National Psychosocial Support Measure

Needs assessment and service model options

December 2018
Acknowledgements
Northern Queensland Primary Health Network (NQPHN) engaged Freestone Associates in November 2018 to complete this needs assessment. Members of the Freestone Associates team include Louise Livingstone, Sandi Taylor, and Pamela Edwards.

NQPHN and Freestone Associates would like to thank all the people and organisations who generously gave their time to inform and guide this needs assessment and service model options. The team would particularly like to thank and acknowledge the work and commitment of individuals with lived experience and their carers who gave up their time to participate in these consultations.

Northern Queensland Primary Health Network acknowledges the Traditional Custodians of the lands and seas on which we live and work, and pay our respects to Elders past and present.
National Psychosocial Support measure

In the 2018–19 federal budget an allocation of $80 million nationally over four years was announced to support the National Psychosocial Support (NPS) measure for individuals experiencing mental health issues who will be ineligible for support through the National Disability Insurance Scheme (NDIS).

The NPS measure is not intended for individuals who need long-term, ongoing psychosocial support, but those who would still benefit from a level of specialised, less intensive psychosocial supports linked to their goals and delivered at a time of need. It is for individuals that have a severe episodic mental illness and a resulting level of reduced psychosocial functional capacity and due to the episodic nature of their illness, would benefit from some short-term, targeted psychosocial support at points of time.

Executive summary

Queensland Health has recently commenced a commissioning process for their psychosocial services within the region and the successful service providers will be notified early in 2019. Northern Queensland Primary Health Network (NQPHN) commissioned services will need to be implemented in a flexible way to complement and/or enhance the Queensland Health funded psychosocial support services. For the NQPHN commissioned services the majority of the target group will receive their clinical care in the primary mental health sector through GPs, private psychiatrists, private psychologists, and practice mental health nurses.

Needs assessment for NQPHN’s region

In November 2018, NQPHN engaged Freestone Associates to facilitate a needs assessment around individuals’ psychosocial needs and scope service model options with a range of consumers, carers, and service providers across the region to assist NQPHN in designing a model of service that meets local needs to be commissioned to support the NPS measure in northern Queensland.
Summary of key findings
of needs assessment

Finding 1
The importance of family and belonging, combined with the unique types of support that families provide emerged strongly from the needs assessment. Additional support provided to the family is very important as family members usually provide support at different times and in varying situations.

Finding 2
It is important to ensure as many community members as possible develop a sound and respectful understanding of social and emotional wellbeing (SEWB)/mental health and its impacts on individuals and families, including the debilitating effects of stigma, shame, and alienation that individuals endure when there is limited compassion and understanding. The stigma experienced by Aboriginal and Torres Strait Islander peoples in small communities is traumatic and contributes to their psychological distress which directly impacts on their mental, spiritual, emotional, and physical wellbeing.

Finding 3
Focused community development and activities that increase inclusiveness of individuals with lived experience in regular community events would be very beneficial to their psychosocial supports and would reaffirm their place as a valued community member.

A space that encourages consumers to informally meet each other and bring family members to enjoy and participate in group activities that could be accepted in the community as a safe place or drop in centre that is managed by the community was identified as a need.

Finding 4
Nature-based activities such as walking and spending time in the bush or beach settings to be resourced and supported for consumers. A low-cost activity with multiple protective factors is an effective early intervention to support consumers when their psychological distress is heightened.

Finding 5
Impoverishment for Aboriginal and Torres Strait Islander peoples living in discrete communities is widely documented and acknowledged as a social health determinant that impacts significantly on their quality of life. This was again highlighted in this needs assessment.

Finding 6
Many individuals with lived experience are disempowered in their daily lives. In particular, their vulnerabilities are often taken advantage of.

Finding 7
For some individuals, addressing long standing tensions in the family setting could significantly improve the dynamics between consumers and their siblings and other family members. Defusing potential escalating tensions that could lead to serious domestic and/or family violence is a priority to respond to meeting the psychosocial needs of some consumers.

Finding 8
The material produced by the NDIS to explain their role, services, and programs is not well understood by some individuals and families. Confusion about the NDIS process and what is expected of the consumer, and the length of time it takes for the consumer to be informed of a decision creates layers of anxiety which further impacts their mental health.

Finding 9
Some services in rural and remote areas have difficulty with recruitment and retention of staff. Stability in staffing is pivotal to the daily service delivery and consumer contact that is required to meet individual and group psychosocial needs.
Summary of key findings of service design consultations

Finding 10
The NPS measure service model needs to be simple to access and navigate for individuals and families and provide flexibility to meet individual’s needs, as well as linked and integrated with the mental health stepped care services within the region.

Finding 11
With the target cohort for the NPS measure being individuals whose clinical care is provided through primary care, there are areas within the NQPHN region where nearly all clinical care is provided through Queensland Health mental health services (Cape York and the Torres Strait Islands). Individuals in these areas would access Queensland Health funded NPS services in the mental health community support sector.

Finding 12
There are a range of success factors that have been identified in the existing psychosocial services that should be considered in the design of the NPS measure.

Finding 13
There needs to be flexibility in relation to intake and access to the service, not only for new clients but also if individuals need to re-access at a later time. It was highlighted as important that to access the service a diagnosis should not be required. Self-referrals, referrals by family, and others, as well as from health professionals were recommended.

Finding 14
Putting time limits on access to this type of service is problematic as it does not account for individual differences as well as time to build trust and relationships. It was identified that there was often an early period of crisis where navigating services, medications, and to limit services to a short period of time (e.g. three months) may not allow enough time to develop necessary relationships and identify needs.

Finding 15
Individuals and families like to have consistency and stability in the services that they receive, particularly continuity of the staff members delivering the service. Feedback was also received that in some areas of our region there are limited providers and individuals would like more choice in the services they can access.

Finding 16
Whilst there are a range of workforce options that could be utilised for this NPS measure service, peer workforce models should be considered with a range of qualifications and skills making up teams. It is important in any workforce model that staff are well supported with training, development, and ongoing professional support. Individuals and families express the need for stability in the workforce. Mental health peer support can bring a range of benefits, such as friendship, empowerment, acceptance, stigma reduction, and shared learning and insights for recovery. Mental health peer support workers and programs can also bring about significant improvements in service cultures, towards more recovery-centred and trauma informed approaches.

