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Acknowledgement

The updated Mental Health (MH) and Alcohol and Other Drugs (AOD) planning for the Northern Queensland Primary Health Network (NQPHN) was conducted in late 2017 in collaboration between the NQPHN Mental Health Team, and Population Health and System Team.

The members of the NQPHN team included Gillian Yearsley, Sandi Winner, Charmaine Knox, Gaynor Ellis and Bernie Triggs.

Members of the Population Health and System team include Frankie Clive, Adnan Choudhury, Paraniala Silas C Lui, Elizabeth Mitchell and Penny Edwards.

NQPHN wishes to acknowledge the contribution of its Clinical Councils, Board, and Staff, Regional Partners, Health Care Service Providers and the residents of Northern Queensland. We recognise the contributions of our four Hospital and Health Services (HHSs) and 10 National Aboriginal Community Controlled Health Services (NACCHSs) within our PHN region, and we thank them for their input and support.

Companion Documents

NQPHN Mental Health Planning Framework 2016
NQPHN Needs Assessment 2016
NQPHN Mental Health and Suicide Prevention Needs Assessment 2016
NQPHN Alcohol and Other Drugs Needs Assessment 2016
Improve Mental Health Services in the Primary Health Care Sector – NQPHN Overview (A3 document) 2017
NQPHN Mental Health and Suicide Prevention Regional Plan 2017
NQPHN Alcohol and Other Drugs Regional Plan 2017
Section 1- Introduction

Primary Health Networks (PHNs) were established in 2015 by the Australian Government with the aim of increasing the efficiency and effectiveness of medical services for people (particularly those at risk of poor health outcomes) and improving coordination of care to ensure people receive the right care in the right place at the right time.

One of the key roles of the Northern Queensland Primary Health Network (NQPHN) is to lead the planning and commissioning of regional mental health and suicide prevention services with a focus on coordination to ensure better outcomes for individuals and their families.

This document contains updated information supplementing the initial mental health and suicide prevention needs assessment conducted in 2016-17. The mental health and suicide prevention priorities as identified in the initial Health Needs Assessment remain relevant and key priorities areas for the NQPHN:

- Equitable access for people from rural and remote populations to low intensity service
- Equitable access to treatment and support services for individuals with severe illness and complex needs
- Equitable access for individuals with psychological distress (mild-moderate illness)
- Equitable access for Aboriginal and Torres Straits Islander people to low intensity services
- Effective suicide prevention programs using a regional approach, in particular for rural and remote areas
- Increase access and support for Australia Defence Force (ADF) personnel and veterans
- Increase access service availability for children & families
- Improve access to perinatal and infant Mental Health services (MH) in primary health care (PHC)
- Increase service capacity for Mental Health Promotion Program and Early Intervention (MHPP&El) programs
National mental health and suicide prevention reform

The Commonwealth Government recognises that the existing mental health system is complex, inefficient and fragmented. As such, the need for long-term system level change has been embraced.

Mental health reform is being led by the Commonwealth Government and it includes a shift to a regional approach and greater focus on the integration of mental health into primary health care (Commonwealth of Australia, 2015).

This discussion paper is principally framed by the context of mental health reform articulated within the following key reports and policy documents:

- Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services, National Mental Health Commission 2014
- The mental health and suicide prevention service planning guidance materials developed by the Australian Government for the Primary Health Networks.

These documents outline objectives, strategic directions and planning principles that are broadly consistent. Together these documents can be viewed as calls for a reformed mental health system that is characterised by:

- comprehensive services across the spectrum of needs from prevention to continuing care, that;
- deliver proven interventions in effective, efficient ways appropriate to the needs of users (stepped care), utilizing;
- person-centred approaches consistent with integrated care pathways, that are;
- applicable or adaptable across settings, and include specific measures to address Aboriginal and Torres Strait Islander needs, and are;
- delivered by a skilled workforce and supported by appropriate research capacities.
Methodology

NQPHN has carried out extensive stakeholder consultation and engagement across the region during the initial needs assessment, service mapping, co-design, and planning workshops for MH and AOD in 2016 and early 2017. Over 600 people participated in these workshops, consultations and online community surveys, representing a cross-section of the footprint including the following:

- General Practice
- Non-Government Organisations (NGOs)
- Aboriginal and Torres Strait Islander Health Authorities
- Local Government Areas (LGAs)
- Allied Health – Public and Private
- Queensland Health
- NQPHN Clinical Council
- Consumers

Information collated from these consultations and engagements are reviewed and triangulated with existing data from the initial mental and suicide prevention Needs Assessment 2016/2017 and integrated together with relevant literature to inform this current update. Qualitative data including an online key informant survey and co-design workshops across the region are incorporated in the update. New data and information are added within this Mental Health and Suicide Prevention Needs Assessment and where applicable, some evidence has been removed and/or restructured to reflect the current health needs of the communities. The most recent secondary data available during the collection and/or presented to NQPHN were used for the overall Health Needs Assessment. The data sources included:

- Australia Bureau of Statistics (ABS), 2016 census
- Australian Institute of Health and Welfare (AIHW) data
- Queensland Health
- Australian Government Department of Health-PHN data
- Chief Health Report-data 2016
- Department of Aboriginal and Torres Strait Islander Partnerships community profiles
- Public Health Information Unit (PHIDU), Social Atlas of Australia, Torrens University
- Queensland Regional Profiles

The NQPHN will work with key stakeholders around mental health system reform at a regional level. This work will be informed by the ongoing needs assessment process and service mapping to identify gaps and opportunities for the efficient commissioning and targeting of services. The activities aim to:
• increase the efficiency and effectiveness of primary mental health and suicide prevention services for people with or at risk of mental illness and/or suicide

• improve access to and integration of primary mental health care and suicide prevention services to ensure people with mental illness receive the right care in the right place at the right time.
SECTION 2 – OUTCOMES OF THE MENTAL HEALTH NEEDS ANALYSIS

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

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>Key Issue</th>
<th>Description of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-economic and cultural determinants of mental health and suicide</td>
<td></td>
<td>The initial NQPHN’s mental health and suicide prevention needs assessment 2016-17 highlighted significant socio-economic, cultural and geographical factors influencing the mental health and wellbeing of people in its footprint. Furthermore, qualitative and quantitative data indicated that children and young people, the elderly, Aboriginal and Torres Strait Islander people (ATSI), people from Culturally and Linguistically Diverse Backgrounds (CALD), Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) and women in perinatal and/or who experience violence are more likely to experience mental health, suicidal/self-harm ideation and behaviours and have difficulty accessing mental health services in NQPHN. The following update incorporates the most recent quantitative and qualitative data on the socio-economic and health factors associated with mental health and suicide.</td>
</tr>
<tr>
<td>Socio-economic factors</td>
<td>Higher proportion of socio-economic disadvantaged population in the footprint</td>
<td>About 49% of the NQPHN population fall in the first two quintiles of the index representing those that are most disadvantaged. There are 12 LGAs (of 31) in Northern Queensland PHN region with 100% of the population in the two most disadvantaged quintiles (Aurukun, Hope Vale, Kowanyama, Lockhart River, Mapoon, Napranum, Northern Peninsula Area, Palm Island, Torres Strait Island, Wujal Wujal, Yarrabah) (National Mental Health Commission, 2017; Queensland Government Statistician’s Office, 2017). For Torres and Cape regions, 73% of the population are within the most disadvantaged quintile, with only Weipa having people in quintile 4 and 5 (least disadvantaged). One third of the population in the Cairns and Hinterland region are in the most disadvantaged quintile. Overall, the population in NQPHN region suffers greater disadvantage than that of Queensland as a whole. The link between social and economic conditions and health inequities is well established; disadvantaged populations almost always have poorer health and poorer access to health care.¹ ²</td>
</tr>
</tbody>
</table>

**Outcome of the needs analysis**

| Poor quality employment and higher unemployment rate | The unemployment rate across the NQPHN is slightly higher than that for both the Queensland state and the National rates (8.5% vs 6.2% vs 5.9%) respectively as of March 2017, (Queensland Government Statistician’s Office, 2017). Approximately 81% (25/31) of LGAs in the region have higher unemployment rates than the state average. Although the proportion of the lowest income bracket (<$400/week or $20,800/year) is slightly lower than that of Queensland (27.3% vs 28.4%), more than half of the LGAs (18/31) population earned less than $400 per week. In Aurukun, Hope Vale, Kowanyama, Lockhart River, Mapoon, Napranum, Northern Peninsula Area, Pormpuraaw, Wujal Wujal, Yarrabah and Palm Island, over 50% of the population fall in the lowest income bracket in 2016/2017, (Queensland Government Statistician's Office, 2017). Studies have indicated that unemployment and poor quality employment (i.e. low wage, no or short term contract, limited control at work) are significantly associated with mental disorders (Allen, Balfour, Bell, & Marmot, 2014; World Health Organization, 2014). |
| Early childhood care and provision of education | In 2016 the NQPHN region had a slightly higher percentage (6.1% vs 5.4%) of the population having not gone to school or whose highest level of education was year 8 or below. The percentage of people completing year 11 or 12 is slightly lower (53.0% vs 58.9%) compared to the state average. Within the region, Aurukun has the largest proportion (26.5%), whose highest level of education was year 8 or below or did not go school followed by Pormpuraaw (19.3%) and Kowanyama (14.6%). Northern Peninsula Area has the largest proportion of whose highest level of schooling was year 11 or 12 (or equivalent) with 61.0%. As of February 2017, there were 541 early childhood and care services in the NQPHN region. The majority of the early childhood and care services are located in the regional centres of Townsville, Cairns, Mackay, Whitsunday, Cassowary Coast, Mareeba and Tablelands. Adverse early life experiences have long lasting effects later in life and are strongly associated with mental health disorders. The Australian Early Development Census (2015) indicated that children within the LGAs of Cooks, Douglas, Northern Peninsula Area, Palm |
### Outcome of the needs analysis

<table>
<thead>
<tr>
<th>Community and cultural determinants</th>
<th>Island, Torres and Torres Strait Island are developmentally vulnerable to two or more of the following: physical health and well-being, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge, compared to the state (14.0%). Family conditions and quality of parenting are significantly associated with child mental health and physical health (World Health Organization, 2014). A study among Aboriginal and Torres Strait Island (ATSI) children noted that improving the social and psychological conditions of families with Aboriginal and Torres Strait Islander children will potentially reduce the inequalities in mental health within the ATSI population (Shepherd, Li, Mitrou, &amp; Zubrick, 2012).</th>
</tr>
</thead>
</table>

#### Aboriginal and Torres Strait Islander People Mental Health and Wellbeing

Epidemiological evidence has shown that membership of certain ethnic groups, language barriers, refugee status and living in deprived neighbourhoods or communities are risk factors for mental ill health (Badland et al., 2014; Shepherd et al., 2012).

The population served by, and the area across which the NQPHN operates, is diverse and challenging with small pockets of high advantage contrasted with areas of extreme disadvantage. The region has the largest population of Aboriginal and Torres Strait Islander Queenslanders (67,752 people), (Queensland Government Statistician's Office, 2017). The distribution of this population reflects both cultural association, as well as Queensland’s political history of isolation, concentration, and segregation. This being so, the discrete Aboriginal communities across the region can represent many different clan groups and histories.

