (Far West Medicare Local (2013) Preliminary Primary Health Care Population Needs Investigation: draft report).

Outcomes of the service needs analysis		
Suicide prevention	Suicide prevention programs	The Black Dog Institute recently released an "Implementation plan for the systems approach to suicide prevention in NSW" (2015) this includes the need for gatekeeper training in workplaces and community organisations, community suicide prevention awareness programs, school based peer support and mental health literacy programs, training of general practitioners and other front line staff, appropriate high quality treatment and appropriate postvention care. It is important that these strategies are appropriate for rural and Indigenous communities; the CRRMH's education SCARF (suspect, connect, ask, refer and follow-up) program for example (http://www.newcastleinnovationhealth.com.au/scarf#.VvIgu3q3pbU). There are also national suicide prevention (e.g. National Suicide Call Back Service (On the Line) and Mental Illness, Bereavement and Suicide Prevention Project (SANE Australia) and postvention measures (e.g. StandBY Response Service (United Synergies) and Hope for Life (Salvation Army) (http://www.livingisforeveryone.com.au/Projects.html?cat=118#73) which may be appropriate. A number of ACCHS programs such as the Mildura and border towns strategy are operating very effectively.
	Access to suicide prevention and post intervention services	There were some lessons from a series of suicides two years ago. Postvention services were provided and Commonwealth funded program was provided including government community and regional organisations. Regular committee meetings are continuing. Suicide is a problem that is bigger than health and it is assumed it will be part of the remit of the mental health and drug and alcohol Council of the PHN. Strong support for the systemic suicide prevention strategy developed by the Black Dog and supported by the New South Wales Mental Health Commission (stakeholder interview, 17/3/2016).
	Historically suicide prevention has not been addressed by LHDs	LHDs have not formulated plans for suicide prevention (stakeholder interview, 17/3/2016).

D & A – SERVICE NEEDS ASSESSMENT

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Data deficiencies	Difficulty in planning without a good picture of what Government, NGO and private services already exist.	There is limited understanding of what D&A services are being provided across Western NSW. For instance, the WLHD MHDA service review found that there was no data on D&A services provided by health, and the best they could discover was that there were 9 FTE D&A workers for every 100,000 people in the region (see below for details). Stocktake needed to be undertaken of available D & A services across district (Federal funded, State and NGO funded outside health) to identify gaps and assist planning efforts to meet population need and contemporary evidence based D & A services (Mental Health Review – Key Service related findings and recommendations (Health Partners for LHD 2014)).
Specific service challenges and gaps for high need populations	Gaps in substance abuse services for rehabilitation, increasing with remoteness.	Stakeholder consultation conducted by WML as part of the 2014 Comprehensive Needs Assessment (C.N.A.) identified a need for drug and alcohol rehabilitation services (*Western Medicare Local Comprehensive Needs Assessment Report* 2014-15). Currently there are 3-4 rehabilitation facilities located in Western NSW - most in regional towns, for instance, Lyndon Community (http://www.lyndoncommunity.org.au/). That service gets an estimated 60-70 calls a week where assessments cannot be completed as there is no capacity. The Lyndon Community provide Commonwealth-funded detoxification, residential rehabilitation and community outreach services. Lyndon detox's 800 people a year, with people coming from all over NSW. Lack of drug and alcohol rehabilitation and treatment services in Far West. D & A service needs were not included in priority actions for
		FWML due to difficulty addressing the issue in the short to medium term, high reliance on other organisations and agencies to resolve, and the lack of funding and/or resources to

Outcomes of the service needs analysis		
		address (Far West NSW Medicare Local Comprehensive Health Needs Assessment May 2014.)
	Gaps in substance abuse community-based services, increasing with remoteness	*Mental Health Review – Key Service related findings and recommendations* (Health Partners for LHD 2014) identified LHD services not meeting needs across the district, especially for Aboriginal people and youth nor are they spread equitably across the district or population – response identified by 59.9% survey responses.
		The highest levels of LHD drug and alcohol service relative to population are in Orange, Cowra, Condobolin, and Lightning Ridge and the lowest levels of service in Mudgee and Parkes. The LHD provides only a small component of the full spectrum of service. The LHD services include: • 8 state-wide Involuntary Drug and Alcohol Treatment (IDAT) inpatient beds on the Bloomfield site • 10.9 FTE for community based OTP programmes • 5 FTE for MERIT programme • 15.6 FTE for community based drug and alcohol services for Orange and region • 10 FTE for community based drug and alcohol services for Dubbo and region. • A visiting psychiatrist addresses opium/methadone on a monthly visit to Broken Hill. The LHD-provided community services equate to 13.4 FTE per 100,000 population. After removing OTP and MERIT programs, 9.4 FTE per 100,000 population were available to provide drug and alcohol services within the community.
		In addition to the LHD services there is a range of other drug and alcohol services available to people of Western NSW provided by local NGOs.