Finding 17
Recruitment and retention of staff is a key issue in rural and remote areas of the NQPHN region. Organisations need acknowledgement and support to manage professional and personal issues and needs of staff, to avoid absences from the workplace. Their roles and responsibilities are pivotal to the daily service delivery and consumer contact that is required to meet individual and group psychosocial needs.

Finding 18
Communication was the key area discussed in relation to the transition period of services. This was communication between services as well as to the community about the changes that were taking place and how they can access the services they require.
Overview of recommendations for NPS measure

Recommendation 1
The establishment of NPS measure services in defined geographical areas of the NQPHN region with the highest number of individuals who receive their clinical mental health care in the primary sector through GPs, private psychiatrists, private psychologists, and practice mental health nurses. The current data available is limited in establishing demand and target cohort numbers however, reviewing what data is available identifies areas of greatest need. It would however be recommended to wait until Queensland Health has been able to announce its successful service providers in early 2019 and review the geographical spread for services prior to NQPHN commissioning the service.

Recommendation 2
Referrals to the NPS measure service come from a primary care setting. Primary care providers can include GPs, mental health nurses, psychiatrists, psychologists, and mental health workers. Existing regional intake processes established for stepped care are utilised as the intake mechanism.

Recommendation 3
Consideration could be given to providing the service as a package of support for rural and remote areas that includes a range of activities, that are provided to a person to meet their psychosocial needs and goals. The services they access may be provided by the service or accessed through other providers within the region.

Recommendation 4
Consideration of a peer workforce model for these services. It is important that the workforce model incorporates:
» systems to ensure 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
» evidence of implementing structures, policies, and programs that move the workforce along the continuum from Aboriginal and Torres Strait Islander cultural awareness, to cultural sensitivity, and to cultural safety.
This could come from within the service or NQPHN could commission workers in a range of existing services across the region as well as an organisation to provide professional support to workers across the region.

Recommendation 5
If assessment tools are used, it is recommended that an appropriate non-clinical tool is applied across all of the programs commissioned within the region with standardised self-assessment tools preferred.

Recommendation 6
In addition to a specific service, it is recommended that an additional element is included in the NPS measure service requirements. This element is the requirement to develop a culturally responsive SEWB/mental health literacy strategy. The aim of the strategy would be to identify a range of activities to inform and build capacity and capability to the carers, and natural helpers within the family circle to increase their knowledge base and provide practical tools to support them. The strategy would also extend to the wider community to ensure as many community members as possible develop a sound and respectful understanding of SEWB/mental health and its impacts on individuals and families, including the debilitating effects of stigma, shame, and alienation that individuals endure when there is limited compassion and understanding.
In the 2018–19 federal budget an allocation of $80 million nationally over four years was announced to support the National Psychosocial Support (NPS) measure for individuals experiencing mental health issues who will be ineligible for support through the National Disability Insurance Scheme (NDIS).

The objectives of the NPS measure are to:
- support people with a severe mental illness and associated psychosocial functional impairment who are not more appropriately supported through the NDIS
- reduce the avoidable need for more intense and acute health services and enhance appropriate/optimal use of the health system.

The NPS measure is not intended for individuals who need long-term, ongoing psychosocial support, but those who would still benefit from a level of specialised, less intensive psychosocial supports linked to their goals and delivered at a time of need. It is for individuals that have a severe episodic mental illness and a resulting level of reduced psychosocial functional capacity and due to the episodic nature of their illness, would benefit from some short-term, targeted psychosocial support at points in time.

In November 2018, Northern Queensland Primary Health Network (NQPHN) engaged Freestone Associates to facilitate a needs assessment and to scope service model options with a range of consumers, carers, and service providers across the region to assist NQPHN in designing a model of service that meets local needs to be commissioned to support the NPS measure in North Queensland.

The purpose of this document is to capture a synthesised summary of the conversations and information gathered during the needs assessment and service model options activities held across the NQPHN region in November 2018.
Overview of National Psychosocial Support measure

Psychosocial support is defined as support and services that are designed to work in partnership with individuals who are significantly affected by severe mental illness which has an impact on their associated psychosocial functional capacity. The services, in partnership with families and carers where appropriate and able, provide a range of non-clinical community-based support to these individuals.

Reviews of the effectiveness of psychosocial support services have highlighted strong evidence for the value of those services which focus on capacity building, particularly from an early intervention perspective. These services build ability and skills to assist people to manage their mental illness, improve their relationships with family and others, and increase social and economic participation.

Key areas of activity could focus on building capacity and stability in one or more of the following areas.

Social and family
- develop social skills and friendships
- build family relationships

Life skills
- manage daily living
- manage money
- find and look after a home
- build broader life skills including confidence and resilience

Vocational
- develop work skills and goals, including volunteering
- support with educational and training goals

Health
- stay physically well
- exercise
- support with drug, alcohol, and smoking issues

Not everyone with severe mental illness will require specialised psychosocial support and for some individuals their broader support needs can be met through mainstream community support programs, or through family and social connections. The NPS measure is targeting individuals for whom clinical care is not enough to help them build capacity for daily living and who would benefit from specialised psychosocial support at particular points in time.

There are no age restrictions on this initiative and the criteria for individuals to be included are that they:
- have a severe mental illness and a resulting level of reduced psychosocial functional capacity
- are not eligible or assisted by the NDIS (possibly due to the episodic nature of their illness)
- are not current clients of existing community mental health programs such as Partners in Recovery (PIR), Day to Day Living (D2DL), and Personal Helpers and Mentors Service (PHaMs).

As part of this measure, the Commonwealth has bilateral agreements with each jurisdiction regarding their continuing or enhanced investment in psychosocial services. The Queensland Health-funded component of the NPS measure will be implemented through the provision of individual support and rehabilitation, and group support and rehabilitation services as defined below.

Individual support and rehabilitation is considered personalised support and psychosocial rehabilitation provided on an individual basis, tailored to the individual in their focus of care and intensity of support. It occurs in the context of outreach to the appropriate setting (e.g. home, work, school, shopping centre) and may or may not be linked to an individuals’ accommodation. It is a non-clinical service that is performed by appropriately qualified workers (which may include having lived experience).