There are also significant refugee and migrant groups (52,072 people) in the region that has their own distinct needs. These groups include Pacific Islanders, PNG Nationals resident in the Torres Strait, migrants from the Mediterranean who have been a major part of the rural workforce for generations, and refugee groups more recently arrived, some of whom live in isolated settings. There is evidence that refugee and migrant groups are vulnerable to depression, suicide, and post-traumatic stress disorder.
### Outcome of the needs analysis

Aboriginal and Torres Strait Islander people are identified as a separate priority population not only because of the universality of their disadvantage but also its intransigence to significant change across the nation. Queensland is home to over 186,482 (4.0%) people of Aboriginal and /or Torres Strait Islander descent of whom over 67,752 live within the area serviced by the NQPHN (Queensland Government Statistician's Office, 2017). This includes a disproportionate number of remote Indigenous communities, greater levels of socially disadvantaged Indigenous people, and a significant majority of the nation’s Torres Strait Islander population.

| Aboriginal and Torres Strait Islander (ATSI) people mental status | Higher rates of hospitalisation and burden of mental illness among ATSI people. | Within the NQPHN region, 10.1% of the population identifies as Aboriginal and/or Torres Strait Islander, 4.9% in the Mackay region, 7.9% in Townsville, 10.2% in Cairns and Hinterland and 79.2% in the Torres Strait and Cape York. This is compared to 4% across Queensland. A landmark report on the burden of disease estimates for Aboriginal and Torres Strait Islander population noted;  
- Two-thirds of years lost among Indigenous Australians were due to poor health caused by mental health and substance use disorder, especially alcohol use disorder, anxiety and depression (39%)  
- Tobacco use (12%) and Alcohol use (8%) were two leading preventable risk factors causing the most burden among Indigenous Australians  
- Over 50% of the disease burden are attributed to alcohol use disorders amongst people aged 15-44 years  
- At the state level, mental & substance use disorders were the leading cause of total disease burden (21%) for Aboriginal and Torres Strait Islander people in Queensland (Australian Institute of Health and Welfare, 2016).  
- 7.7% of individuals hospitalised with mental disorders were Aboriginal Queenslanders  
- There were higher rates of Aboriginal and Torres Strait Islander people hospitalised for schizophrenia and other psychotic disorders (2.2:1) than other Queenslanders (The State of Queensland (Queensland Health), 2016). The admitted patient episodes of care for mental and behavioural disorders (ICD10AM F00-F99 as principal diagnosis) indicated a general increase in the |
### Outcome of the needs analysis

<table>
<thead>
<tr>
<th>HHS</th>
<th>2014-15 episodes</th>
<th>2015-16 episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cairns &amp; Hinterland</td>
<td>669</td>
<td>803</td>
</tr>
<tr>
<td>Mackay</td>
<td>147</td>
<td>142</td>
</tr>
<tr>
<td>Torres &amp; Cape</td>
<td>160</td>
<td>186</td>
</tr>
<tr>
<td>Townsville</td>
<td>400</td>
<td>578</td>
</tr>
</tbody>
</table>

Although reliable local information is wanting, existing community surveys demonstrate inequality between the mental health status of Indigenous Australians and the wider society\(^3\) and that while data on prevalence rates are very limited, it is clear from available data that rates of major mental disorders are high\(^4\). Based on existing data sources (published and service activity collections) and expert input, the Australian Institute of Health and Welfare (AIHW) is currently generating prevalence rates for Indigenous mental health diagnoses based on estimated rate ratios by comparison to the national population for adult males and females respectively. Preliminary findings suggest that rates are nearly double for most major mental disorders and substantially higher for substance use disorders (Australian Institute of Health and Welfare, Australian Burden of Disease Study: Technical Methods Report 2011, in press). There is also recent research demonstrating that the leading cause of non-fatal burden of disease in the Indigenous population, (27%) are due to anxiety disorders and depression, and alcohol misuse.\(^5\)

There is evidence for increased service use, not only in terms of public hospital admissions but also of outpatient services such as the Access to Allied

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5 Begg, S., et al., The burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people. 2014, Queensland Health: Brisbane.
| Outcome of the needs analysis | Psychological Services (ATAPS)\(^6\). All the more surprising, then, that – regardless of assertions in relation to ‘what works’ – there is a dearth of reliable evidence for effective interventions – mainstream or culturally adapted – as demonstrated in a systematic review of interventions for Indigenous adults with mental and substance use disorders in Australia, Canada, New Zealand and the United States (Lesk, Harris et al, in press).

In a survey of service providers in the NQPHN region, respondents identified Aboriginal and Torres Strait Islander people as a group most in need of mental health services.

Key barriers to accessing mental and wellbeing services in Aboriginal and Torres Strait Islander (ATSI) Communities include (Matthews V, Bailie J, Laycock A, Nagel T, & Bailie R, 2016);
- Systems and approaches for recruitment and retainment of Aboriginal and Torres Strait Health Workers
- Mentoring and support systems for ATSI health workers
- Lack of mental health training and development programs for ATSI mental health workers at all levels from certificate through to tertiary
- Limited finance and resources for mental health and wellbeing services.

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| Integrated Social and Emotional Wellbeing responses for Aboriginal and Torres Strait Islander people across primary health care. | As identified by Dudgeon et al (2014), Indigenous views of mental health and social and emotional wellbeing are very different to those of non-Indigenous Australians. This affects the way in which policies, programs, early prevention and intervention initiatives need to be framed, formulated, implemented, measured and evaluated. Indigenous Australians experience persistently poorer

In consultations with communities across the region the following feedback was identified:
- A need to expand Social and Emotional Wellbeing (SEWB) teams delivering evidence-based services in outer regional, rural and remote communities to at-risk groups including disengaged youth, migrant and refugee populations, Aboriginal and Torres Strait Islander people, homeless and dislocated people.

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### Outcome of the needs analysis

| Health outcomes for their entire lives than non-Indigenous Australians.  
| Key priorities identified by Aboriginal and Torres Strait Islander communities were for services to be embedded within a SEWB framework that address: welfare; grief, loss and trauma; alcohol and substance misuse; tobacco use; gambling; and the social determinants of health.  
| Aboriginal and Torres Strait Islander people have experienced significant levels of loss, grief, disempowerment and cultural alienation as a result of colonisation and policy contexts of isolation, concentration and segregation (Hunter, 1993; Purdie et al., 2010). These policies have profoundly impacted upon many Indigenous people’s sense of identity, spiritual and physical wellbeing, and general psychological adjustment (Human Rights and Equal Opportunity Commission, 1997; Berry et al., 2012).  
| Social and emotional well-being problems are seen as being distinct from mental illness. This is based on differences in severity, duration, and whether the presenting problems  
| • A need to expand SEWB Services and Programs for Aboriginal and Torres Strait Islander people and rural and remote locations.  
| A study on SEWB screening for ATSI people in primary health care concluded that there is a need for the development of national best practice guidelines for SEWB screening and management, accompanied by dedicated SEWB funding, and training for health service providers as well as ongoing monitoring of adherence with the guidelines’ (Langham et al., 2017).  
| A recent critical review on SEWB for use by ASTI communities in Australia also noted similar findings, stating that most western developed health and wellbeing frameworks failed to address issues that were directly associated with indigenous health and wellbeing such as connectedness, loss, resilience, empowerment, and control (Le Grande et al., 2017). This was also recognised in the Prime Minister’s report 2017: Closing the Gap (The Department of Prime Minister and Cabinet, 2017).  
| Indigenous people also experience poorer social and emotional wellbeing outcomes than non-Indigenous Australians. For instance, among Indigenous adults high or very high levels of psychological distress are nearly 3 times the rate of non-Indigenous adults. Rates of intentional self-harm among young Indigenous people aged 15–24 years are 5.2 times the rate of non-Indigenous young people.

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### Outcome of the needs analysis

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| meet the criteria and threshold for a diagnosable condition, etc. However, it is recognised that the two can be mutually constituted and reinforcing (Social and Emotional Wellbeing Framework). |

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| --- |
| Ten% of the health gap between Indigenous and non-Indigenous Australians in 2003 has been linked to mental health conditions, and another 4% of the gap is attributable to suicide. |

### Vulnerable population groups

The region serviced through the NQPHN contains the most decentralised population in Australia. Within this are subpopulations characterised by elevated risk of negative mental health outcomes. These groups are identifiable either by features of identity and personal characteristics (e.g. Aboriginal and/or Torres Strait Islander peoples, lesbian, gay, bisexual, trans, and/or intersex (LGBTI), migrant/refugee) or as a consequence of social settings and circumstances (rural and remote, homeless, detained populations). There is, of course, overlapping and compounding risk (for example remote Indigenous populations) and some groups are at elevated risk in part because these groups concentrate people with mental disorders as a consequence of poor mental health and wellbeing (detained populations, homeless).

#### Prison populations on release – Youth and Adult

Within the NQPHN region there is over-representation of the homeless, Indigenous people, those with mental disorders, and those with intellectual disability in the correctional system. Release and return to community has been identified as a major period of vulnerability.

Release from prison is associated with a range of poor health outcomes including homelessness, risky patterns of substance use, drug overdose and death. Among the leading causes of death among recently released prisoners is suicide, highlighting the

There is limited Australian data available on the health outcomes of Aboriginal and Torres Strait Islander people with a mental disorder following release from custody.  

Stakeholder consultations and responses to the online survey identified a significant need in relation to the engagement of released prisoners with primary care to prevent relapse. This included follow up in remote communities as well.

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**Outcome of the needs analysis**

<table>
<thead>
<tr>
<th><strong>pivotal role of mental health in shaping post-release outcomes for vulnerable ex-prisoners. Drug-related deaths are also common, particularly in the weeks immediately following release from custody.</strong>&lt;sup&gt;9&lt;/sup&gt;</th>
<th>** Queensland research demonstrates extremely elevated rates of mental health disorders in the incarcerated population**&lt;sup&gt;11,12&lt;/sup&gt; and of psychotic disorders in the remote Aboriginal communities in Cape York.&lt;sup&gt;13&lt;/sup&gt; Most recently, a qualitative study on how prison-to-community transition risk environment influences the experience of men with co-occurring mental health and substance use disorder in Queensland concluded that there is a shared responsibility between individuals, the criminal justice, and mental health systems to support ex-inmates during the transition. This should include a comprehensive integrated, evidence based support and treatment service during the transition(Denton, Foster, &amp; Bland, 2017).</th>
</tr>
</thead>
</table>
| **Individuales and families living in rural and remote areas** | **There are a range of rural communities within the NQPHN with existing health facilities who have identified an interest in exploring innovative models for their mental health services e.g. ’rooming in’ models to enable services at a local level. Information obtained through stakeholder consultations identified:**  
- People in rural and remote areas as the group most in need of mental health services across the NQPHN  
- Access to ATAPS services is not available in most rural and remote areas  
- Although access to internet services can be challenging and very expensive in many rural and remote sites across the region, a recent qualitative study among stakeholders working in Indigenous communities in Northern Territory indicated e-mental health interventions could potentially be effective in supporting or extending existing mental health services(Puszka, Dingwall, Sweet, & Nagel, 2016). Recent Clinical Council consultations also expressed** |
| **In rural and remote areas there is an identified lack of appropriate access to the spectrum of mental health services. This issue was identified across the region the Torres Strait as a key area of need.**  
**In rural areas, the regional economy is a key influence on mental health. Events such as drought, flood and bushfire can have a heavy impact, especially in agricultural areas. The mental health consequences of regional economic recession can be long-lasting.**  
**Social isolation as a result of distance is an important factor in the mental health and well-** |  

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<sup>11</sup> Heffernan, E., K. Andersen, and A. Dev, Inside out - The mental health of Aboriginal and Torres Strait Islander people in custody. 2012, Queensland Forensic Mental Health Service: Brisbane.  
### Outcome of the needs analysis

<table>
<thead>
<tr>
<th>Consideration to needs of children in out-of-home care</th>
<th>Within the NQPHN region, with high rates of unemployment and social disadvantage and a large Indigenous population living in remote settings in which disadvantage is concentrated, children in care represent a population with dramatically elevated risk of mental and behaviour disorders.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being of rural people. Geographic isolation can also affect access to mental health services where the closest mental health service may be several hours drive away. A culture of self-reliance in rural areas can also make people reluctant to seek help. Additionally, there can be considerable stigma attached to mental illness, even more so than in cities. Therefore, patients in rural areas are often less likely to report mental health problems.</td>
<td>a similar view as stated by one of the members: ‘e-mental health has a growing body of evidence for its use, inexpensive and under utilised’. The 2016 census data indicated that approximately 80% of private dwellings in the NQPHN footprint had internet access. However, Napranum (53%) had the largest percentage of dwellings without internet access, followed by Yarrabah and Lockhart River (50%) and Palm Island (40%)(Queensland Government Statistician's Office, 2017). A study commissioned by The Royal Flying Doctors Service of Australia early this year reported that mental health was the second highest important health issue affecting rural and remote communities in Australia (Lara B, Andy R, &amp; Martin L, 2017).</td>
</tr>
</tbody>
</table>