Outcomes of the service needs analysis		
		There are particular challenges in regard to integrated provision of services presented with communities such as the Dareton/Sunraysia area. Dareton, due to its proximity to state and PHN borders, tends to be overlooked and hence underserviced. There needs to be a rebalancing of services in the Sunraysia area (Stakeholder consultation 17/3/16 with Director, Mental Health Drug and Alcohol Services, Far West Local Health District).
		There is currently no Addiction Medicine specialist working in Western NSW - only a visiting Addiction Medicine Specialist once every 2-3 months. This must be addressed, as these positions provide vital clinical leadership in this under resourced area (Personal communication).
	Changing composition of population demanding services with rise of methamphetamine addition not being accommodated	Drug and alcohol service demand rapidly outstrips resource and data is only recently becoming available. The first priority is still alcohol but it is being challenged by increasing demand for services to address Methamphetamine issues.
		Crimes relating to use of the drug ice a concern for Western New South Wales; new program will help assist with investigations in to manufacturing if the drug in local areas (http://www.markcoulton.com.au/Media/MediaReleases/tabid/74/ArticleType/ArticleView/ArticleID/1218/Default.aspx). Opioid treatment program required in Bourke. Fentanyl overdose and health issues in Aboriginal people related to injection (Allan, J (2015) Prescription Opioids and Treatment in Rural Australia: A Failure of Policy for Indigenous Australians, Substance Abuse, 36:2, 135-137).

Outcomes of the service needs analysis		
	Service challenges for people with dual diagnosis	In Far West NSW, the Mental Health Team at the LHD provides integrated care also for people with AOD problems. No other specific service for people with a dual diagnosis was identified. The complexity of AOD requires a specific AOD atlas. Salvador-Carulla, L., Fernandez, A., Maas, C., Feng, X., Astell-Burt, T.,Salinas-Perez, JA (2015). *The Integrated Mental Health Atlas of the Far West –Version for public comments*. Mental Health Policy Unit, Brain and Main Centre, Faculty of Health Sciences, University of Sydney.
Specific service challenges and gaps for moderate & low need populations (including carers)	Increased capacity for self-help and treatment in primary health care setting	Drug and alcohol services are currently not working well and are required to be delivered in the community. What is needed is a consultancy service to support GPs. This might include Consultant liaison/ outreach (Stakeholder interviews 16/3/16).
	Health promotion	Services currently delivered from a variety of sources and uncoordinated. Some of the noted preventive health efforts: • support smoking cessation in Aboriginal women through the Giving Up Smoking (GUS) program • support the use of the IRIS D&A Screening tool for pregnant Aboriginal women • support midwives to use brief interventions for women with substance use issues, in particular alcohol and tobacco • support Schools and the School Link Coordinator to support drug and alcohol education in schools (Far West LHD Draft Drug and Alcohol Service Plan 2016-2021). Fragmented efforts affecting tobacco use quit attempts.
		Wellington Aboriginal Corporation Health Service (WACHS) to receive a grant to address smoking by Aboriginal people in the local area under the newly-formed National Best Practice Unit (http://www.markcoulton.com.au/Media/MediaReleases/tabid/74/ArticleType/ArticleView/ArticleID/1182/Default.aspx).

Outcomes of the service needs analysis		
Access to effective, culturally safe mental health and drug and alcohol services for Aboriginal people	Lack of mental health, drug and alcohol service gaps for Aboriginal people	From the WNSW LHD Health Partners' Mental Health Review 2014; and, FWML and WML community consultations, mental health, drug and alcohol service gaps were identified by stakeholders. In particular, key stakeholders concern that drug and alcohol service delivery is one of the greatest unmet needs for the WNSW LHD population, in particular for Aboriginal people and youth. In this regard, the Orana Haven hostel provides a rehabilitation service in Brewarrina (initiative of the Murdi Paaki/Orana Region Aboriginal communities also open to non-Indigenous people) that adopts a program of cultural reconnection (http://www.oranahaven.com.au/OranaHaven/Home.htm). In addition, Bila Muuji provides community based Drug and Alcohol services in Bourke, Brewarrina, Coonamble, Orange, Walgett and Wellington (http://www.bilamuujihealthservices.org.au/our-services.htm).
		Lack of drug and alcohol support programs, regionalisation of services for indigenous population, need highlighted in Wilcannia (http://www.austlii.edu.au/au/journals/ILB/2009/27.html).
		The top priority for Aboriginal drug and alcohol services is to build new respectful and transparent relationships for a process of deliberate and careful engagement. Different localities require different solutions and it is critical to build on what is happening at the moment (Stakeholder consultation 17/3/16 with NSW State-wide Coordinator of the Aboriginal Mental Health Workforce Program).
Coordination between and integration of services	Improved efficiency & productivity in the delivery of existing services	There is a need to develop an integrated approach to healthcare delivery for people with mental health or drug and alcohol needs in at least one rural or remote area in partnership between the LHD, primary care, Medicare Locals, AMS and NGOs (Mental Health Review – Key Service related findings and recommendations (Health Partners for LHD 2014).
		A partnership is critical and there is a community drug action team. A key that should be addressed in this context is gambling addiction.

Outcomes of the service needs analysis		
		Stakeholder consultation 17/3/16 with Director, Mental Health Drug and Alcohol Services, Far West Local Health District
		Transform mental health and drug and alcohol services into an integrated Western NSW system of care that is tailored to the needs of its rural and remote communities and improves access to health care and outcomes with particular focus on closing the Aboriginal health gap. Includes developing multidisciplinary mental health and drug and alcohol teams (Western LHD MHDA Service Transformation Project Implementation Plan – 6 months November 2015 to June 2016).