Group support and rehabilitation is considered structured or unstructured group activities that are delivered to groups of people simultaneously. It primarily engages people in one or more social, recreational, prevocational or physical activities, and is centre-based or conducted in community environments. Groups are led by an employee that may or may not be a peer worker.

Northern Queensland Primary Health Network (NQPHN)-commissioned services will need to be implemented in a flexible way to complement and/or enhance the Queensland Health-funded psychosocial support as well as the local hospital and health service (HHS) mental health services to meet the needs of individuals and families in the region. Queensland Health has recently undertaken a commissioning process for their psychosocial services within the region and the successful service providers will be notified early in 2019. For the NQPHN-commissioned services, the majority of the target group will receive their clinical care in the private sector through GPs, private psychiatrists, private psychologists, and practice mental health nurses.
The National Psychosocial Support (NPS) Measure Needs Assessment is a working document, that evolves as new and more relevant information becomes available through both data as well as ongoing community consultations and feedback. The needs assessment is not an exhaustive list of all services and consumer needs, it is part of essential processes of stakeholder consultation to engage and identify key areas of need specific to our region. This document has been developed in line with Department of Health NPS Guidance Material, 2018.

Through the implementation of a facilitative process to engage either face-to-face and/or videoconference or teleconference, the intention of the needs assessment is to extrapolate psychosocial best practice needs, insights, and service design features that could inform the NPS measure model and pathways for eligible individuals across the Northern Queensland Primary Health Network (NQPHN) region.

Northern Queensland Primary Health Network (NQPHN) covers an area of half a million square kilometres and a population of over 692,832 people (ERP 2016), with four Hospital and Health Services (HHSs) and nine Aboriginal Medical Services. The region has a population of 10.1% that identifies as Aboriginal and Torres Strait Islander compared to 4% across Queensland. There are significant refugee and migrant groups in the region and there is evidence of vulnerability to depression, suicide, and post-traumatic stress disorder in these groups.

The population of those born overseas varies from 9% in outback Queensland to 19.1% in the Cairns region.

In 2013 it was estimated that 146,311 people across Queensland were treated for mental or substance use disorders that were classified as severe, and in 2011, 33,526 people were accessing subsidised mental health related services across the region.

Consultations were conducted throughout November and early December 2018 with workshops held across the region in Cairns, Townsville, Mackay, and two Indigenous communities, Palm Island and Yarrabah as well as additional interviews and online focus groups. Overall, 63 people participated in these consultations including 27 individuals who identified as having lived experience, 5 identified as being a carer, and 33 individuals who identified as being Aboriginal and/or Torres Straits Islander. In addition to the consultations, information was obtained via a survey from service providers within the region that deliver PiR, PHaMS, and D2DL programs. Eight responses were received from service providers informing referral numbers and current clients.

Access to treatment and support for individuals with severe illness was identified in stakeholder consultations as a key area of inequity in rural and remote communities and rural and remote areas as the most in need of mental health services across NQPHN. Mental health issues constitute 3.5% of all emergency department presentations and mental health-related inpatient separations across NQPHN are forecast to increase if current trends continue.

In a recent wellbeing survey conducted by the University of Canberra, between 6% in far North Queensland and Torres Strait Islands and 11.1% in regional Queensland are at high probability for serious mental illness. Figures from the Medicare Benefits Schedule have indicated in 2016–17 there were 1,015 general practitioners providing mental health services across the NQPHN to 50,939 clients and providing 88,143 services in that year alone.

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5 ibid
One of the challenges in assessing needs is the availability of accurate data and information about the target population group and estimating the demand for services. Where there is stability across time in service delivery there are opportunities to model demand through experience. There is a current landscape of change within the disability sector and supports for mental illness, including funding models as the NDIS is implemented across the country. In each sector there are transitioning issues and limited information to be able to accurately predict or identify the demand for services being designed and developed. In this case the provision of NPS measure services is for a group of individuals fitting specific criteria of a severe mental illness and requiring psychosocial supports but who are not eligible for the NDIS. If they are clients of the HHS mental health services they can be provided with support through state funded specialist mental health services.

In this snapshot there has been an attempt to use current literature, survey information and data from a number of sources to estimate the potential demand for psychosocial supports for key areas within the region. Diminic (2013) estimated the proportion of people with a mental or substance use disorder in Queensland receiving treatment and the service sector delivering this treatment. Figure 1 outlines the proportion of people with a mental illness who were treated in Queensland by services. Notable in this case, is that 51% of people did not seek treatment for their mental health or substance use disorder overall, however this varied according to the severity of the disorder from 94% of those with severe illness seeking treatment to only 26% of those with mild illness accessing clinical care. Figure 2 outlines the estimated number of people treated by service sector and by severity of disorder with data from 2011-12.

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**Figure 1:** Estimated proportion of people with a mental or substance use disorder in Queensland receiving treatment 2011–12, hierarchically by service sector

**Figure 2:** Estimated number of people treated for a severe mental or substance use disorder in Queensland 2011–12, hierarchically by service sector

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9 ibid

10 ibid

11 ibid
The national mental health commission review estimates that 3.45% of the population will experience a severe mental illness and in 0.45%, this illness will be severe and persistent with complex multi-agency needs. This group of people are likely to be eligible for NDIS support. In 3% of the population experiencing mental illness this will be a severe, persistent episode with major limitations in functioning without remission across a long period of time or severe episodic illness with periods of remission. It is a sub-set of the individuals with a severe mental illness that are targeted by the national psychosocial support measure, which is expected to be a proportion up to 3% of the population. These estimates are obviously influenced by local and regional demographics and characteristics.

According to the national Aboriginal and Torres Strait Islander social survey, there were 15,700 Aboriginal and Torres Strait Islander peoples living in remote areas with a mental health condition and 114,600 in non-remote areas across Australia. They are twice as likely to report a mental illness in non-remote (33%) than remote areas (16%) and mental health issues are less likely to be reported by young people (22%). It has been identified that people in rural and remote locations as a group are most in need of mental health services.

At a state level, mental and substance use disorders were the leading cause of total disease burden (27%) for Aboriginal and Torres Strait Islander peoples living in remote areas. Two thirds of years lost among Indigenous Australians were due to poor health caused by mental health and substance use disorders. The proportion of the population that identifies as Aboriginal and/or Torres Strait Islander varies from 64% in Torres and Cape to 4.9% in the Mackay region.