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14 https://www.ranzcp.org/Publications/Rural-psychiatry/Mental-health-in-rural-areas.aspx


### Outcome of the needs analysis

| Homeless population | Within the NQPHN region, service provision to this population has been significantly compromised with the decision to reduce funding to homeless health outreach teams. The gap between homeless populations and mainstream services remains unfilled. There is a dynamic relationship between homelessness and compromised mental health, with particular groups at elevated risk including those with existing mental illness, CALD populations, youth and others.\(^\text{17}\) Returning mental health services to the community also requires another consideration as the current process is creating | Within the FNQ statistical division (from Ingham north) the rates were also generally equivalent, with rates for non-Indigenous residents being twice as high as state non-Indigenous rates, and rates for Indigenous residents being approximately three-quarters of Statewide rates. The highest rates in that area are for Indigenous people in Cairns and non-Indigenous people in non-urban settings (presumably regional towns, which is likely to have been increased with the downturn in employment in the mining industry). These elevated rates are correlated with levels of social and economic disadvantage.\(^\text{18}\) These figures confirm concerns about Indigenous homelessness, particularly in urban settings, but also emphasize the importance in this area of non-Indigenous homelessness. Data from the AIHW (2016) study on exploring drug treatment and homelessness in Australia identified the following cohorts of people as more vulnerable to homelessness;  
- Having a current mental health issue  
- Experiencing domestic and family violence  
- Young aged 15-24 |

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\(^{18}\) Queensland Council of Social Services, QCOSS regional homelessness profile: Far North Statistical Division. 2011, Queensland Council of Social Services: Brisbane.
### Outcome of the needs analysis

<table>
<thead>
<tr>
<th>Individuals with psychological distress (mild-moderate)</th>
<th>Homelessness through the process of transition.</th>
</tr>
</thead>
</table>
| As identified in the needs assessment, in an area such as North Queensland, access to the full continuum of services is not always possible due to limited availability in rural and remote areas. This creates great challenges in establishing cost effective and efficient services to ensure a system of delivering and monitoring treatments so that the most effective yet least resource-intensive treatment is delivered to individuals first. As identified in the needs assessment, the region’s urban areas have access to a greater range of services, whereas the rural and remote areas are less well serviced. | Older aged 50+  
(Australia Institute of Health and Welfare, 2016)  
The Guddi project (2017) reported that the rate of indigenous homelessness in Cairns is higher than in Brisbane and Gold Coast. The participants from the study revealed in-depth problematic cyclical homelessness, poor levels of health and psychosocial well-being, imprisonment, loss of children and lack of physical and emotional safety (Townsend, Cullen J., & White, 2017).  
Stakeholder consultations identified:  
- A lack of mental health support services for the homeless (and a need to support and expand current services) associated with increased risk behaviour such as reoffending, drug and alcohol use.  
- Indigenous people often become dislocated when they travel to Cairns from rural and remote communities for treatment, experiencing isolation, risk of homelessness and mental health issues.  

Further research, consultation and analysis across the NQPHN is required.|

In a survey of service providers in the NQPHN region, 64% of respondents indicated that the mental health needs of the population in the region are being met ‘somewhat’.  
As identified earlier, access to ATAPS services in rural and remote areas is limited and practitioners in the region are reporting increasing presentations regarding mild/moderate MH issues in older people, particularly in rural areas. NQPHN is seeking to source additional data in this area. Though some in-roads have already been made with the development of VC hubs in Bamaga, Cooktown, Weipa and Thursday Island.  
A recent survey assessing psychological resilience, risk for self-harm and service use among primary and secondary school students from 11 Cape York Communities and Palm Island reported high level (72.9%) psychological distress
### Outcome of the needs analysis

| Access to internet for e-mental health services is also limited due to the limited availability and high cost of internet access in rural and remote areas. | and high exposure to risk factors for self-harm among Aboriginal primary and secondary students (Redman-Maclaren et al., 2017). |

| Inequitable access to treatment and support services for individuals with severe illness and complex needs | Within the NQPHN region, the needs assessment highlighted the inadequate and often inaccessible mental health services for individuals and families living in rural and remote locations with severe illness and complex needs. The Mental Health Nurse Incentive Program coverage is limited across the region and care coordination is made difficult with the transient population. With the exception of long-stay facilities and sub-specialty services (such as for high secure treatment setting or for residential eating disorders programs) all levels of the service pyramid are only present in the three urban centres. Townsville does, however, have a medium secure forensic mental health unit. Access to those highly specialised services are only available in Brisbane. Outside urban settings and larger towns, specialist service access is largely reliant on visiting teams from Queensland Health and a small group of other providers. Townsville and Mackay areas do not have access to a Partners in Recovery program. |

In a survey of service providers and communities in the NQPHN region, 64% of respondents indicated that the mental health needs of the population in the region are being met 'somewhat'. Partners in Recovery Cairns (the only PIR program in the region) data indicates that for the period 1 June 2013 – 30 June 2016:  
- 59% (n=406) of referrals were accepted  
- mood disorders (43%) and schizophrenia spectrum disorders (29%) were the principal mental health diagnoses  
- 30% of patients accepted by PIR were involuntary patients at some time during their engagement.  
- 56% of accepted patients were aged 35-54 years of age  
- 27% identified as being of Aboriginal and/or Torres Strait Islander origin  

Overnight hospitalisation for Schizophrenia and delusion disorders were higher in the following (SA3 level) regions compared to the regional average (159/100,000) in 2014-15:  
- Cairns-North (235/100,000)  
- Cairns-South (239/100,000)  
- Bowen Basin-North (233/100,000)  
- Far North (210/100,000)  
- Townsville (162/100,000)  

Overnight hospitalisation for Bipolar and mood disorders were also higher in the following SA3 region compared to the regional average (104/100,000):  
- Cairns-North (126/100,000)  
- Cairns-South (129/100,000)  
- Tableland (East)-Kuranda (130/100,000)  
- Mackay (103/100,000)
### Outcome of the needs analysis

<table>
<thead>
<tr>
<th>Outcome of the needs analysis</th>
<th>Overnight hospitalisation for Dementia was higher in the following SA3 regions than the regional average (47/100,000) in 2014-15:</th>
</tr>
</thead>
</table>
|                                | • Cairns-North (74/100,000)  
• Cairns-South (54/100,000)  
• Innisfail-Cassowary (78/100,000)  
• Tablelands (East)-Kuranda (48/100,000)  
• Mackay (49/100,000)  
• Townsville (79/100,000) |
|                                | (Source: AIHW database) |
|                                | Additional data includes: |
|                                | • burden of mental health illness on the health system has increased as reflected by hospitalisations associated with mental health and substance use |
|                                | • ED presentations for Mental Health issues constitute 3.7% of all ED presentations |
|                                | • 3% of all in patient care was for primary diagnosis mental health disorder |
|                                | • consumer transfers for hanging, overdose, self-harm or psychiatric episodes accounted for 3% of all transfers to hospitals and as high as 5% for the Cairns region (Health, 2015) |
|                                | • residents of Cairns – South SA3 are responsible for 1,508 Mental health-related inpatient separations for FY2013-14, with the next highest number falling in Townsville at 1005 |
|                                | Mental health-related inpatient separations across NQPHN are forecast to increase from 5595 in FY2013-14 to 8002 in FY 2026-27, if current trends continue. |

<table>
<thead>
<tr>
<th>Mental health of LGBTI people</th>
<th>As identified by the National LGBTI Health Alliance, the mental health of LGBTI people is among the poorest in Australia, with at least 36.2% of trans and 24.4% of gay, lesbian and bisexual Australians meeting the criteria for experiencing a major depressive episode in</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>In a survey of service providers in the NQPHN region, respondents identified LGBTI people as a group in need of mental health services.</td>
</tr>
<tr>
<td></td>
<td>Information from the Mental Health Commission (2013) identifies that “LGBTI Queenslanders have poorer mental health outcomes and higher rates of suicidality and self-harm than the rest of the population, and that in the previous</td>
</tr>
</tbody>
</table>
### Outcome of the needs analysis

<table>
<thead>
<tr>
<th>Limited access to perinatal and infant mental health in primary health care.</th>
<th>Within the NQPHN region there are no dedicated mother/infant mental health beds. Families need to travel to Brisbane for multidisciplinary tertiary level residential care. The mental health and wellbeing of parents is critically important to the emotional and physical development of the infant. If left unaddressed, these issues can have long-term consequences for both the mother and the child. <strong>Studies have demonstrated significant associations between mental health problems experienced during pregnancy and postnatal on the physical, cognitive, social, behavioural, and emotional well-being of a child and also on the mothers health</strong> (Geia, West, &amp; Power, 2013; Jongen, McCalman, Bainbridge, &amp; Tsey, 2014; Patel et al., 2016; Raine, Cockshaw, Boyce, &amp; Thorpe, 2016; Simcock et al., 2017). For example, perinatal depression is strongly associated with insecure maternal attachment and personality style (Raine et al., 2016). In a survey of service providers in the NQPHN region, respondents identified women who are LGBTI as being at higher risk of mental health issues.</th>
</tr>
</thead>
</table>
| 2005, compared with 6.8% of the general population.\(^{19}\) The elevated risk of mental ill-health and suicidality among LGBTI people is not due to sexuality, sex or gender identity in and of themselves but rather due to discrimination and exclusion as key determinants of health. | 12 months, 41% of homosexual/bisexual people had a mental disorder compared to 20% of heterosexual people." Data on mental health and wellbeing of LGBTI communities across Australia indicated that the proportion of mental health disorders and suicide attempts are higher compared to non-LGBTI:  
- 16% of LGBTI (aged 16-27) attempted suicide compared to 3.2% non-LGBTI (age 16+)  
- 33% (LGBTI aged 16-27) compared to 8.1% (non-LGBTI aged 16+) engaged in self-injury in their lifetime.  
- 37.2% of LGBTI compared to 20% of non-LGBTI aged 16+ were diagnosed for mental disorder and had symptoms in the past 12 months  
- 24.4% of LGBTI compared to 11.6% non-LGBTI aged 16+ have experienced a depressive episode in the past 12 months  
- LGBTI aged 16+ scored a higher average on the Kessler Psychological Distress (K10) score of 19.6 vs 14.6 non-LGBTI (national average), indicating moderate levels of psychological distress among LGBTI communities. (Sally Morris, 2016) Further research, consultation and analysis across the NQPHN is required. |

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**Outcome of the needs analysis**

<table>
<thead>
<tr>
<th>untreated, parental mental health issues can have negative impacts on the parents, the infant and the whole family. It is important to identify parents at risk of mental health issues, and support them, as early as possible. There is evidence to suggest that early intervention programs can assist in reducing family violence, substance misuse and child protection cases. Infants and young children may require secondary and tertiary mental health services in their own right. Studies show that difficult temperament; non-compliance; and aggression in infancy and toddlerhood (age 0 to 3 years) predict internalising and externalising psychiatric disorders at 5 years of age (Keenan et al 1998). Left untreated, up to 50% of these problems escalate throughout childhood and result in poorer outcomes emotionally, socially and scholastically (Bayer et al 2009).</th>
<th>in the perinatal period as a group in need of mental health services. As identified by Queensland Health, in Queensland in the period 2009-2011, suicide was the leading cause of maternal deaths, accounting for as many maternal deaths as all obstetric causes combined. Data from service mapping activities within the region indicated a need to enhance access and identify vulnerable mothers for early interventions, especially in the rural and remote communities in NQPHN. There is a disconnect between the prevalence of maternal perinatal mental health problems and the number of women receiving appropriate treatment. Each year nearly 10,000 Queensland women require primary care for perinatal mental health issues, nearly 3000 require specialist psychiatric treatment, and over 200 require hospitalisation. Disorders of the perinatal period are among the most preventable and treatable of all mental illness (Oates 2000; Salmon et al 2003), yet Queensland has no dedicated public beds for perinatal mental health admissions and provides specialist community perinatal mental health services in only four of 17 Hospital and Health Services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health services, suicide prevention and wellbeing services for children and young people</td>
<td>Higher rates of mental health disorders among children and young people in NQPHN. The age and gender distribution of Northern Queensland mostly follows that of Queensland in the middle years; however Northern Queensland has a greater percentage of infants and children (0-14 years) than the State and a smaller proportion of people over 60. In a survey of service providers in the NQPHN region, respondents identified young people as a group most in need of mental health services.</td>
</tr>
</tbody>
</table>

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20 Children’s Health Hospital and Health Service (2014) Discussion Paper Perinatal and Infant Mental Health Service Enhancement for Queensland Mental Health Commission

21 Children’s Health Hospital and Health Service (2014) Discussion Paper Perinatal and Infant Mental Health Service Enhancement for Queensland Mental Health Commission
### Outcome of the needs analysis

In FY 2015 there were 12,144 occasions of service at headspace centres in NQPHN (43% at Cairns centre, 37.5% Townsville centre, 19.5% Mackay centre) with 73% of these being for mental health disorders. The average visit frequency was 3.9. Some centres have indicated that the percentage of Aboriginal and Torres Strait Islander young people utilising the service is very small.

There is a higher prevalence of mental health disorders among children and young people aged 4-17 years in NQPHN (19.6%) compared to the national average (16.3%). The Young Minds Matter Program estimated the prevalence of mental health disorders among children and young people aged 4-17 years at SA3 level with the NQPHN:

- Cairns – North (15.9%)
- Cairns – South (19.0%)
- Innisfail - Cassowary Coast (17.5%)
- Port Douglas – Daintree (16.1%)
- Tablelands (East) – Kuranda (17.4%)
- Bowen Basin - North (17.1%)
- Mackay (14.1%)
- Whitsunday (16.1%)
- Far North (20.1%)
- Charters Towers - Ayr - Ingham (16.0%)
- Townsville (17.6%)

The data also revealed about 8.7% (aged 4-17 years) experience internalising disorders (anxiety disorders and major depressive disorder), while 7.1% experienced externalizing disorders (attention deficit/hyperactivity disorder and conductor disorder).

### Military and ex-military

As home to Lavarack Barracks in Townsville and other military facilities. North Queensland has, within its population, a high proportion of military personnel with experience of active service in areas of conflict and exposure to peacetime incidents such as the Blackhawk tragedy in 1996 that resulted in 18 deaths.

Of veterans receiving medical treatment, Queensland has the highest proportion of the national population of veterans receiving treatment for males, and the second highest proportion for females and has a relatively higher proportion of younger veterans receiving treatment. Suicide within the military has received significant attention in the public domain and has been identified as an issue in
### Outcome of the needs analysis

<table>
<thead>
<tr>
<th>Ageing population and mental health</th>
<th>Therefore, there are opportunities to work with the military to address transition-related stress, with veteran groups who already have organised networks and meetings, such as Pandanus Park on the banks of the Normanby River in Cape York.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>the veteran population.22 23 An important role of stress and disturbances in the mechanisms modulating allostatic load have been review specifically in relation to veterans.24</td>
</tr>
<tr>
<td></td>
<td>Recent data by AIHW (2017) indicated the following between 2001 - 2015:</td>
</tr>
<tr>
<td></td>
<td>➢ 325 deaths by suicide with at least 1 day of service with ADF</td>
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<tr>
<td></td>
<td>➢ Men accounted 303 deaths (93%)</td>
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<td></td>
<td>➢ Women accounted for 22 deaths (7%)</td>
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<td></td>
<td>➢ 51% (166) were ex-serving at the time of death</td>
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<td>➢ 28% (90) serving fulltime at the time of death</td>
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<td></td>
<td>➢ 21% (69) were of people serving in the active and inactive reserves at the time of death</td>
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<tr>
<td></td>
<td>➢ Ex-serving men are two times more likely to be suicidal compared to those serving fulltime or in the reserve (26 suicide deaths/100,000 vs 11 and 12 suicide deaths/100,000)</td>
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<tr>
<td></td>
<td>➢ Ex-serving men aged 18-24 are two times more likely to die from suicide than Australian in the same age group.</td>
</tr>
<tr>
<td></td>
<td>Further research, consultation and analysis across the NQPHN is required</td>
</tr>
</tbody>
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Outcome of the needs analysis

Older Aboriginal and Torres Strait Islander people have poorer health and higher rates of disability than other Australians in the same age group. For example, older Aboriginal and Torres Strait Islander people were reported at the Census to be almost 3 times as likely as non-Indigenous people to need help with self-care, mobility or communication tasks. Age related stigma, multiple chronic conditions and social isolation can exacerbate feelings of exclusion, poor self-esteem, helplessness and fear.

Because many Aboriginal and Torres Strait Islander people live in remote areas, providing appropriate and accessible services presents a major challenge. This is particularly the case for those with a diagnosis of dementia, which is an emerging problem for this population group, especially in the 50–79 year age range.


The overnight hospitalisation for dementia by SA3 level was higher than the NQPHN regional average (61/100,000) in Cairns-North (74/100,000), Innisfail-Cassowary Coast (78/100,000), and Townsville (79/100,000).

Further research, consultation, and analysis across the NQPHN is required.

Culturally and linguistically diverse groups

The needs assessment identified particular mental health service needs for the growing migrant and refugee communities across the region. Queensland is also home to refugees, who have a unique and often traumatic experience of migration.

There is a marked reluctance among many people from culturally and linguistically diverse backgrounds to voluntarily access both hospital and community-based mental health services. This lower level of service use is not related to lower levels of need, but rather to difficulties in understanding and accessing mainstream systems of care and lack of access to services that are culturally safe and appropriate. Stigma, lack of information about mental illness and mental health services in appropriate and accessible formats, and poor communication and cultural differences between clients and clinicians have been reported as major barriers to timely access to mental health services.25

## Outcome of the needs analysis

| Links between substance abuse and mental health | Community consultations in all areas within the region identified concerns about the lack of coordination and collaboration between AOD and mental health services and the difficulties experienced by individuals with comorbid conditions accessing coordinated care and support. 35% of people who use drugs also have a co-occurring mental illness. Although people with mental illness benefit from alcohol, tobacco and other drug treatment, they have poorer physical and mental health and poorer social functioning following treatment than other people. National data;  
- 17.5% of people aged 18+ who reported using illicit drugs also experienced high/very high levels of psychological distress; compared to those (8.6%) who had not use illicit drug  
- 26.5% of those who had reported using Meth/amphetamine also experienced high/very high level of psychological distress  
- 20.7% of illicit drug users had been diagnosed or treated for a mental illness (Queensland Mental Health Commission, 2015) |
<table>
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<tr>
<td>Stakeholder feedback identified within the region the need to focus on the high level of co-morbidities that are under diagnosed and under treated, and develop targeted multi-disciplinary responses.</td>
<td></td>
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</table>

### Suicide Prevention

<table>
<thead>
<tr>
<th>Higher than average incidence of suicide</th>
<th>For the three years 2011 to 2013, data prepared by AISRAP for NQPHN provides analysis of 328 suicides in the region, of which 225 (69%) were male, and 49 of 321 (15%) for whom Indigenous status was identified as of Aboriginal and/or Torres Strait Islander heritage. Of these deaths 122 (37%) occurred within the Cairns and Hinterland HHS, 98 (30%) within Townsville HHS, 89 (27%) within Mackay HHS, and 16 or 17 (5%) within Torres and Cape HHS (2 or 3 were identified as being “North West”). The age distribution followed a bimodal distribution with peaks among youths and young adults (25 to 24 years, 68 deaths) and those aged between 35 and 54 (67 and 62 deaths for each decade). The suicide rate in NQPHN is higher (16.4/100,000) than both the Queensland (13.2/100,000) and National (12.4/100,000). Within the region where data is</th>
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<tr>
<td>Within the NQPHN region, higher than average incidence of suicide and self-harm were identified. While suicidal and other self-harmful behaviours do not necessarily indicate mental illness, it is reasonable to assert that such behaviours are not consistent with positive mental health and wellbeing. Furthermore, certain mental disorders do confer significant risk of completed suicide, including major depression, bipolar disorder and schizophrenia, with that risk amplified by comorbid substance misuse.</td>
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### Outcome of the needs analysis

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<td></td>
<td>The agreed approach to conceptualising the spectrum of activities related to suicide prevention and response nationally is the LIFE framework. It provides for universal, selective and indicated prevention, symptom identification, early treatment and standard treatment, and longer-term treatment and support, and ongoing care and support. A coordinated strategy balances investment across the three broad areas of prevention, intervention/treatment, and continuing care, investing effectively and efficiently in promoting resilience vs responding to identified needs. Self-care/mental health promotion is relevant to everyone regardless of their mental health status or service need. As with mental health planning, suicide prevention planning must be seen as a process building on experience and understanding of local circumstances and capacity. It must also foreground the experience and knowledge of people with lived experience within the planning process.</td>
<td>available, the rates are higher in most LGAs, with Palm Island (57.7), Cook Town (39.8) and Hinchinbrook (21.0) having the highest rates (PHIDU, 2017). Common suicide methods used within the region:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Cairns &amp; Hinterland HHS and Torres &amp; Cape HHS</td>
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<tr>
<td></td>
<td></td>
<td>- Hanging (56.8%)</td>
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<td></td>
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<td>- Poisoning (15.1%)</td>
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<td>- Other methods (14.4%), (cutting with sharp objects and crashing a motor vehicle)</td>
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<td>- Fire arms (10.1%) higher than QLD overall (6.7%)</td>
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<tr>
<td></td>
<td></td>
<td>- Townsville HHS</td>
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<tr>
<td></td>
<td></td>
<td>- Hanging (59.2%)</td>
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<tr>
<td></td>
<td></td>
<td>- Poisoning (15.3%)</td>
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<tr>
<td></td>
<td></td>
<td>- Firearm (4.7%)</td>
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<tr>
<td></td>
<td></td>
<td>- Mackay HHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Hanging (49.4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Other (22.5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Firearms (11.2%)</td>
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<tr>
<td></td>
<td></td>
<td>- Carbon monoxide (10.1%)</td>
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<tr>
<td></td>
<td>(Potts, Kõlves, O’Gorman, &amp; De Leo, 2016).</td>
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<td></td>
<td>The rate of hospitalisation at SA3 level due to intentional-self harm within the NQPHN in 2014-15 reporting period is generally higher than the national (161/100,000). The following are higher than the NQPHN Regional (253/100,000):</td>
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<td>- Innisfail-Cassowary Coast (313/100,000)</td>
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<td></td>
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<td>- Port Douglas-Daintree (401/100,000)</td>
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<tr>
<td></td>
<td></td>
<td>- Tablelands(East)-Kuranda (304/100,000)</td>
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<td></td>
<td></td>
<td>- Whitsunday (347/100,000)</td>
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<tr>
<td></td>
<td></td>
<td>- Townsville (292/100,000)</td>
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<td>(Data Source: AIHW).</td>
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<tr>
<td>Outcome of the needs analysis</td>
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<tr>
<td>Data for the state as a whole for the period 2008 to 2011 shows rates in the ‘North and Far North’ and ‘Mackay-Fitzroy’ higher (not statistically significant) than the state, with the Mackay region having a higher proportion of males, and rates increasing across the state with remoteness, with a greater proportion of deaths in remote areas being in younger age groups and dying as a consequence of hanging, than in regional or metropolitan areas. Consistent with these higher rates of mental disorder in the Indigenous population, suicide rates are higher in Queensland’s Indigenous population, with Indigenous Queenslanders less likely to have had previous contact with the mental health system, more likely to have a history of substance abuse, and to have verbally communicated intent. For the period 2000 to 2010, suicides of Indigenous children aged 5 to 14 years were over 12 times higher than other children, accounting for 46% of all Queensland child suicides, being more likely to be in remote areas, and less likely to have had contact with mental health care systems. Consumer transfers for hanging, overdose, self-harm or psychiatric episodes accounted for 3% of all transfers to hospitals and as high as 5% for the Cairns region as the receiving hospital. 5.1% of all referrals from Torres and Cape HHS were due to mental health/substance misuse illnesses, higher than any other HHS in the NQPHN region (Health 2015a).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Workforce**