This needs assessment has collected and sourced information to provide a best estimate of the number of individuals in this target group in an attempt to provide information for future service design and delivery. The implementation of the NDIS has far reaching impacts on current services that are yet to be identified. In a survey conducted as part of this needs assessment, five North Queensland service providers delivering PHaMs to 379 current clients have identified 49 clients being eligible for NDIS, 67 clients were found ineligible, 105 have not yet applied and 76 do not intend to apply.

In a recent Mental Illness Fellowship of Australia submission, it is estimated that 225,000 people nationally with severe mental illness and psychological disability, will not be within scope of the NDIS. Further, the report estimates that 40% of PIR existing clients, 60% of PHaMs clients, and up to 50% of D2DL clients will not transition to the NDIS and will be eligible for Continuity of Support (CoS) services. These predictions are important in order to assess the need for these services but to also have an understanding that these services are transitioning to CoS and there may be gaps in the provision of services or as yet unidentified aspects for in a new service model for psychosocial supports.

The delivery of services across the region, and service design is impacted by the vast geographical area of North Queensland and the availability of state funded specialist mental health services, NDIS services, and the ability to provide suitable services where people need them. The following map defines the inner regional, outer regional, remote and very remote regions of Queensland where the NQPHN covers three main regions of Cairns, Townsville, and Mackay. However, NQPHN also covers Cape York, the Torres Straits, Palm Island, the Whitsunday Islands, and other remote locations. This geographical spread was identified by stakeholders as an ongoing challenge for the design and delivery of services that are equitable. Within the information gathered, there were a number of groups and locations that may require special consideration, such as support for youth, outreach to areas such as Proserpine and Charters Towers or the lack of the available services in remote areas that prevent the provision of additional supports within existing service models.

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13 Rohani M & Stevenson (2018) Mental Illness Fellowship of Australia. Submission to the Joint Standing Committee on the NDIS. Transitional arrangements for the NDIS
Remoteness Area, 2011\textsuperscript{16}

Table 1 on the following page outlines the information gathered from the service providers as part of the needs assessment consultation activities. Of specific interest were the number of active clients and recent experiences with the application and assessment outcomes for the NDIS. This is important as one of the criteria for the target group of this needs assessment is that the individuals are not eligible for the NDIS.

Service providers indicated there are 379 current clients of PHaMs with approximately 272 incoming referrals received each year. Overall, with the exception of those that are awaiting an outcome from their application, 58% of applicants that applied for the NDIS have not been eligible. On average, 30% of PHaMs participants identify as Indigenous, however this varies from none to 100% of participants depending on geographical location.
Table 1: Service data for PHaMs, D2DL, and PIR providers

<table>
<thead>
<tr>
<th>Program name</th>
<th>Personal helpers and mentors</th>
<th>Day to Day Living &amp; Partners in Recovery</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants*</td>
<td>379</td>
<td>339</td>
<td>718</td>
</tr>
<tr>
<td>Indigenous clients</td>
<td>37%</td>
<td>21%</td>
<td>29%</td>
</tr>
<tr>
<td>Incoming referrals per year</td>
<td>-272</td>
<td>-350</td>
<td>-622</td>
</tr>
<tr>
<td>NDIS status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepted</td>
<td>49</td>
<td>104</td>
<td>153</td>
</tr>
<tr>
<td>Rejected</td>
<td>67</td>
<td>37</td>
<td>104</td>
</tr>
<tr>
<td>Not yet applied</td>
<td>105</td>
<td>49</td>
<td>154</td>
</tr>
<tr>
<td>Don’t want to apply for NDIS</td>
<td>76</td>
<td>41</td>
<td>117</td>
</tr>
<tr>
<td>Awaiting outcome</td>
<td>NC*</td>
<td>104</td>
<td>&gt;104</td>
</tr>
</tbody>
</table>

* Data collected November/December 2018
- An approximation based on previous or expected referrals
* NC: Not collected from all respondents
Table 2: Descriptives of regions and target population estimates based on available information

<table>
<thead>
<tr>
<th>Descriptives of regions and target population</th>
<th>Cairns and Hinterland</th>
<th>Townsville</th>
<th>Mackay (surrounds)</th>
<th>Torres and Cape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>240,190</td>
<td>229,031</td>
<td>169,688</td>
<td>26,365</td>
</tr>
<tr>
<td>Aboriginal and/or Torres Strait Islander population</td>
<td>23,961 (10%)</td>
<td>18,008 (7.9%)</td>
<td>8,289 (4.9%)</td>
<td>16,873 (64%)</td>
</tr>
<tr>
<td>Population born overseas</td>
<td>45,928 (19.1%)</td>
<td>28,766 (12.6%)</td>
<td>20,759 (12.2%)</td>
<td>1,050 (4%)</td>
</tr>
<tr>
<td>Born overseas in non-English speaking country^</td>
<td>29,585 (12.3%)</td>
<td>17,921 (7.8%)</td>
<td>12,050 (7.1%)</td>
<td></td>
</tr>
<tr>
<td>Proportion of population identifying as not-proficient in English</td>
<td>6.4%</td>
<td>4.7%</td>
<td>3.6%</td>
<td>5.7%</td>
</tr>
<tr>
<td>3.45% expected to have severe mental illness</td>
<td>8,287</td>
<td>7,902</td>
<td>5,854</td>
<td>910</td>
</tr>
<tr>
<td>94% of severe illness likely to receive treatment</td>
<td>7,789</td>
<td>7,427</td>
<td>5,503</td>
<td>855</td>
</tr>
<tr>
<td>3% expected target population supported by QH MHS, COS or NPS</td>
<td>6,773</td>
<td>6,485</td>
<td>4,785</td>
<td>743</td>
</tr>
<tr>
<td>Mental Health Nurse Incentive Program (MHNIP) FTE</td>
<td>2</td>
<td>16</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

^ Includes countries not identified individually, 'Inadequately described', and 'At sea'. Excludes not stated.
Table 2 outlines descriptives, population figures, and estimates for the four main regional areas of Cairns, Townsville, Mackay, and Torres and Cape. A population estimate of 3.45% was applied to 2016 ERP population estimates to identify the number of individuals they might be experiencing severe mental illness. According to Diminic’s estimates, 94% of individuals with severe mental illness receive treatment\textsuperscript{17}, therefore it could be expected that only 94% of the estimated population would be sourcing clinical care and associated supports. The 3% estimates indicate the possible number of individuals experiencing severe mental illness that would not be eligible for NDIS.

Within the NQPHN region there are a range of existing psychosocial support services. For a full list of services refer to Appendix 1.

Summary of findings

Individuals who identify as having lived experience and who are accessing specific Aboriginal and/or Torres Straits Islander services

Specific consultations were held with Aboriginal and/or Torres Strait islander individuals who identify as having lived experience.

Protective factors/activities that support their psychosocial needs

Respondents identified a range of factors and activities that support their psychosocial needs, these include:

- Having a safe non-judgemental and enabling space to meet, and where possible also in the family and community environment. This includes having places where individuals can be supported to immerse themselves in individual and/or small group activities to stay connected to nature and traditional Country, through regular walks in the bush and/or on the beach collecting shells.
- Access to activities such as painting, craft-work, beading, and being creative with ghost nets.
- Participating in group activities such as fishing, dragging the net, camping, playing and listening to music, sitting around the camp fire, cooking, and gardening activities. Other activities identified included playing arcade games, PlayStation (Mario games), pool/snooker, going to the movies, shopping in town (retail therapy), going on long drives to different places.
- Yarning at home with supportive family members who understand their situation and help them every step of the way as well as with staff at PHaMs.
- Having access to services that support recovery (e.g. ATODS, mental health services, Aboriginal & Torres Strait Islander family violence legal service). Also ensuring that service providers explain their roles and programs in a user-friendly consumer/client centred communication style that individuals understand fully. Having this occur over several informal sessions would be beneficial.
- Inclusion in joint BBQ/social events with other groups in the community such as the Men’s, Women’s, and Open groups.
- Participating and contributing to NAIDOC and other community events as the inclusiveness aspects support an overall community social cohesion for all community members. This was identified as critical support as it helps to reduce stigma and alienation in the community as these community events demonstrate an acceptance and understanding of social and emotional wellbeing and/or mental health conditions.
- Having access to reliable transport is a key support, but at times is quite challenging to access due to limited transport options available to consumers. Transport cannot always be guaranteed by the service provider due to demands placed on staff with a range of responsibilities and the limited number of cars available to meet their transport logistical needs. E.g. appointment with a range of health/medical professionals, other departmental/community services, shopping etc.
- Having culturally competent GPs, in particular GPs that do home visits was identified as an important need.
- Positive role modelling in the community and by the Men’s Group in organising and promoting White Ribbon Day has had a strong positive influence to support psychosocial activities. Incorporating fun day activities in the White Ribbon Day program enables community members in general to increase their awareness around positive role modelling and the way language and the use of abusive language can affect the wellbeing of individuals (children and adults), family, and community members.
- Support to enable visits to family and friends, physical exercise such as playing cricket.
- Support to access the hospital and getting medication in a timely manner
- Establishing trust and strong rapport with staff members who can help such as the peer support workers and recovery workers from Thrive/PHaMS and Strong Mob team from Life without Barriers as well as having access to the local Deacon of the Anglican Church and fellow church members.
- Just having a cup of tea/coffee and having a really good yarn with people that are genuine and caring on a daily basis.

» Participating and contributing to NAIDOC and other community events as the inclusiveness aspects support an overall community social cohesion for all community members. This was identified as critical support as it helps to reduce stigma and alienation in the community as these community events demonstrate an acceptance and understanding of social and emotional wellbeing and/or mental health conditions.

» Having access to reliable transport is a key support, but at times is quite challenging to access due to limited transport options available to consumers. Transport cannot always be guaranteed by the service provider due to demands placed on staff with a range of responsibilities and the limited number of cars available to meet their transport logistical needs. E.g. appointment with a range of health/medical professionals, other departmental/community services, shopping etc.

» Having culturally competent GPs, in particular GPs that do home visits was identified as an important need.

» Positive role modelling in the community and by the Men’s Group in organising and promoting White Ribbon Day has had a strong positive influence to support psychosocial activities. Incorporating fun day activities in the White Ribbon Day program enables community members in general to increase their awareness around positive role modelling and the way language and the use of abusive language can affect the wellbeing of individuals (children and adults), family, and community members.

» Support to enable visits to family and friends, physical exercise such as playing cricket.

» Support to access the hospital and getting medication in a timely manner

» Establishing trust and strong rapport with staff members who can help such as the peer support workers and recovery workers from Thrive/PHaMS and Strong Mob team from Life without Barriers as well as having access to the local Deacon of the Anglican Church and fellow church members.

» Just having a cup of tea/coffee and having a really good yarn with people that are genuine and caring on a daily basis.
Psychosocial needs currently not being met

Respondents identified areas that they felt where their current psychosocial needs were not being met. These included:

- Access to proper transport (including wheelchair access) to get around the community and to activities as well as support to enable them to get a driver’s license.
- Psychosocial support to strengthen family engagement through culturally responsive community and family education (SEWB/mental health literacy). Specifically addressing stigma in all its forms and reducing stigma in the community. Understanding the difference between clinical diagnosis/treatment and cultural illness (e.g. black magic).
- Feelings of not being listened to and people taking advantage of them including wanting money, intimidation, and bullying.
- People not explaining and/or communicating in a clear and appropriate manner.
- Reports of violence including sexual violence against individuals.
- Access to computers to enable them to report to Centrelink, browse the internet, record music, and learn how to use different software to create art and craft projects.
- Access to more money—not enough money to live on.
- Need to have timely responses to support in times of high need and crisis points including help in the home setting when arguments become heated and violent that causes fights. Need help to mediate between family members, to help them reconcile their issues and needs, to enable the family unit to re-unite to support their family member with the lived experience.
- Need support/help with drug and alcohol usage. Appropriate effective counselling and support for individuals and family groups.
- Incorporate activities that not only build skills but provide food for families such as going deep fishing.

Respondents reported a high level of disempowerment as they felt their voices were not being heard and they were not being listened to on issues important to them, such as domestic violence, sexual assault, harassment, and bullying behaviours by a number of men in the community.

Needs identified by carers

Carers identified specific needs including:

- Current carer supports include family members and friends who come and spend plenty of time with the lived experience consumer.
- Carers struggle with having enough time and energy to perform their role and responsibilities.
- Understanding the health system and getting access to services needed can be complex and create more anxiety and stress.
- Can be supported by joining other groups in the community such as men’s and women’s groups.

Individuals who identify as having lived experience and who are currently accessing mainstream services

Specific consultations were held with individuals who identify as having lived experience. As summary of the needs they identified as follows.
Protective factors/activities that support their psychosocial needs

Respondents identified a range of factors and activities that support their psychosocial needs. These included:

» Walking and talking to friends who will listen and not judge.
» Access to peer support, to be safe and comfortable and to open up about your thoughts, feelings, and behaviours so as to avoid going to hospital.
» Acquire practical assistance with shopping, house cleaning, and attending doctor’s appointments
» Having access to hospital services and staff (e.g. psychologist and psychiatrist, case managers, clozapine clinic nurse).
» Having telephone access to Lifeline counsellors.
» Having out-of-hours support.
» Having family, partners, and friends support.
» Support such as the local psychosocial program where consumers are members and board members and actively engaged in the management and day-to-day operations of the service. Through this daily contact and engagement to build and deliver the service model, consumer’s identified their empowerment and well-being as incrementally increasing and their actions as validated. This included planning and implementing activities such as day trips around the region.
» Attending markets, events, and live gigs.
» Creative activities such as sewing, crafts, art, gardening.
» Tailor made wellness and health care such as access to nutritionist, dietitian, exercise physiologist, yoga.
» Social interaction over coffee and tea, BBQs, cooking etc.
» Learning new skills such as computers, sports, repairing bikes.
» Providing peer support to others.

Regional workshops

The key themes and discussion points from the workshops in Cairns, Townsville, and Mackay have been summarised below. Whilst there were some individuals with lived experience attending, the majority of participants at these sessions were service providers.

Critical success factor from existing programs

Respondents identified what they considered to be the key success factors for improving participant outcomes from the existing psychosocial support programs in the region. They considered the below factors important to be included in any service design for the NPS measure.

» Services that support recovery, choice, and control.
» Services that are culturally safe and have culturally competent staff.
» Psychosocial wellbeing tools to identify consumer’s issues and goals to achieve.
» Incorporation of flexible funding to respond to individuals needs.
» Individualised assistance through support facilitators to ensure access to other services.
» Provision of support to populations that have been traditionally very difficult to reach and engage.
» Services that focus on coordination and integration of services.
» Services that provide support not only to the individual but also the family through education and facilitating respite options.
» Services where a person does not require a formal diagnosis to access the service enabling a ‘soft’ entry point for those who otherwise may...
not approach traditional mental health services.

» Services that work in collaboration with a wide range of services across sectors, non-duplication of effort, build strong relationships with sector (including GPs). Strong relationships that are built over time.

» Easy referral processes into service and ability for people to reconnect when they want to.

» Services that have good retention/consistency of staff who build relationships and trust with individuals and families.

» Peer support models who use a mentoring and coaching model.

» Flexible timeframes for length of service based on realistic goals with clients.

» Services that listen to individuals and work with them at their own pace on what is important to them.

» Services that work with individuals in their own home/environments.

» Existing support plans are detailed and implemented whereas the NDIS plan are very generic.

Barriers to access existing services

Respondents identified that were a range of barriers that still prevented individuals and families from accessing services in this region. These included:

» The lack of services available in rural and remote areas.

» Staffing levels can fluctuate daily in some communities due to community issues.

» Services were changing all the time and community had lack of awareness of what services were available.

» Individuals experiencing social isolation and/or homelessness had difficulty accessing services.

» Cost to access services such as general practice and associated services was identified as an issue.

» Individuals not connected to the system may find the ‘front door’ difficult to access.

Service system changes required

Respondents identified that the current changes occurring to the service system may be causing more fragmentation than before. Some of the issues included:

» There are key areas needed to support an individual that is not included under the NDIS. These include accommodation and household related expenses, gym memberships etc.

» There is a greater need to work collaboratively across the sector and services. Collaboration happens between Government and sector levels, clinical and community services, family, and individuals. Do not want a siloed approach.

» It is important to have a localised approach to service planning to ensure services are in response to the local needs and priorities.

» Can thought be given to not using recovery terminology as it implies a person is broken.

» Need to have a stable workforce that works consistently with consumers to support them to reach their wellbeing goals.

» Need to have a collaborative approach with other services to develop a SEWB/mental health literacy strategy and a community development and engagement strategy.

Additional supports / services required

Respondents identified a range of supports that were required within the region. These included:

» Increase the support for individuals who are experiencing homelessness and sleeping rough.

» Increase in processes to engage individuals that are often hard to engage in services and missing support they need.

» Additional support for and enhancement of the role of carers as this can also improve client engagement and support.

» More support to develop a range of psychosocial and psycho-educational material and possibly community training to increase the knowledge base of people’s understanding about trauma from an early age, lack of nurturing, lack of goal setting, substance abuse, and self-medicating. Clinical services to support and resolve entrenched intergenerational trauma, grief, and loss.

» In some communities there are not enough activities to keep consumers busy and interested.

» Need to strengthen family and carer supports for consumers.

» To strengthen the Life Skills psychosocial supports and to help consumers overcome drug addiction.

» Need to work more closely with the NDIS/LAC to align support plan goals for consumers.
NPS measure service model design

As part of the needs assessment respondents were asked about the possible service models that they would like to see considered for this region under the NPS measure funding. Key areas were discussed as outlined below. This feedback has been collated from all the workshops, interviews, and focus groups.

Intake and access

Respondents outlined elements and aspects of the intake process and service access that they believed were important to consider in designing the NPS measure service model. These included:

- There must be an easy access process and flexibility, not only for new clients but also if individuals who need to access the service again.
- Individuals should not have access only if they have a diagnosis.
- Referrals should be able to come from a health professional, family, or a self-referral.
- The service should be linked to and integrated with stepped care in the region.
- If using an eligibility screen tool, it must be non-clinical and appropriate. Self-assessments were valued. Feedback from the consultations were supportive of continuing to utilise the PHaMS Eligibility Screening Tool (EST), the Camberwell Assessment of Needs (CANSAS) used in PIR, or tools currently used by Queensland Health including the Occupational Self-Assessment or the Allen Cognitive Levels scale.
- Putting time limits on access to service is problematic as it does not account for individual differences, time to build trust, and relationships. In some circumstances it may take three months to navigate medication and clinical supports before psychosocial support is able to be provided in a meaningful way.

Service design

Respondents identified a range of service elements that need to be considered in developing the NPS measure service model. These include:

- Input from individuals with lived experience is vital in designing the service model.
- It is good if a range of services can be co-located together. Community hubs work well. Individuals and families should be able to walk in and get the whole picture (you are not eligible for this but there is service available).
- There needs to be a balance between individual and group work. The transition to community groups is not always easy, even though desirable. Needs to be a workable model and group work needs to be effective.
- There needs to be a spread of services across the geography of the region and include service aspects for remote and rural communities. This can be through phone and skype support if needed.
- Building resilience and cultural activities to be included.
- Would be good to build on existing service and capacity in the region. Reinvest in established services that are working.
- Good models exist that have been evaluated such as New Access program from beyondblue. Could be utilised in this region.
- Build flexibility into the model to respond to needs.
- Support coordination—a stable workforce that is knowledgeable about available supports is critical.
- Service needs to be health and wellbeing focused not illness driven. The service should provide opportunities for personal growth.
- Important to balance service outputs with KPIs and not just run groups because you have to under your contract. It was understood that reporting is essential however it needs to be realistic.
- If the NPS measure services commissioned by Queensland Health are only for individuals accessing clinical services by Queensland Health then case managers may ‘hold on’ to clients longer than might be required.
**Workforce options**

A range of workers were identified that would make up the NPS measure workforce. These included:

- A mix of teams with lived experience and non-lived experience
- Peer support workers—consider a buddy system
- Certificate IV trained in disability/community services
- Group program facilitators
- Workers with a high level of skill in understanding recovery and its attributes (strength focused)
- Family and carers
- Natural supports.

Other considerations around the workforce in this region include:

- Peer workforce models should be considered if they are well supported with training, development, and ongoing professional support. Sometimes peer workers don’t want the label of peer worker, just worker, or an alternative. This concern was fairly consistent.
- There is a need for a stable service model/funding for a minimum of three years to build capacity and retain staff.
- There is a need to have a range of suitable skills and qualifications in the workforce including Cert 4 Community Services, Mental Health, Intentional Peer Support.
- Consider minimum level of education Mental Health First Aid and lived experience.
- Consider subsidised training for staff to achieve qualifications.
- Attributes of the workforce include empathy, need to be a ‘calling’ not just a job; respectful, good listener, non-judgmental, compassionate, advocate, pro-active in delivering outreach services, watch for signs of unwellness, act to intervene, and respond appropriately.

**Establishment/transition**

Respondents identified areas for consideration during the establishment phase of the NPS measure services. These included:

- Ensuring the individuals and families have a choice of service if possible.
- Existing service providers need to know as soon as possible the date for service commencement to plan when to cease accepting new referrals into existing programs.
- It would be good to advertise widely for NPS measure services to ensure additional capacity and options to the region.
- Ensure good communication to inform consumers constantly around transition issues. Be there to hold their hand throughout the entire transition process. Be aware of the different points in the timeline. Make sure there are no surprises for the consumer, that would trigger anxiety and/or unwellness.

**NDIS considerations**

- Individuals who apply for and are not accepted to the NDIS are reporting that it is very upsetting and a traumatic process for them.
- Some individuals are choosing not to apply as they do not want to get rejected.
- A key role of the LAC is to support those not eligible for NDIS to access other services.
Recommendations and considerations

The project team identified the following recommendations for the NPS measure.

**Recommendation 1**

The establishment of NPS measure services in defined geographical areas. These are the defined areas within the Northern Queensland Primary Health Network (NQPHN) region where there are the highest number of individuals who receive their clinical mental health care in the primary sector through GPs, private psychiatrists, private psychologists, and practice mental health nurses. The current data available is limited in establishing demand and target cohort numbers however, using what data is available it would mean focusing the service provision in areas of high need. It would however be recommended to wait until Queensland Health has been able to announce its successful service providers in early 2019 and review the geographical spread for services prior to the NQPHN commissioning.

**Recommendation 2**

Referrals to the NPS measure service come from a primary care setting. Primary care providers can include GPs, mental health nurses, psychiatrist, psychologists, and mental health workers. Existing regional intake processes established for stepped care are utilised as the intake mechanism.

**Recommendation 3**

Consideration could be given to providing the service as a package of support for rural and remote areas that includes as a range of activities that are provided to a person to meet their psychosocial needs and goals. The services they access may be provided by the service or accessed through other providers within the region.

**Recommendation 4**

Consideration of a peer workforce model for these services. It is important that the workforce model incorporates:

- systems to ensure 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
- evidence of implementing structures, policies, and programs that move the workforce along the continuum from Aboriginal and Torres Strait Islander cultural awareness, to cultural sensitivity, and to cultural safety.

This could come from within the service or NQPHN could commission workers in a range of existing services across the region as well as an organisation to provide professional support to workers across the region.

**Recommendation 5**

If assessment tools are used, it is recommended that an appropriate non-clinical tool is applied across all of the programs commissioned within the region with standardised self-assessment tools preferred.

**Recommendation 6**

In addition to a specific service, it is recommended that an additional element is included in the NPS measure service requirements. This element is the requirement to develop a culturally responsive social and emotional wellbeing (SEWB)/mental health literacy strategy. The aim of the strategy would be to identify a range of activities to inform and build capacity and capability to the carers, and natural helpers within the family circle to increase their knowledge base and provide practical tools to support them. The strategy would also extend to the wider community to ensure as many community members as possible develop a sound and respectful understanding of SEWB/mental health and its impacts on individuals and families, including the debilitating effects of stigma, shame, and alienation that individuals endure when there is limited compassion and understanding.
Additional considerations

Through the consultations associated with this needs assessment a range of issues were highlighted that were out of the scope of the development of the NPS measure, however they have been included to ensure that they are captured as part of the ongoing needs assessment processes of Northern Queensland Primary Health Network (NQPHN).

The importance of family and belonging, combined with their unique types of support emerged strongly from the needs assessment. As family members are usually a carer with other family members supporting the individuals at different times and in different situations, it is imperative that a culturally responsive social and emotional wellbeing (SEWB)/mental health literacy strategy is developed. The aim of the strategy would be to inform and build capacity and capability to the carer’s, and natural helpers within the family circle to increase their knowledge base and provide practical tools to support them. The strategy would also extend to the wider community to ensure as many community members as possible develop a sound and respectful understanding of SEWB/mental health and its impacts on individuals and families, including the debilitating effects of stigma, shame and alienation that individuals endure when there is limited compassion and understanding.

The stigma experienced by Aboriginal and Torres Strait Islander consumers in small communities is significantly more traumatic and contributes to their psychological distress which directly impacts on their mental, spiritual, emotional, and physical wellbeing.

Complimenting and/or adding value to the above SEWB/mental health strategy, a focused community development and engagement strategy to increase inclusiveness of individuals with lived experience in regular community events would be very beneficial to their psychosocial supports and would reaffirm their place in the community is just as valued as any other community member.

Impoverishment for Aboriginal and Torres Strait Islander peoples living in discrete communities is widely documented and acknowledged as a social health determinant that impacts significantly on quality of life. NQPHN could consider facilitating the development of scoping economic hardships for individuals with lived experience across the region. Engaging with the Public Trustees—Adult Guardian Teams and their networks should be a priority to scope the feasibility of support for individuals to meet the current cost of living and remote area living costs.
### Appendix 1
#### Current community managed psychosocial services—NQPHN region

#### Cape York and Torres Straits Island area

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Location</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare</td>
<td>Thursday Island</td>
<td>Personalised support, family support, group work, mutual self-help</td>
</tr>
<tr>
<td>Life without Barriers</td>
<td>Hopevale</td>
<td>Strong Mob program</td>
</tr>
<tr>
<td></td>
<td>Wujul Wujul</td>
<td>Strong Mob program</td>
</tr>
<tr>
<td>Apunipima Cape York Health Council</td>
<td>Aurukun</td>
<td>PHaMS program</td>
</tr>
</tbody>
</table>

#### Cairns and Hinterland area

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Location</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centacare FNQ (Mental Health Resource Service)</td>
<td>Cairns and outreach to Ravenshoe</td>
<td>Recovery coaching program, group programs, mutual self-help programs, carer support</td>
</tr>
<tr>
<td></td>
<td>Cairns - FNQ Region</td>
<td>Transition from correctional facilities—personalised support services provided 4 weeks prior and 6 months after discharge from a correctional facility</td>
</tr>
<tr>
<td>Royal Flying Doctors Service - Headspace Cairns</td>
<td>Cairns</td>
<td>Dialectical Behaviour Therapy program in conjunction with QH</td>
</tr>
<tr>
<td>Mareeba Community Centre</td>
<td>Mareeba</td>
<td>Personalised support—small MH counselling program</td>
</tr>
<tr>
<td>Life without Barriers</td>
<td>Cairns</td>
<td>Strong Mob—Aboriginal and Torres Strait Islander peoples. Personalised support, family support, group activities</td>
</tr>
<tr>
<td></td>
<td>Yarrabah</td>
<td>Strong Mob—Aboriginal and Torres Strait Islander peoples. Personalised support, family support, group activities</td>
</tr>
<tr>
<td>Mind Australia</td>
<td>Cairns</td>
<td>PARC—Recovery program and 28 days residential facility for step-up step-down clients + outreach after discharge</td>
</tr>
<tr>
<td>Neami National</td>
<td>Cairns</td>
<td>Community Care Unit and Bawu Day Program</td>
</tr>
<tr>
<td>Aftercare</td>
<td>Cairns</td>
<td>PHaMS program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Take 2—Early Intervention program to children and young people up to the age of 18 and their families. Located in Cairns South</td>
</tr>
</tbody>
</table>
### Cairns and Hinterland area (continued)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Location</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thrive/ Worklink</td>
<td>Yarrabah</td>
<td>PHaMS program</td>
</tr>
<tr>
<td>Tablelands and Cassowary Coast</td>
<td>PhaMS program</td>
<td></td>
</tr>
<tr>
<td>Junction Clubhouse</td>
<td>Cairns</td>
<td>International Clubhouse Model</td>
</tr>
</tbody>
</table>

### Townsville area

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Location</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>SelectAbility</td>
<td>Townsville</td>
<td>Personalised support Multicultural program—in conjunction with Townsville Migrant Services group. Personalised support, group activities</td>
</tr>
<tr>
<td></td>
<td>Clubhouse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transition from correctional facilities—personalised support services provided 4 weeks prior and 6 months after discharge from a correctional facility</td>
<td></td>
</tr>
<tr>
<td>Townsville City Council LGA</td>
<td>PHaMS program</td>
<td></td>
</tr>
<tr>
<td>Palm Island</td>
<td>PHaMS program</td>
<td></td>
</tr>
<tr>
<td>Mind Australia</td>
<td>Townsville</td>
<td>Youth residential x2 Step-up step-down facility for young people</td>
</tr>
<tr>
<td>Ozcare</td>
<td>Townsville</td>
<td>PHaMS program</td>
</tr>
<tr>
<td>Northern Australia Primary Health Limited (NAPHL)</td>
<td>Townsville</td>
<td>“Me Too” Program—early intervention program to children and young people up to the age of 18 and their families</td>
</tr>
</tbody>
</table>

### Mackay area

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Location</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>SelectAbility</td>
<td>Mackay</td>
<td>Personalised support—readiness for NDIS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Horizon Clubhouse</td>
</tr>
<tr>
<td>Mind Australia</td>
<td>Mackay</td>
<td>Step-Up Step-Down Residential facility—residential recovery program</td>
</tr>
<tr>
<td>Ozcare</td>
<td>Mackay</td>
<td>Support Time and Rehabilitation Recovery Service (STARR)—co-located with Mackay MHAODS providing psychosocial programs and peer and carer supports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PHaMS program</td>
</tr>
<tr>
<td>Uniting Care Community</td>
<td>Mackay</td>
<td>Early intervention program to children and young people up to the age of 18 and their families</td>
</tr>
</tbody>
</table>