27 Begg, S., et al., The burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people. 2014, Queensland Health: Brisbane.  
Outcome of the needs analysis

<table>
<thead>
<tr>
<th>Workforce shortages in the primary health care sector</th>
<th>The NQPHN has the largest remote, rural and regional workforce in the state. The needs assessment identified:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• maldistribution of the workforce resulting in workforce shortages in rural and remote areas</td>
<td>With regards to medical practitioners working in remote, rural and regional Queensland, the average age of the workforce was 49.4 years and 39% were female, although, in very remote communities female practitioners represented only 28% of the workforce. Practitioners reported an average 44 hours per week on routine GP clinical work but there were increased hours from remote (52 hours) and very remote (49 hours) practitioners. Female practitioners (38 hours) averaged approximately 10 hours per week less than males (48 hours). Just 53% of the workforce were trained in Australia and less than 4% of practitioners were working in solo practices. Nine out of 10 practitioners were working in private practices but this decreased with increasing remoteness to only four out of 10 in very remote Queensland.</td>
</tr>
<tr>
<td>• potential future shortfalls in mental health nurses, psychiatrists, key allied health professionals and need for task shifting and building a local workforce</td>
<td>National data(^3) indicates the following key characteristics regarding the mental health workforce:</td>
</tr>
<tr>
<td>• short fall in Indigenous participation in the health workforce across all disciplines, including the need for increased supply and utilisation of Aboriginal and Torres Strait Islander primary health care workers</td>
<td>• a low proportion of mental health professionals working in rural and remote areas</td>
</tr>
<tr>
<td>• limited organisational structures to ensure staff receive adequate supervision, support and professional development</td>
<td>• an ageing workforce particularly in the disciplines of psychiatry, mental health nursing and Indigenous health workers</td>
</tr>
<tr>
<td>• ongoing gap in cultural capability of primary health care workforce to support people with mental health and AOD issues</td>
<td>The mental health nurse workforce is predicted to be in significant shortage by 2025, by nearly 8000 workers or nearly 36% of total projected demand.</td>
</tr>
<tr>
<td>• limited primary health care workforce capacity and training to appropriately screen, assess, support and refer people experiencing mental health and AOD issues.</td>
<td>There were 3,131 psychiatrists, 20,834 mental health nurses and 24,522 registered psychologists in Australia in 2015. About 88.1% of psychologist worked in the major cities, 5.6 in inner regional and remote area, 4.3% in outer regional and 2.1% in very remote areas. Similar observations were also noted for mental health nurses. The Full-time-equivalent (FTE) and clinical FTE per 100,000 population were lower in the remote and very remote areas across the nation (Australia Institute of Health and Welfare, 2017). Qualitative data from</td>
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</table>

Consultation feedback also identified the challenges of project based and short-term employment that was occurring due to funding

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### Outcome of the needs analysis

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>Key Issue</th>
<th>Description of Evidence</th>
</tr>
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<tbody>
<tr>
<td>Insufficient monitoring and evaluation systems and processes</td>
<td>At this stage there are insufficient systems and processes across the region to ensure that sufficient data is being collected and collated to measure impact of the service provision across the NQPHN footprint. Relationships, partnerships and collaborative arrangements are being established across the NQPHN region. As these further develop, systems will improve.</td>
<td>There is a need for NQPHN to capture data and information to further understand the responsiveness, effectiveness and overall performance of the mental health service system within its region.</td>
</tr>
<tr>
<td>The NQPHN mental health and suicide prevention service needs assessment 2016-17 identified lack of systematic coordination between primary health care services and related MH services in the region. There are difficulties in accessing AOD and MH services in the rural and remote communities especially in the Aboriginal and Torres Strait Islander communities. There is a need to enhance the capacity of MH health workers across the NQPHN. There are emerging MH service needs for specific groups within the region, (Aboriginal and Torres Strait Islander, young people, homeless people, LGBTI) and MH after hours services.</td>
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### SECTION 3 – OUTCOMES OF THE MENTAL HEALTH SERVICE NEEDS ANALYSIS

This section summarises the findings of the mental health service needs analysis in the table below.
# Outcomes of the service needs analysis

The current MH service needs outcome indicated that it aligns well with the National and the NQPHN mental health and suicide prevention strategic framework. The update in this section is very limited as it appears that the region is still faced with the identified service needs and where applicable additional data are incorporated.

## Planning and Coordination

| Stronger integration and coordination between services and sectors across the whole region | Fragmented service systems - weak links between hospitals, GPs, MH services, AOD services, and other related sectors (e.g. corrections, housing, social support, employment support) - resulting in poor coordination of care. Service planning and coordination needs to include the full range of support responses from self-help, prevention, early intervention to psycho-social support such as housing and employment to community mental health sectors services. While some of these responses may be out of scope for the NQPHN commissioning, these are an integral part of community supports and systemic advocacy. | Feedback from stakeholder/community consultations and online survey identified:  
- poor coordination of care noted as particularly concerning for those transitioning across the spectrum of treatment acuity, people with severe needs, the aged, people exiting prison or rehab, people with dual diagnoses, and people in rural areas  
- services operating in silos, resistance to shared clients, competitive tendering inhibits cooperation/collaboration  
- identified need for navigator and care coordinator roles; cross-sector training; networking opportunities; co-design of services (across services, sectors and consumers); well planned, culturally appropriate and integrated local service systems  
- highlights that integrated service models - through collaboration and coordination, and recognition that complex needs require services from multiple agencies - are key to improving outcomes  
- consistency in practices and approaches to MH is needed as a person receiving support from multiple services can sometimes find the conflicting information they are receiving very challenging.  
Analysis of local service planning reports and initial service mapping activities highlighted:  
- need for increased collaboration between support services in some areas of the region. This was particularly highlighted in the Torres Strait region  
- need for greater collaboration between state and federal governments in service planning  
  
  service mapping did not include details re existing coordination and collaborative mechanisms. |
### Outcomes of the service needs analysis

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Feedback from stakeholder/community consultations and online survey identified:</th>
</tr>
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</table>
| Lack of understanding of mental health service systems within local areas | • widely noted that not all GPs are adequately linking people in with appropriate community and/or mental health services. GPs, service providers, and community members reported as being unaware of what services are out there and appropriate referral options.  
• need for localised service mapping identified in many communities and better communication of services. |
| Referral and other system-wide administrative processes are complex and time-consuming – acting as barriers to access. | Feedback from stakeholder/community consultations and online survey identified:  
• the bureaucracy surrounding the Access to Allied Psychology Services limits access and flexibility.  
The current suicide assessment tool is culturally inappropriate, onerous, not useful or validated and doesn’t comply with accreditation requirements. |

### Service enhancements

| Increase availability of services for mild-moderate mental illness through Aboriginal community controlled and primary health care sectors with focus on social and emotional wellbeing and healing | Feedback from stakeholder/community consultations and online survey identified:  
• social and emotional wellbeing is a better way; mental health is seen as labelling. Social determinants and wellbeing models need to be addressed overall in programs  
• culturally inappropriate services - particularly noted several rural communities where choice of provider is limited.  
• need for: culturally grounded service frameworks (e.g. in Hopevale this was noted as basing services around place, person, passages, processes; men's/women's groups; social and emotional wellbeing, AMHFA; using music, performance and creative therapies; building on existing capacities; financial counselling (budgeting is a major issue and leads to conflict, stress).  
• in a survey of service providers in the NQPHN region, 76% of respondents identified Aboriginal and Torres Islander people as a group most in need of mental health services.  
Similarly, as noted earlier in the needs analysis outcome, SEWB for use by ASTI communities must address issues that are directly associated with indigenous health and wellbeing such as connectedness, loss, resilience, empowerment and control (Le Grande et al., 2017). |
<p>| Some existing services and programs within the NQPHN region are not culturally appropriate service models and reduce access and treatment outcomes for Aboriginal and Torres Strait Islander people. |  |</p>
<table>
<thead>
<tr>
<th>Outcomes of the service needs analysis</th>
<th>Analysis of local service planning reports and initial service mapping activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve accessibility into/within the mental health system</td>
<td>- Aboriginal and Torres Strait Islander people in FNQ should be engaged in meaningful and genuine dialogue with all levels of government about their needs, and empowered by government to solve their own problems, their way. Service delivery should be culturally appropriate ensuring Aboriginal and Torres Strait Islander people feel secure and welcome accessing mainstream services.</td>
</tr>
<tr>
<td></td>
<td>- strengthen pathways for individual and community healing.</td>
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<td></td>
<td>- culturally insensitive communication by some services creates tension. Some services lack understanding about Torres Strait cultural and healing practices. Need to re-instate cultural values and implement education promoting understanding of the spiritual and healing practices of the Torres Strait to strengthen the cultural competence of government and NGOs.</td>
</tr>
<tr>
<td></td>
<td>Specific details around cultural appropriateness was not explored in the initial service mapping apart from community feedback. More detailed and localised service mapping is required to identify cultural appropriateness and capacities of locally-based organisations.</td>
</tr>
<tr>
<td>Improve accessibility into/within the mental health system</td>
<td>Accessibility can be affected by remoteness, isolation, feelings of discrimination or stigma and lack of understanding from GPs and other services regarding the complexities of mental illness. Programs and services across the region are not always designed and implemented in ways that are engaging for young people or other hard to reach populations such as farmers and men.</td>
</tr>
<tr>
<td>Improve accessibility into/within the mental health system</td>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
</tr>
<tr>
<td></td>
<td>- stigma is a broadly noted issue across the region, particularly in smaller towns, and particularly for men, farmers, and older people. Stigma issue is furthered in rural areas by lack of continuity of GPs</td>
</tr>
<tr>
<td></td>
<td>- feedback from stakeholders indicated that there are limited GPs with an interest in mental health issues and in some cases they fail or are unaware how to link people into the mental health service system</td>
</tr>
<tr>
<td></td>
<td>- living in a rural or remote community provides limited choice of provider.</td>
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<tr>
<td></td>
<td>- accessibility is limited by the lack of culturally competent services – communities can distrust services and service provision. However, there are indications that responsibility for sustaining relationships does not rest solely with Aboriginal and Torres Strait Islander patients. Rather, healthcare providers need to commit to the process of building and maintaining relationships(Davy et al., 2016).</td>
</tr>
</tbody>
</table>
### Outcomes of the service needs analysis

<table>
<thead>
<tr>
<th>Analysis of local service planning reports and initial service mapping activities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• accessibility concerns regarding the digital gateway were consistently highlighted. Accessibility was noted to be limited for rural and remote, Aboriginal and Torres Strait Islander populations, social disadvantage, the aged, internet connectivity/costs, limited internet/computer literacy, unwillingness to use online services. Digital gateway needs to account for culturally/age appropriate content and useability; need for community champions to promote use and access; need for computer/internet literacy education; potential to situate points of digital access within existing public spaces (e.g. the library), and for up-skilling community members within those places (e.g. librarians, community legal centres, other community leaders) in MH literacy. However, digital gateway identified as a good way of engaging young people. In some rural areas though – high usage of telehealth</td>
</tr>
<tr>
<td>• reported lack of continuity for young people accessing help lines. Need to expand options re phone supports - i.e. has to be no cost to callers (including from mobiles), no call-backs (by then, moment has passed)</td>
</tr>
<tr>
<td>• need for technology in mental health services to increase service access and availability – yet support required for providers to utilise telehealth and online gateway</td>
</tr>
</tbody>
</table>

This was also noted in a recent qualitative study among stakeholders working in Indigenous communities in Northern Territory (a nearby PHN) that indicated e-mental health interventions could potentially be effective in supporting or extending existing mental health services (Puszka et al., 2016). Recent Clinical Council consultations also expressed similar view as stated by one of the members: ‘e-mental health has a growing body of evidence for its use, inexpensive and under utilised’.
### Outcomes of the service needs analysis

| Outcomes of the service needs analysis | Limited availability and accessibility of affordable mental health services in rural and remote areas. Access to mental health nurses in general practices in the region were limited and community feedback indicated that this was a great need in the rural areas. Additionally, an increase in the number of bulk billing practices is required. | Feedback from stakeholder/community consultations and online survey identified:  
- respondents to the online survey identified people in rural and remote areas as the group most in need of mental health services  
- barriers to access include: limited availability of bulk-billing GPs, limited and inconsistent availability of mental health and support services, long wait times, transport, small-town stigma, Queensland Health services at capacity, resources wasted on travel, lack of culturally appropriate services (particularly highlighted in Ingham), inability to claim MBS for MH and allied health practitioners providing telehealth  
- difficult to attract and retain staff (psychologists, GPs, youth workers etc.). Expensive to get practitioners to outreach  
- target groups noted as youth, children with parents with MH issues, veterans and older people  
- rural mental health services are not equipped to provide appropriate care for consumers experiencing psychotic episodes and so they are often transported out of their community and estranged from family supports  
- peer support is needed; need for more group work.  
Feedback from peak state-wide agencies, local experts and NQPHN Clinical Councils identified:  
- number of sessions available through ATAPS is not always sufficient for complexity of some mental health issues e.g. trauma related or personality disorders.  
Analysis of local service planning reports and initial service mapping activities indicated that there are very limited to no private psychologists in the lesser populated towns and more remote areas, and the regularity of primary mental health and QH mental health outreach visits to rural, remote and remote Indigenous areas is unknown as feedback indicated that scheduled visits did not always occur due a range of reasons. | Limited early intervention and prevention services across the region. | Feedback from stakeholder/community consultations and online survey identified:  
- respondents to the online survey identified early intervention as the services that are most required to meet the needs of people who are missing out on services |

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**Department of Health PRIMARY HEALTH NETWORKS Needs Assessment reporting template**  
*Update November 2017*  
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### Outcomes of the service needs analysis

| Increased access to the range of mental health and wellbeing services for Torres Strait Islander people. | • inadequate resources for early intervention. Social services are increasingly required to provide MH support in rural areas - absence of specialised MH services  
• need to refocus resources on early intervention (EI). Need EI services for children in out-of-home care (do not meet criteria for CYMHS), families, children and young people and programs supporting culturally strong parenting. Need for expanding school-based mental health literacy and early intervention and prevention  
• MHFA needs investment on a broader scale so that it is accessible to families  
• early intervention support for children and young people and their families on each island in the Torres Strait is limited – resources limit the ability to provide equity of services to all islands.  
Analysis of local service planning reports and initial service mapping activities:  
• need for early intervention services noted in Townsville  
The service mapping indicates very limited early intervention services across the region. However, more detailed and localised service mapping is required to better understand the localised service systems and individual service capacity. |
| Within the Torres Strait there are very limited mental health and wellbeing services, particularly on the outer islands. | Feedback from stakeholder/community consultations and online survey identified:  
• lack of services to support people living in the Torres Strait with mental health needs; limited services to the outer islands  
• some telephone counselling and support works well for outer islands.  
Analysis of local service planning reports and initial service mapping activities indicated:  
• limited understanding of approaches to promote mental health and wellbeing by some service providers  
• men have little opportunity for healing. There is a need for healing programs/services for young people (aged 13–26) who have experienced violence, abuse and are dealing with trauma  
• support the development of community-led healing teams. Support healing teams to co-design methodologies with community members to ensure healing processes fit community needs and address wellbeing needs. Build local capacity to respond to trauma. |
### Outcomes of the service needs analysis

<table>
<thead>
<tr>
<th>Increased services for mild-moderate mental illness</th>
<th>The service mapping indicates that there is very limited Queensland Health mental health and wellbeing services supporting the remote islands. There are very limited counselling and other support services within the Torres Strait region. There is a community controlled health service in the Northern Peninsula region, but none on Thursday Island or outer islands.</th>
</tr>
</thead>
</table>
| There is limited access to services for mild to moderate mental illness across the region, particularly for rural and remote communities. The existing ATAPS service model does not enable access in rural, remote and remote Indigenous communities. The biggest barriers are travel costs and the lack of providers willing to provide the services. | Feedback from stakeholder/community consultations and online survey identified:  
• it is a widely noted issue that there are gaps in services addressing mild-moderate needs for youth and adults (including for older people) and this can be a particular issue within rural/remote/remote Indigenous areas. Mild conditions are not getting the adequate attention/treatment in a timely manner that would likely prevent escalation  
• the mental health needs of the CALD population also need to be addressed – this was a particular concern within the Townsville HHS  
• there is no systematic support for non-crisis mental health needs in remote Indigenous communities. Non-crisis MH needs can be hidden within families until acute episodes occur.  
Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:  
• the lack of access to available services within the region for individuals with eating disorders. The lack of services makes it very difficult to access the level of care required to prevent hospital admissions.  
Analysis of local service planning reports and initial service mapping activities:  
• there are limited numbers of psychologists in rural/remote areas. There are some NGOs providing counselling services in the more populated rural areas, but no such services are apparent in the more remote and lesser populated areas. |
| Ensure effective carer supports are in place | Across the region the support services for carers varied depending on the NGO services available. | Feedback from stakeholder/community consultations and online survey identified:  
• need for primary health care organisations to better understand the supports required for carers  
• limited carer supports – particularly noted in rural areas and across Cape York and Torres Strait. |
## Outcomes of the service needs analysis

| Suicide prevention programs and develop suicide prevention response protocols in rural areas | Lack of suicide prevention programs and services across the region. | Feedback from stakeholder/community consultations and online survey identified:  
- many respondents from the online survey identified that current models of suicide prevention in their area are limited in their effectiveness. This is due to suicide prevention models being culturally ineffective, a lack of services, lack of sector coordination, lack of awareness of evidence based interventions, difficulty accessing services, and the need to develop greater capacity within services  
- there is an identified need for programs that address stigma, target those most at risk and for holistic programs of early intervention and prevention (including within schools), appropriate intervention and postvention  
- The large Aboriginal and Torres Strait Islander populations have specific suicide prevention needs. Youth, the elderly and drought affected farming communities are also at risk groups  
- there are sometimes delays between seeing a GP and the psychologist receiving the referral  
- lack of knowledge regarding developing suicide prevention plans  
- suicide prevention needs a regional approach. There is a need for good community protocols around suicide within Aboriginal and Torres Strait Islander communities as well as the need for hospital and PC staff training in suicide risk assessment and screening for social and emotional wellbeing issues and culturally appropriate responses.  
Analysis of local service planning reports and initial service mapping activities: very limited suicide prevention activities – especially in rural/remote areas |
| Stronger support with transitions from prison/rehab back into communities | There are no systematic linkages to primary care or other services for prisoners or those exiting rehab returning to communities. | Feedback from stakeholder/community consultations and online survey identified:  
- problems widely noted across the whole region with people returning from custody to the community or to rehab facilities. Within the region there are very limited specific programs to address this issue, particularly in the adult population  
- stakeholder feedback also identified the lack of diversionary programs for young people as an alternative to detention |
### Outcomes of the service needs analysis

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems widely noted with people being released from planning with</td>
<td>• problems widely noted with people being released from planning with no discharge planning and no linkages to primary care or any support for ongoing mental health issues. There are limited specific programs to address this issue. Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:</td>
</tr>
<tr>
<td>no discharge planning and no linkages to primary care or any support</td>
<td>• QAIHC identified this as a significant service gap.</td>
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<td>for ongoing mental health issues.</td>
<td>• NQPHN Clinical Council also expressed the need for evidence based programs for transition prisoners to prevent relapse.</td>
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<td></td>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
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<td></td>
<td>• current headspace funding does not include provision for family support; Better Access does not always accommodate family therapy</td>
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<td></td>
<td>• high rates of children in out of home care and there is lack of support for postnatal and perinatal mental health</td>
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<td></td>
<td>• There is a need for parenting programs, family support, family therapy, and early childhood services (Torres Strait) as well as funding models that are inclusive of families, focus on social and emotional wellbeing versus clinical language and services addressing family violence (Cape York and Torres Strait).</td>
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<tr>
<td></td>
<td>Increase in flexible programs that work with families and address the mental health and support needs of families.</td>
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<tr>
<td></td>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
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<tr>
<td></td>
<td>• address mental health stigma and improve mental health literacy</td>
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<td></td>
<td>• need to refocus resources on mental health promotion and early intervention; need investment in community development and community hubs to prevent social isolation and MH issues and as soft entry point to the MH system</td>
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<td></td>
<td>• lack of community education around MH and wellbeing for communities</td>
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<td>• education information needs to be culturally accessible and appropriate.</td>
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<td></td>
<td>• Clinical Council highlighted the need for mental health promotion targeting school pupils.</td>
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<td></td>
<td>Increase the capacity of GPs to identify and support people with mental health issues, as it is the closest and easiest form of care</td>
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<td></td>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
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### Workforce

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
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<tbody>
<tr>
<td></td>
<td>Increase the capacity of GPs to identify and support people with mental health issues, as it is the closest and easiest form of care</td>
</tr>
<tr>
<td></td>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
</tr>
</tbody>
</table>
### Outcomes of the service needs analysis

<table>
<thead>
<tr>
<th>Develop and support the primary health care mental health workforce</th>
<th>Potential future shortfalls in mental health nurses, psychiatrists, key allied health professionals and need for task shifting and</th>
<th>Feedback from stakeholder/community consultations and online survey identified the following training priorities:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>available, located near to peoples’ homes and communities. Therefore, GPs need to be supported to have the necessary skills to identify and support people with mental health issues. There are less GPs per capita in Cairns, Mackay and Cape/Torres HHS region. GP shortfalls can have impacts on capacity of GPs to adequately identify and coordinate care for individuals with mental health issues.</td>
<td>the training and support needs to be increased to GPs particularly around mental health screening and assessment, understanding of referral options/pathways; program guidelines such as ATAPs and MH care plans</td>
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<tr>
<td></td>
<td></td>
<td>need for MHNIPs in more GP practices across the region</td>
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<td></td>
<td>need for upskilling GPs in suicide risk assessment and developing a collaborative management plan.</td>
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<td></td>
<td>Training priorities identified from consultations and online survey included:</td>
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<tr>
<td></td>
<td></td>
<td>• advanced training in suicide prevention</td>
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<tr>
<td></td>
<td></td>
<td>• advanced mental health care plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• understanding ATAPS guidelines; MHNIP</td>
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<td></td>
<td></td>
<td>• managing mental and physical health comorbidity, particularly for aging population.</td>
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<td></td>
<td>Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified that the key reasons for ensuring GPs have capacity to identify and support people with mental health issues include:</td>
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<tr>
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<td>• ensures that the population as a whole has access to the mental healthcare that they need early in the course of disorders and without disruption</td>
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<tr>
<td></td>
<td></td>
<td>• when people receive treatment in GP practices the likelihood of better health outcomes, and even full recovery, as well as maintained social integration, is increased.</td>
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<tr>
<td></td>
<td></td>
<td>Analysis of local service planning reports and initial service mapping activities: Cairns, Mackay and Cape/Torres HHS have lower than Queensland average for GPS per 100,000 (especially Cape/Torres). The AIHW mental health workforce report also revealed the need for more mental health workers in the remote and very remote areas across Australia (Australia Institute of Health and Welfare, 2017).</td>
</tr>
</tbody>
</table>

### Outcomes of the service needs analysis

<table>
<thead>
<tr>
<th>Increase the capacity of the primary healthcare workforce (and other workers in education, emergency and welfare sector) to support people with mental health issues</th>
<th>Many primary health care workers (and workers in education and welfare) are frontline staff who come in contact with people experiencing mental health issues but they have limited skills/training to screen, assess, provide brief interventions and appropriately refer. Upskilling primary health care, education and welfare workers in mental health is key to addressing issues of undersupply of mental health professionals.</th>
</tr>
</thead>
<tbody>
<tr>
<td>building a local workforce due to the ageing workforce and low proportion of mental health professionals working in rural and remote areas.</td>
<td>• screening and assessment, substance use and dual diagnosis, trauma therapy, suicide prevention and better understanding, utilising Aboriginal and Torres Strait Islander MH workers, utilising peer workers/consumer focused care, how to work in a recovery oriented framework, culturally appropriate techniques/resources and approaches, supporting individuals with complex mental health needs.</td>
</tr>
<tr>
<td>Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:</td>
<td>• national and state data indicating shortfalls in mental health nurses; psychiatrists and Aboriginal and Torres Strait Islander mental health workers.</td>
</tr>
<tr>
<td>Analysis of local service planning reports and initial service mapping activities:</td>
<td>• attraction and retention of mental health professionals to Mackay and other regional areas is a key issue and impacts on continuity of services.</td>
</tr>
<tr>
<td></td>
<td>• very limited investment in peer support activities across the region.</td>
</tr>
<tr>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
<td>• the need to build capacity of primary health care workers to support people with mental health issues.</td>
</tr>
<tr>
<td></td>
<td>• need to support initiatives that enhance access to appropriate vocational education and training and higher education programs for Aboriginal and Torres Strait Islander people that are supported by block release times and backfilling for education and training purposes</td>
</tr>
<tr>
<td></td>
<td>• need to provide training in screening and assessment, brief intervention</td>
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<tr>
<td></td>
<td>• cert IV in Mental Health to be available for all staff.</td>
</tr>
<tr>
<td>Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:</td>
<td>• the need for the ‘mental health workforce to be redefined and expanded to include not only medical and health professionals but also workers in the</td>
</tr>
</tbody>
</table>

35 Mackay Regional Mental Health Network, Identified Gaps in Services across the Mackay Region
### Outcomes of the service needs analysis

| Sustainable primary mental health care workforce that can meet growing demand with an increase supply and utilisation of Aboriginal and Torres Strait Islander primary health care workers | Difficulties with retention of staff – which impacts on continuity of care and provision of services was identified as a key service issue. These is a need for strategies to retain workers in primary mental health care workforce including:  
- systems to provide adequate supervision and support; including policy and procedure for staff to access debriefing, counselling and employee assistance programs  
- systems to ensure adequate continuing professional development  
- organisation has structures, policies, and programs that move the workforce along the continuum from Aboriginal and Torres Strait Islander cultural awareness, to cultural sensitivity, ultimately to cultural safety  
- heavy work demands and a lack of clearly defined roles and boundaries reflecting high community need and a shortfall of  
| Feedback from stakeholder/community consultations and online survey identified:  
- high staff turnover; staff feeling overwhelmed with lack of skills and training in mental health; need for more formalised structures for professional development and supervision  
- primary health care workers report higher caseloads of people who have mental health issues in recent years  
- need to support training and development that enhances the capacity of Aboriginal and Torres Strait Islander primary health care workers to provide screening, assessment, brief intervention and referral services for Indigenous clients.  
Feedback from peak statewide agencies, local experts and NQPHN Clinical Councils identified:  
- the Indigenous Doctors Association report that the causes of staff turn over from Aboriginal and Torres Strait Islander staff are due to feelings of isolation, high workloads and lack of cultural capability  
- the need to ensure primary health care workers are supported by mental health specialist was identified by Human Capital Alliance in their report to the National Mental Health Commission.  
- The need for training for ATSI people to be extended beyond Certificate level to include diploma and higher tertiary education. |

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36 Fact Sheet 12 – What this means for workforce and research capacity  
37 Indigenous Doctors Association, 2013  
### Outcomes of the service needs analysis

<table>
<thead>
<tr>
<th>Needs Assessment</th>
<th>Description</th>
<th>Feedback from stakeholder/community consultations and online survey identified:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support and expand appropriate services for Aboriginal and Torres Strait Islander people</td>
<td>There is a need to improve access for Aboriginal and Torres Strait Islander people experiencing mental health issues by supporting and expanding services for Aboriginal and Torres Strait Islander people. Within this, there is a need to build capacity and capability of the mental health service system, particularly Aboriginal and Torres Strait Islander community-controlled services and its workforce. Integral to building the supply of an Aboriginal and Torres Strait Islander AOD workforce is the need to ensure staff are suitably trained and supported. Furthermore, in order to improve access to mental health services for Aboriginal and Torres Strait Islander people there is a need for organisations to have structures, policies, and programs that move the workforce along the continuum from Aboriginal and Torres Strait Islander cultural awareness, to cultural sensitivity, ultimately to cultural safety.</td>
<td>- a need for more Aboriginal and Torres Strait Islander workers in mental health, especially in Aboriginal community controlled health services within the region. - there is need for strategies that grow a local Aboriginal and Torres Strait Islander mental health workforce, as currently there is a labour skills shortage - need to move the workforce along the continuum from Aboriginal and Torres Strait Islander cultural awareness, to cultural sensitivity, ultimately to cultural safety - the need for more Aboriginal and Torres Strait Islander primary health care staff with mental health skills to improve access for Aboriginal and Torres Strait Islander people. Very limited specified positions for Aboriginal and Torres Strait Islander people locally. Indigenous staff employed can feel isolated and experience burn out due to high workloads. It was suggested that more Aboriginal and Torres Strait Islander staff would support more culturally appropriate responses and approaches to mental health treatment - consistent need for primary health care and mental health workers to better understand the significant contribution an Aboriginal and Torres Strait Islander primary health care worker can make to supporting people with mental health issues - need to ensure formalised training and career pathways for Aboriginal and Torres Strait Islander people.</td>
</tr>
<tr>
<td>Need for primary health care organisations to develop/implement structures,</td>
<td>Many mainstream primary health care organisations need to strengthen the cultural</td>
<td>Feedback from stakeholder/community consultations and online survey identified:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- need for more Aboriginal and Torres Strait Islander workers in mental health</td>
</tr>
</tbody>
</table>

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**Outcomes of the service needs analysis**

| Policies and programs that build cultural capability of workforce | Competence of their mental health and social and emotional wellbeing services. | Need to move the workforce along the continuum from Aboriginal and Torres Strait Islander cultural awareness, to cultural sensitivity, ultimately to cultural safety. |

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**SECTION 4 – OPPORTUNITIES, PRIORITIES AND OPTIONS**

This section summarises the priorities arising from the Needs Assessment and options for how they will be addressed.

<table>
<thead>
<tr>
<th>Priority Issue</th>
<th>Actions</th>
<th>Who (lead)</th>
<th>Expected outcome (performance indicator)</th>
</tr>
</thead>
</table>
| Cairns                                                                        | • Provide transport options for people from rural and remote populations to access low intensity services. Fuel subsidy? Promotion of digital/video?  
• Improve coordination of services – continues to be a barrier  
• Provide outreach services  
• Although some populations will engage in digital gateway (online/phone) such as youth, other groups will prefer face-to-face contact (at least initially). | • GP’s, Schools, local health clinics, Dept. of Agriculture (Agforce) Local council, Community controlled agencies, Neighbourhood Centre and NGO’s, wellness hubs, headspace Outreach, RFDS inreach, rural/remote visiting services.  
• Coordination group with a focus on building relationships, consisting , of 6 representatives: Qld Health, GP, Private Psychologist, Indigenous services, | • Develop and implement programs to support natural supporters.  
• Identify and design better services/models  
• Design early intervention approaches  
• Enhanced awareness  
• Able to access treatment easily |

**Priority Groups:** Single mothers; CALD, youth; disability

**Priority Regions of Need:** Georgetown/Croydon/Forsyth/Einasleigh; Dimbulah/Chillagoe; Gordonvale/Edmonton; Yarrabah; Tully/Cardwell/Mission Beach/Babinda; Kuranda; Mossman and north; Ravenshoe.
Feedback is that people are seeking a relationship that is face-to-face. NB. Indigenous Young do not use digital technology to access health inform/seek help.

**Build strengths**
- Training of community members – what to look for, how to support, referral to hubs and better trained community members, teachers/artists. Youth workers, peer support, coaches.

<table>
<thead>
<tr>
<th>Equitable access for individuals with psychological distress (mild-moderate illness)</th>
<th>Social determinants of health addressed as first priority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority Groups:</strong> People with mild to moderate emotional distress</td>
<td>Develop culturally appropriate care co-ordination for ATAPS similar to “Closing the Gap”</td>
</tr>
<tr>
<td><strong>Priority regions of need:</strong> Cardwell/Croydon/Cairns/Torres Strait</td>
<td>Build capacity of local leaders/communities/individuals</td>
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<td>Workforce development</td>
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<td></td>
<td>Community profile/map of resources/pathways</td>
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<td></td>
<td>Identify models of self-determination for individuals and communities</td>
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<tr>
<td></td>
<td>Establishment of connecting hubs and local connectors – these provide linkages and referrals hubs and also act as relationship builders in communities – teach, educate and share information</td>
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<td></td>
<td>Reciprocal working relationship agreements - MOU’s, service</td>
</tr>
</tbody>
</table>

<p>| Equitable delivery of psychological services through various means – i.e. digital, face-to-face leasing to digital, culturally appropriate, training/info delivered to local volunteers/community members, (e.g. Mental Health First Aid). |
| Individuals |
| Communities of interest |
| NGO’s and community groups |
| Schools/P &amp; C’s/ sports groups |
| Skilled helpers – psychologists, nurses, social workers, occupational therapists |
| Community connectors (new) |
| Digital resources. |</p>
<table>
<thead>
<tr>
<th>Priority areas of need</th>
<th>Build strengths</th>
<th>Build strengths</th>
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<tbody>
<tr>
<td>Hubs in Cairns Tablelands Innisfail</td>
<td>• Equitable access for Aboriginal and Torres Straits Islander people to low intensity services</td>
<td>• Training: Building capacity at the local level – hub and spoke.</td>
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<td>• Build strengths</td>
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<td>• Within 6/12 months have:</td>
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<td>- identification of models that are working</td>
<td>- identification of models that are working</td>
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<td>- Write up the successes</td>
<td>- Write up the successes</td>
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<td>- Enhance the programs</td>
<td>- Enhance the programs</td>
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<td>- wider consultation throughout the services</td>
<td>- wider consultation throughout the services</td>
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<td>- identify the lead agency.</td>
<td>- identify the lead agency.</td>
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<td>• Men’s Groups</td>
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<td>• Women’s Groups</td>
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<td>• SEWB</td>
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<td>• AMS</td>
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<td>• Youth Services.</td>
<td>• Youth Services.</td>
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<td>• Developed Robust Structure; Hub and Spoke</td>
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<td>• Implement Prevention, Promotion and Early Intervention Programs</td>
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<td></td>
<td>• Deliver Digital services including Videoconferencing, mobile phone, HITNET, electronic MH practice.</td>
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</tr>
</tbody>
</table>
Effective suicide prevention programs using a regional approach, in particular for rural and remote areas

**Priority Groups (identified risk)**
- Men
- Aboriginal and Torres Strait Islanders
- Youth
- Elderly
- People experiencing mental health issues
- Defence Forces personnel.

**Build strengths**
- Programs in Primary Schools - i.e. emotion awareness, self-esteem, self-awareness
- COPMI
- P and C’s
- GP’s and emergency departments
- Healthy Mind/Body programs
- Friend and Family Alerts - develop skills in what to say/ask
- Widen ATAPS suicide prevention program.

**Townsville**

Increase the access and availability of Mental Health services for children, young people and their families.

Need for child (0-12 yrs of age) counsellors, eating disorder services and Family Early Intervention

**Service models**
- Flexible hours
- Additional youth workers
- Age appropriate, early intervention and early/timely access to services
- Linkages with PCYC/sports/arts/child safety etc.

**Resources**
- Health and Wellbeing at school engagement activities (i.e. physical activity, diet, life skills)
- Early intervention (e.g. engagement of people with lived experience in safe environments for children)
- Positive parenting

- GP’s/ Paediatricians
- Specialist child counsellors
- Parents
- PHC Teams
- Social services
- ACCHO’s
- Child safety
- Education Qld in all schools – government and non-government

- Develop funding models
- Improved referral pathways
- Improved practice models
- Service mapping of available practitioners

- Prevention of people using suicide as a maladaptive coping strategy.
<table>
<thead>
<tr>
<th>Increase service capacity to provide MH health promotion and early intervention programs (next 20 years plus)</th>
<th>Suicide Prevention</th>
</tr>
</thead>
</table>
| • Upskilling and education of GPs  
• Case managers  
• Broadening referral pathways  
• Increase PHC capacity e.g. child, youth and family health  
• Educational/Health and wellbeing  
• Capacity building and development for all schools  
• Service delivery and place of requirement | • Capacity development  
• Community MH sector  
• Community engagement strategies  
• Engagement and support for first responders  
• Early intervention  
• MHFA  
• Recognition – early warning signs | • Community MH  
• NGO’s  
• Wider community  
• PH sector  
• Shire Councils  
• Community  
• Workplaces  
• Employers  
• Peers  
• Family  
• Support Networks  
• Schools  
• GPs | • Improved support and supervision  
• Better sustainable models  
• Improved early intervention  
• Enhanced awareness  
• Well Trained community  
• Increased pre and post QoL scores  
• Improved psychosocial/emotional assessment/treatment tools (K10, DASS)  
• Increased attendance rates at wellness groups and completion rates  
• Less acute/ED presentations  
• More self-referrals for support following completion of an early intervention program (i.e. wellness program). |

**What:**  
Developing early intervention programs – education/psychoeducation and awareness (re: triggers, self-care management)  
What would this look like/where would it sit? – Community organisations (hub, communication centres)  
Rural and remote – capacity for outreach/extend metropolitan programs  
Telehealth Intervention – early intervention – Social workers,
psychs (psychosocial support), collaborative intervention/program – services, disciplines, skills sets etc.
- Train the trainer (educations/referring to community based programs run by mentors (i.e. men’s sheds/women’s groups)
- Upskilling staff in general re: mental Health – what language are we using to promote mental health – stigma/shame.

**How:**
- Developing networks between sectors/organisations – facilitators/trainers to provide education/information to community-based support groups
- Regular health check screening (GPs) and
- GP education (re: questions ‘how’s everything going?’ encouraging a holistic approach to health)
- workforce wellness programs offered (reframing language).

| Equitable access for individuals with psychological distress (mild-moderate illness) | **Improve service delivery –**
| --- | --- |
| - Client perspective: do people recognise they may require assistance/help – awareness/health promotion activities.  
- SP Perspective: Do providers/GPs/organisations | - PHN (drive this process, develop robust stepped care model)  
- GPs  
- Community |

|  | Reduced wait times  
- Develop easier referral system  
- Increased participation rates in Surveys – individuals, service providers  
- Increased use of technology (hits on websites) |
| Improve Access to perinatal and infant mental health in primary health care | **What:**  
- Increased coordination of services — ease of access is central driver  
- Preparing for parenthood — community-wide not person centred (especially for people who have not been parented themselves)  
- Greater recognition and screening of mental health at all contact points (pre and post-delivery i.e. child health nurse, GP, Obstetrician/gynaecologist, midwife).  
- Consumer inputs — young new mums, dads.  
- Leverage from mother’s groups for service pathways.  
- Increased workforce skills — recognised skillset, currency of practice. | **Practice Nurses**  
- Child Health Nurses and midwives.  
- PHNs to advocate with local council. | **Mums at child milestone checks increased.**  
- Develop tools to assess possible mental health issues at pre-and post-delivery |
- Service Coordination positions working across sectors (especially for those not accessing GP).
- Focussed Education and support for practice nurses, community health nurses, midwives, GPs, Obstetricians/gynaecologists.
- Facilitation and support for peer support groups driven by community and councils – community development.

### Mackay

**Equitable access to treatment and support services for individuals with severe illness and complex needs**

*These people need to be seeing someone monthly or fortnightly – they need ongoing care for their lives. Need a longer treatment model – doesn’t work with a 12 session treatment limit. Need to keep people well.*

- Long term evidence based counselling sessions that traditionally private psychologists provide
- Establish model in Mackay
- Community of practice.

- HHS
- Headspace
- NAPHL

**People living with mental illness are happy with the support, care and treatment.**

**Equitable access for individuals with psychological distress (mild-moderate illness)**

*Issues with timeliness of responses with service access where the person is.*

- Mental Health First Aid training for Reception Staff, School Nurses and interested community members
- Service provision criteria must allow for a mental health assessment e.g. MH Nurse
- Develop a MHNIP model of service with integration into GP clinics,

- Reduced wait times
- Develop easier referral system
- Increased participation rates in Surveys – individuals, service providers
- Increased use of technology (hits on websites)
| Ensure effective family/carer supports are in place | • Need to recognize the importance of families and friends and include them in information sharing and decision making in relation to support  
• Need to support GP’s, AHP’s etc. to identify family context and this | • Community Mental Health Sector in partnership with:  
• QH Acute services  
• Community Mental Health Teams  
• E.D.  
• GP’s  
• Primary Health Care MHP’s  
• Family members with (caring) lived experience | • Hospital Admission Reduction  
• Improved Family Wellbeing  
• Discharge Planning (Audits)  
• Service Mapping e.g. location and face to face support availability |
| --- | --- | --- | --- |
|  | increased capacity/numbers and effective service.  
• Care Planning in collaboration with a GP rather than sign off, bulk billing psychological services for ongoing management and increased sessions.  
• Focus on increasing the capacity of MHNIP services with an education pathway, increased autonomy (not needing to be connected to a GP) and credentialing outside of QH resolved.  
• Allow the Care Plans to prescribe therapy based on need (not what is allowed). Care Planning also needs to have Outcome measures and for them to be meaningful e.g. patient experience, DASS or other measure, return to increased functioning/discharge |  |  |
<table>
<thead>
<tr>
<th>Support networks needs and respond</th>
<th>Also need links with First Responders such as QPS and QAS, Generic service providers such as Centrelink, Housing and Employment Support Services and with key schools stakeholders such as the SBYHN’s.</th>
<th>Improved workforce Capacity e.g. targeted counselling and advocacy skills</th>
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<tbody>
<tr>
<td>• Important to build the local community capacity to support family members through education, advocacy, psycho-social support and stigma reduction. This initiative requires appropriately trained MHP’s, materials/tools/programs such as education packages, community awareness strategy to address stigma and service access and continuity of care related communication e.g. discharge planning protocol</td>
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**Effective suicide prevention programs using a regional approach, in particular for rural and remote areas**

Note: Suicide Prevention Community Action plans are established and implemented in all 4 HH&S areas

| Increases level of awareness of available options for services | Increased level of awareness of available options for services |

**Equitable access for Aboriginal and Torres Strait Islander people to low intensity services**

| Increased uptake of services | Increased uptake of services |

| A Workforce Strategy is needed to ensure there are appropriately qualified workers, develop pathways e.g. Cert 4 Mental Health connection to clinical qualifications, develop careers, target employment, develop traineeships for school leavers and provide education e.g. counsellors in schools | Local NGO’s with support from: Queensland Health, National AMS and Education networks. |
| | More qualified psychologists, social workers, nurses, mental health workers and SEWB workers on the ground. |
- Need to support behavioural change for youth, ensure identified positions, support willingness to change, utilize DATSIP and Employment agencies
- Use a Brokerage Model e.g. for Psychological services

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<th>Torres and Cape</th>
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| Stronger integration and coordination between services and sectors across the whole region | Develop systematic referral pathways, care co-ordination, case management, clinical data sharing and evaluation across services in the region. This include:
  - Integration of first responders to psychosis or other acute presentation in the community, e.g. co-responder model learnings
  - Coordination of support for people returning to community from custody, e.g. Lotus Glen
  - Coordination of suicide prevention, intervention and post-vention responses, e.g. post-vention protocol | NQPHN in conjunction with peak bodies, GPS, ACCHOs and A&TSI health authorities. | • Improved collaboration between mental health service providers |
<p>| Develop culturally grounded mental health service frameworks – e.g. the Hope Vale framework can be used as a guide. | NQPHN in conjunction with peak bodies, GPS, ACCHOs and A&amp;TSI health authorities. | • Implementation and evaluation of culturally grounded mental health framework in the region |
| Early intervention and prevention services for individuals and families at risk | Design and implement culturally appropriate mental health promotion | NQPHN in conjunction with peak bodies, GPS, ACCHOs and A&amp;TSI health authorities. | • Increased knowledge and level of awareness about mental health |</p>
<table>
<thead>
<tr>
<th>Increased access to the range of mental health and wellbeing services for Torres Strait Islander people</th>
<th>Work with key stakeholders in the region to develop capacity of A&amp;TSI service providers focusing on community development rather than service delivery to deal with mental health issues.</th>
<th>NQPHN in conjunction with peak bodies, GPS, ACCHOs and A&amp;TSI health authorities.</th>
<th>• Improved workforce capacity for A&amp;TSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased services for mild to moderate mental illness</td>
<td>Support service providers to develop therapeutic counselling options that are culturally appropriate to the region</td>
<td>PHC providers in the regions/</td>
<td>• Improved workforce capacity for A&amp;TSI</td>
</tr>
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<td></td>
<td>Support PHC and NGOs to embed SEWB concepts into therapeutic programs in the region</td>
<td>NQPHN/A&amp;TSI health authorities/other NGOs</td>
<td>• A&amp;TSI health workers/service providers are competent in providing culturally appropriate mental health and wellbeing services.</td>
</tr>
</tbody>
</table>

and literacy through the delivery of Mental Health First Aid

• Confident in performing basic first aid skills in managing mental health issues in the community

• Improved skills and workforce capacity of service providers to support people in the region
<table>
<thead>
<tr>
<th>Increase mental health support for children and young people</th>
<th><strong>Build on the learnings from existing Cairns Co-responders model to explore options to expand co-responder model in after hours services in the region</strong></th>
<th><strong>Develop and implement culturally appropriate after-hours service</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Explore models for delivering recovery orientated, early intervention services for A&amp;TSI children and young people experiencing a first episode of psychosis or at high risk of experiencing psychosis.</td>
<td>Headspace or other youth agencies with capacity.</td>
<td><strong>Develop and implement culturally appropriate mental health early intervention services for children and young people in the region</strong></td>
</tr>
</tbody>
</table>
| | • Work with A&TSI council to design and implement culturally appropriate community based interventions for young people | **A&TSI health authorities**
**Youth agencies**
**NGOs** | **Develop and implement culturally appropriate community based interventions for young people.** |
SECTION 5 – REFERENCE


The State of Queensland (Queensland Health). (2016). *Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016–2021*. Retrieved from Brisbane: