Mental Health and Suicide Prevention Regional Needs Assessment

May 2017
Acknowledgement

The initial mental health and alcohol and other drugs planning for the Northern Queensland Primary Health Network (NQPHN) was conducted in 2016 in collaboration between the NQPHN Mental Health team and Abt Associates.

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

Members of the Abt Associates team include Louise Livingstone, Dr Ernest Hunter, Dr Mark Wenitong, Dr Geri Dyer, Dallas Mc Keown, Kristy Hill, and Lisa Stott.

Companion documents

NQPHN Mental Health Planning Framework 2016
NQPHN Health Needs Assessment 2016
NQPHN Mental Health and Suicide Prevention Needs Assessment 2016
NQPHN Alcohol and Other Drugs Needs Assessment 2016
Improving 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

Mental Health and Suicide Prevention Regional Needs Assessment 2017

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

This document contains information obtained in the initial mental health and suicide prevention needs assessment conducted in 2016. Ongoing mental health and suicide prevention planning will be informed by this locally undertaken needs assessment which has encompassed consultations with our key partners and communities.

NQPHN is working directly with peak bodies, general practitioners, other primary health care providers, secondary care providers, and hospitals to facilitate improved outcomes for individuals, families, and communities across the region. The six local key priorities for NQPHN have been identified as:

• improve access to health services in rural and remote areas
• improve access to mental health services
• promote health workforce expansion and sustainability
• transition chronic disease management to community level care
• improve Aboriginal and Torres Strait Islander health
• improve childhood and maternal health.

NQPHN will work with key stakeholders around mental health system reform at a regional level. This work will be informed by this 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.

North Queensland regularly experiences climate-related disasters, including prolonged drought inland, and cyclones and flooding along the coast. The Indigenous populations of the NQPHN region are exposed to far more frequent critical events as a consequence of violence, accidents, and suicide—many of which receive intense scrutiny in the mainstream media.

The United Nations Inter-Agency Standing Committee, planning for mental health and psychosocial responses to emergencies, requires consideration of an appropriate balance of responsibilities and actions (utilising the service pyramid framework of the WHO that frames NQPHN planning) across agencies and sectors.¹

Consultation from stakeholders identified:

• the need to provide a coordinated health response to critical incidents in communities
• support communities to develop community led responses that are appropriate to the culture of the community.

Further research, consultation, and analysis in remote Aboriginal and Torres Strait Islander communities is required.

¹ Inter-Agency Standing Committee (IASC), IASC guidelines on mental health and psychosocial support in emergency settings. 2007, Inter-Agency Standing Committee: Geneva.
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 sets of 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

The Mental Health and Suicide Prevention Regional Needs Assessment is a working document, that evolves as new and more relevant information becomes available, through data as well as ongoing community consultations and feedback. The needs assessment is not an exhaustive list of all services and consumer needs, rather, it is an essential process in identifying key areas specific to our region.

This document has been developed in line with Commonwealth guidelines using primary data sources obtained from Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW), the Commonwealth Department of Health, in addition to specific data provided by Queensland Health and other local health service providers. Furthermore, we include summaries of workshops obtained during stakeholder consultation, and specific consumer consultation and feedback.

Forty five workshops facilitated by local mental health, alcohol and other drugs, and Aboriginal and Torres Strait Islander health experts were conducted in a wide range of locations across the NQPHN region in 2016. Over 268 people participated in these workshops. In addition to the face to face consultations, an online survey was conducted with 197 individuals completing the mental health survey, and 95 completing the alcohol and other drugs survey.

Additional workshops were held across the region with key stakeholders including consumers and carers to feedback the information obtained in the needs assessment and as a group to prioritise ongoing activity. The NQPHN team is actively building on these early consultation structures and engagement across the region. In December 2016 and January 2017, co-design workshops were held in six locations across the region to progress from the needs assessment into the co-design phase, and priorities for inclusion in the Mental Health and Suicide Prevention Regional Plan to be finalised in 2017.
Outcomes of the health needs analysis
Identified need:  
Socio-economic status of the region’s population

Key issue

The socio-economic status provides useful insight into the broader determinants of health within a population. Overall, the population in the Northern Queensland Primary Health Network (NQPHN) region suffers greater disadvantage than that of Queensland as a whole.

Affordable and accessible health services in rural and remote areas, where there is a high proportion of people who are low income earners, will be critical to delivering improved health outcomes in the NQPHN region.

Lower educational achievement is strongly associated with higher levels of dependence on government benefits. In addition to indicators of poverty, these socio-economic indicators identify a group of very vulnerable people within the population who are often trapped in a downward spiralling poverty cycle.

The NQPHN region is comprised of some very remote areas with a diverse range of health needs. For health consumers, remoteness generally translates to reduced access to health services. While for providers, remoteness is associated with difficulty in attracting and retaining workforce. Remoteness and distance can also increase the cost of fresh fruit and vegetables, which can impact on the population’s health and wellbeing.

Low rates of completed schooling in Torres and Cape and other remote areas indicate that there may be reduced health literacy in these areas.

Persons with disabilities are identified as one of the most vulnerable groups within a society. Within the NQPHN region, a large proportion of those who report a disability were Indigenous Australians. Persons with disabilities and those who care for them require additional support and equality of access to primary health services. Early detection of a disability also enables better management and outcomes for these persons, often with extensive allied health professional involvement.
Description of evidence

Household income in the NQPHN region approximately follows that for Queensland more broadly, however there are pockets of the region that have significantly lower incomes than the state average. 43 per cent of the Torres Strait and Cape York population fall in the lowest income bracket (<$400/week or $20,800/year), compared to 32 per cent across the NQPHN region (or 35 per cent in Queensland). In Aurukun, Wujal Wujal, Yarrabah, Hope Vale, Kowanyama, Lockhart River, Mapoon, Napranum, Northern Peninsula Area, Pormpuraaw, the Torres Strait Islands and Palm Island, over 50 per cent of the population falls in the lowest income bracket.

Overall, the NQPHN region's labour force participation rate is on par with Queensland, with its unemployment rate of 5.4 per cent lower than that of Queensland (6.1 per cent). Noticeable variations from this average are:

- Mackay HHS region has the lowest unemployment rate (3.6 per cent) and the highest labour force participation rate
- Torres and Cape region has the highest unemployment rate (8.7 per cent) and lowest labour force participation rate of 53 per cent
- Yarrabah, Aurukun, Hope Vale, Napranum and Palm Island local government areas (LGAs) have unemployment rates over 20 per cent, as well as noticeably lower labour force participation rates indicating a significantly lower proportion of working population.

In almost all categories, the NQPHN region shows a higher proportion of people on government benefits than the State and National averages. Although most indicators are approximately one per cent higher than the State average, some LGA are far above the average.

Over 30 per cent of the population aged 16 to 64 in Aurukun, Wujal Wujal and Yarrabah receive an unemployment benefit. These LGAs also have higher proportions of people receiving unemployment benefits for more than six months (Aurukun 25.6 per cent, Wujal Wujal 37.1 per cent and Yarrabah 36.3 per cent). Poverty is more likely to affect young children than any other group. The number of low income, welfare-dependent families (with children) is higher in some LGAs such as Northern Peninsula Area, Torres, and Torres Strait Island, where the proportion of families in this category is over 30 per cent. Over 40 per cent of children in Cook, Northern Peninsula Area, Torres and Wujal Wujal areas live in low income, welfare-dependent families.

On average people in the NQPHN region have a slightly higher percentage of dwellings without a registered motor vehicle. In some small remote LGAs this percentage is much higher, though a vehicle may not be necessary to access local infrastructure and services.

Overcrowding is highly associated with increased disease carriage rates, in particular childhood ear and diarrhoeal diseases. These both have long-term sequelae as ear disease leads to hearing loss and deafness, and long-term diarrhoeal diseases are associated with malnutrition, failure to thrive, and stunting in infants.² ³

2,263 people across the NQPHN region did not go to school, with a further 62,000 (13 per cent) who did not complete year 10. Torres and Cape has the lowest proportion of people that completed year 12 (33.9 per cent against 46.6 per cent for Queensland) and the highest proportion that did not finish year 10 (16.7 per cent, against 11.7 per cent for Queensland).

In Croydon, Etheridge, Wujal Wujal, Yarrabah, Aurukun, Hope Vale, Kowanyama, Napranum, Torres Strait Island, Charters Towers, Flinders and Hinchinbrook, 20 per cent or more did not finish year 10. In Mapoon, Pormpuraaw and Palm Island, 30 per cent or more did not complete year 10.

In 2015, there were 26,548 persons in the NQPHN region (3.9 per cent) reported as ‘has need for assistance with core activities’. Of these, 2,389 were Indigenous Australian persons (approximately nine percent). Those with disabilities represent three per cent of the entire Indigenous Australian population of the NQPHN region.

[Identified need: Cultural determinants]

Key issue

A ‘social and cultural determinants’ approach recognises that there are many drivers of ill-health that lie outside the direct responsibility of the health sector and which therefore require a collaborative, inter-sectoral approach.

Description of evidence

For Aboriginal and Torres Strait Islander peoples there is an increasing body of evidence demonstrating that protection and promotion of traditional knowledge, family, culture, and kinship contribute to community cohesion and personal resilience. Current studies show that strong cultural links and practices improve outcomes across the social determinants of health.¹
Aboriginal and Torres Strait Islander people are identified as a separate priority population not only because of the universality of the disadvantage but also intransigence to improved outcomes reflected in other sectors of the community.

Recent research demonstrates that mental health is the leading cause of non-fatal burden of disease in the Indigenous population at 27 per cent. The largest contributions being from anxiety disorders and depression, and alcohol misuse. 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 Psychological Services (ATAPS).

The NQPHN region identified Aboriginal and Torres Strait Islander people as a group most in need of mental health services.

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6 Begg, S., et al., The burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people. 2014, Queensland Health: Brisbane.
Aboriginal and Torres Strait Islander peoples mental health and wellbeing

[ 4 ] Identified need:
Integrated social and emotional wellbeing responses for Aboriginal and Torres Strait Islander people across primary health care

Key issue

Aboriginal and Torres Strait Islander 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.

Key priorities identified by Aboriginal and Torres Strait Islander communities were for services to be embedded within a social and emotional wellbeing (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 wellbeing problems are seen as being distinct from mental illness. This is based on differences in severity, duration, and whether the presenting problems 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).

Description of evidence

In consultations with communities across the region, the following feedback was identified:

- integration of mental health and SEWB teams delivering evidence-based services in outer regional, rural, and remote communities to at-risk groups
- a need to expand access to integrated mental health and SEWB services to people living in rural and remote locations.

Ten per cent of the health gap between Indigenous and non-Indigenous Australians in 2003 has been linked to mental health conditions, and another four per cent of the gap is attributable to suicide.8

Identified need: Mental health, suicide prevention, and wellbeing—vulnerable groups

Overview

The region serviced through 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), and migrant/refugee) or as a consequence of social settings and circumstances (rural and remote, homeless, and detained populations).

In a survey of service providers in the NQPHN region, respondents identified people in rural and remote areas as the group most in need of mental health services.

Respondents to the online survey identified the following as top key features of the individuals and families accessing their services:

- Aboriginal and Torres Strait Islander people
- People with complex mental health and/or social needs
- People from disadvantaged socio-economic backgrounds
- Men and women
- People living in rural and remote areas
- People with disabilities (mental, physical, intellectual)
- Children and young people.
5.1 Prison populations on release—youth and adult

Key issue

Within the NQPHN region there are two adult correctional centres and one youth detention centre. Lotus Glen is situated in the Mareeba Hinterland with Stuart Creek and Cleveland both in Townsville.

All these facilities identify an over-representation of the Aboriginal and Torres Strait Islander population, and many of those incarcerated identify as homeless, mentally ill, intellectually disabled, and vulnerable upon return to community.

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 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.\(^9\)

Description of evidence

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.\(^10\)

Stakeholder consultations and responses to the online survey identified a significant need in relation to the engagement of released prisoners with primary care, which included follow up in remote communities. Queensland research demonstrates extremely elevated rates of mental health disorders in the incarcerated population\(^11,\,12\) and of psychotic disorders in the remote Aboriginal communities in Cape York.\(^13\)

5.2 Individuals and families living in rural and remote areas

Key issue

In rural and remote areas there is an identified lack of appropriate access to the spectrum of mental health services. Whist this issue was identified across the region, the Torres Strait was identified 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 wellbeing of rural people. Geographic isolation can also affect access to mental health services—the closest mental health service may be several hours’ drive away.


\(^10\) 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.


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.

Description of evidence

There are a range of rural communities within the NQPHN region with existing health facilities who identified an interest in looking at 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 region
- access to ATAPS services is not available in most rural and remote areas
- access to internet services can be challenging and very expensive in many rural and remote sites across the region.

5.3 Consideration to needs of children in out-of-home care

Key issue

Within the NQPHN region, children are in out-of-home care not only because of safety concerns. Northern Queensland has a high proportion of children in boarding school, of whom a significant number come from remote Indigenous communities. This is a population identified as confronting particular emotional challenges.

Description of evidence

Between 2009–2010 and 2013–14, intakes for child protection and Child Protection Orders in Queensland increased by 22 per cent and 11 per cent respectively. As the Carmody report demonstrates, over the decade to 2013, the number of children in out-of-home care in the state doubled, with the over-representation of Indigenous children in the Commissioner’s overview of particular note:

“...they are now five times more likely than their non-Indigenous counterparts to be notified, six times more likely to have harm substantiated and nine times more likely to be living in out-of-home care. More than 50 per cent of the Aboriginal and Torres Strait Islander children in the state are expected to have contact with the child protection system in 2012-13.”

5.4 Homelessness population

Key issue

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, culturally and linguistically diverse (CALD) populations, youth, and others.\(^\text{17}\)

Returning mental health services to the community also requires another consideration as the current process is creating homelessness through the process of transition.

Description of evidence

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, and 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.

5.5 Mental health of LGBTI people

Key issue

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 per cent of trans and 24.4 per cent of gay, lesbian, and bisexual Australians meeting the criteria for experiencing a major depressive episode in 2005, compared with 6.8 per cent of the general population.\(^\text{18}\)

Description of evidence

In a survey of service providers in the NQPHN region, respondents identified LGBTI people as a group in need of mental health services.


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 12 months, 41 per cent of homosexual/bisexual people had a mental disorder compared to 20 per cent of heterosexual people.”

5.6 Ageing population and mental health

Key issue

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 in the 2011 Census to be almost three 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.

Due to 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.

Description of evidence

In a survey of service providers in the NQPHN region, respondents identified older people as a group in need of mental health services.

Consistent with state and national trends, the evidence suggests that NQPHN will have a greater number of elderly in future years, assuming that elderly populations do not move to other locations outside of the region for retirement.

Further research, consultation, and analysis across the NQPHN region is required.
5.7 Culturally and linguistically diverse groups

Key issue

The needs assessment identified particular mental health service needs for the growing migrant and refugee communities across the region.

Access by the CALD community to mainstream mental health services is impacted by the lack of awareness and understanding of current services, and the lack of availability to services which 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.19

Description of evidence

In a survey of service providers in the NQPHN region, respondents identified culturally and linguistically diverse groups as in need of mental health services.

Within the NQPHN region, 89,913 persons (or 14 per cent) were born overseas, compared to 888,636 persons (or 20.5 per cent) across Queensland.

The majority of persons born overseas were born in English-speaking countries (England and New Zealand).

Within the region, Cairns LGA had the largest number of persons born overseas with 29,516, while the highest proportion of persons born overseas within the region was Cook Shire LGA with 23.1 per cent.

5.8 Links between substance abuse and mental health

Key issue

Stakeholder feedback focussed upon on the high level of mental health and alcohol and other drugs (AOD) co-morbidities experienced by the community.

These are often under diagnosed, under treated, and require targeted multi-disciplinary responses.

Description of evidence

Community consultations identified 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.

Thirty five per cent 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.

[ 6 ] Identified need:
Individuals with psychological distress (mild to moderate)

Key issue

Access to the full continuum of services has not always been possible due to services limitations and clinician availability in rural and remote areas.

This creates significant challenges in establishing appropriate, cost effective, and efficient services.

The region's urban areas have access to a greater range of services, though this still remains dependent upon locality to some extent.

Access to internet for e-mental health services is also limited due to the limited accessibility and high cost of internet access in rural and remote areas.

Description of evidence

In a survey of service providers in the NQPHN region, 64 per cent of respondents indicated that the mental health needs of the population in the region are being met 'somewhat'.

However some in-roads have already been made with the development of video conferencing hubs in Bamaga, Cooktown, Weipa, and Thursday Island.
[7] Identified need:
Inequitable access to treatment and support services for individuals with severe illness and complex needs

Key issue
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.

Access to most levels of the service pyramid are present in the three urban centres—other than the Supra Sate specialised services such as High Secure Forensic Mental Health, Specialised Eating Disorders Unit. Townsville does, however, host the medium secure mental health rehabilitation and the in-patient adolescent units for northern Queensland.

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 (PIR) program.

Description of evidence
In a survey of service providers and communities in the NQPHN region, 64 per cent 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:
- fifty nine per cent (n=406) of referrals were accepted
- mood disorders (43 per cent) and schizophrenia spectrum disorders (29 per cent) were the principal mental health diagnoses
- thirty per cent of patients accepted by PIR were involuntary patients at some time during their engagement
- fifty six per cent of accepted patients were aged 35–54 years of age
- twenty seven per cent identified as being of Aboriginal and/or Torres Strait Islander origin.
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
- emergency department (ED) presentations for mental health issues constitute 3.7 per cent of all ED presentations
- three per cent of all in patient care was for primary diagnosis mental health disorder
- consumer transfers for hanging, overdose, self-harm, or psychiatric episodes accounted for three per cent of all transfers to hospitals and as high as five per cent for the Cairns region (Health 2015a)
- 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 1,005
- mental health-related inpatient separations across NQPHN are forecast to increase from 5,595 in FY2013-14 to 8,002 in FY 2026-27, if current trends continue.
Identified need:
Limited access to perinatal and infant mental health in primary health care

Key issue

Within the NQPHN region there are no dedicated mother and 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 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 zero to three years) predict internalising and externalising psychiatric disorders at five years of age (Keenan et al 1998). When left untreated, up to 50 per cent of these problems escalate throughout childhood and result in poorer outcomes emotionally, socially and scholastically (Bayer et al 2009).

Description of evidence

In a survey of service providers in the NQPHN region, respondents identified women 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.

This figure does not include antenatal mental health problems, mental health problems other than postnatal depression (such as postpartum psychosis), or postpartum issues in the context of pre-existing mental illness. In line with other developed countries, the prevalence rate for clinically significant maternal perinatal mental health issues in Queensland is around 15 per cent.

There is a disconnect between the prevalence of maternal perinatal mental health problems and the number of women receiving appropriate treatment. Nearly 10,000 Queensland women require primary care for perinatal mental health issues, nearly 3,000 require specialist psychiatric treatment, and over 200 require hospitalisation each year. 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.


Northern Queensland has a greater percentage of infants and children (0-14 years) than the state, and a smaller proportion of people over 60 years old.

Of critical importance for this region is that the Indigenous population is significantly younger than the non-Indigenous population, with a youth dependency ratio (i.e. the number of 0-14 year olds per the working-age population) that is approximately twice that for non-Indigenous Australians. This has significant consequences for social stressors (as well as for service delivery) within these contexts.

[9] Identified need: Mental health services, suicide prevention, and wellbeing services for children and young people

Key issue

In the needs assessment, services that address the specific needs of children and young people were identified as a need in the NQPHN region. Also the need for creative ways through social media of engaging young people to utilise the services that are available.

Mental health problems can have a significantly adverse impact on children, adolescents, parents, and families, particularly in relation to quality of life. It is therefore important that interventions provide broadly based help for the parents and families of young people with problems as well as for the young people themselves.

Population general health clinical needs are greatest in early life (childhood communicable diseases and developmental disorders), and with advancing age past mid-adulthood (chronic, degenerative, and neoplastic diseases).

Population mental health clinical needs rise rapidly from adolescence, peaking in young to middle adulthood, and falling in older age.

Most of the significant mental health disorders have their onset or prodrome in childhood and young adulthood (psychotic, anxiety, affective, and substance use disorders), which also applies to key later-life physical conditions (cardiovascular, metabolic, and smoking-related respiratory disorders). There are important synergies in the lifestyle approaches (diet, exercise, and stress management), and the opportunities for general health and mental health early detection and intervention are greatest in childhood in which the key social ‘agencies’ are family, school, and primary health care services.

The same applies in relation to prevention. The greatest opportunity for effective and efficient preventive interventions—for both mental and physical disorders—is at the beginning of life, focusing on the physical, family, and social contexts of the perinatal period. This is equally important for later life chronic diseases (metabolic and cardiovascular) and mental health conditions (anxiety disorders, attachment disorders, and substance use disorders). This is the arena in which primary care providers—through maternal-child services—have privileged opportunities.
Description of evidence

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 years old.

In a survey of service providers in the NQPHN region, respondents identified young people as a group most in need of mental health services.

In FY 2015 there were 12,144 occasions of service at headspace centres in the NQPHN region (43 per cent at the Cairns centre, 37.5 per cent at the Townsville centre, and 19.5 per cent at the Mackay centre). Seventy three per cent of these were for mental health. 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.

The point prevalence of eating disorders in Australia is estimated at around four per cent—with binge eating disorder constituting approximately half, bulimia nervosa around 12 per cent, and anorexia nervosa three per cent of those affected—with the remaining third being other eating disorders. Australian population surveys have demonstrated that these disorders are increasing.\textsuperscript{22} Data from the Institute for Health Metrics and Evaluation demonstrate that these conditions constitute 0.19 per cent of total disability adjusted life years (DALYs) for Australia and 0.34 per cent of years lived with disability (YLD), these proportions increasing respectively by 0.45 per cent and 0.48 per cent annually. For those Australians aged 15 to 49, eating disorders make up 0.55 per cent and 0.73 per cent of DALYs and YLD, which are increasing at 0.77 per cent and 0.82 per cent respectively.

Eating disorders show high levels of comorbidity, particularly with anxiety and depression. Some two thirds of those with eating disorders are female with rates for males and females closer in childhood, with an increasing prevalence for boys and men generally being higher than females. Eating disorders are associated with increased mortality and, while rare, for anorexia nervosa this is by more than a factor of five, with one in five of those dying doing so by suicide.\textsuperscript{23} While it has been long thought that Indigenous Australians are, relatively, protected, this does not appear to be the case from the limited data available.\textsuperscript{24}

In most of the region there is a lack of appropriate inpatient facilities for adolescents, and their care is often in the children’s ward with a lack of staff with skills in mental health.

The RANZCP clinical practice guidelines for the treatment of eating disorders\textsuperscript{25} recommend a collaborative approach to address psychological and physical needs, consistent with a stepped care model, drawing on a range of psychotherapeutic interventions from on-line and non-specialist mediated approaches, to evidence based, specialist-led psychological therapies with or without adjunctive pharmacological treatments. A small proportion of those, particularly with anorexia nervosa, will require hospital admission with joint medical/paediatric and psychiatric input in regional hospitals, and a very small proportion will require longer-term admissions in specialist units that, at the moment, are restricted to capital cities.


Identified need: Military and ex-military

Key issue

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. 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.

Description of evidence

Queensland has the highest proportion of the national population of veterans receiving treatment for males, and the second highest proportion for females—and has, relatively, a 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 the veteran population. An important role of stress and disturbances in the mechanisms modulating allostatic load have been reviewed specifically in relation to veterans. Further research, consultation, and analysis across the NQPHN region is required.

Identified need: Higher than average incidence of suicide

Key issue

Within the NQPHN region, higher rates of suicide and self-harm are reported. Whilst 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. Some mental disorders do confer significant risk of completed suicide, including major depression, bipolar disorder, and schizophrenia, with that risk amplified by comorbid substance misuse. The agreed approach to conceptualising the spectrum of activities related to suicide prevention and response nationally is the LIFE framework.

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27 Australian Institute for Suicide Research and Prevention, Suicidal behaviour and ideation among military personnel: Australian and international trends Summary report prepared for the Department of Veterans' Affairs. 2015, Australian Institute for Suicide Research and Prevention: Brisbane.
28 Dunt, D., Independent study into suicide in the ex-service community. 2009, Department of Veterans' Affairs: Canberra.
A coordinated strategy balances investment across the three broad areas of prevention, intervention and continuing care.

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 is a process building on experience and understanding of local circumstances and capacity. It also recognises the experience and knowledge of people with lived experience within the planning process.

Description of evidence

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 per cent) were male, and 49 of 321 (15 per cent) for whom Indigenous status was identified as of Aboriginal and/or Torres Strait Islander heritage. Of these deaths 122 (37 per cent) occurred within the Cairns and Hinterland HHS, 98 (30 per cent) within Townsville HHS, 89 (27 per cent) within Mackay HHS, and 16 or 17 (five per cent) within Torres and Cape HHS (two or three 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). 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.29

Consistent with these higher rates of mental disorder in the Indigenous population30, suicide rates are higher in Queensland’s Indigenous population31, with Indigenous Queenslanders less likely to have had previous contact with the mental health system32, more likely to have a history of substance abuse, and to have verbally communicated intent.33

For the period 2000 to 2010, suicides of Indigenous children aged five to 14 years were over 12 times higher than other children, accounting for 46 per cent 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.34

Consumer transfers for hanging, overdose, self-harm or psychiatric episodes accounted for three per cent of all transfers to hospitals and as high as five per cent for the Cairns region as the receiving hospital. Furthermore, 51 per cent 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).

29 De Leo, D., J. Sveticic, and E.-K. Kumpula, Suicide in Queensland, 2008-2010: Mortality rates and related data. 2013, Australian Institute for Suicide Research and Prevention: Brisbane
30 Begg, S., et al., The burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people. 2014, Queensland Health: Brisbane.
Identified need:
Workforce shortages in the primary health care sector

Key issue

The NQPHN region has the largest remote, rural and regional workforce in the state. The needs assessment identified:

- maldistribution of the workforce resulting in workforce shortages in rural and remote areas
- potential future shortfalls in mental health nurses, psychiatrists, key allied health professionals, and need for task shifting and building a local workforce
- shortfall 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
- limited organisational structures to ensure staff receive adequate supervision, support, and professional development
- ongoing gap in cultural capability of primary health care workforce to support people with mental health and AOD issues
- limited primary health care workforce capacity and training to appropriately screen, assess, support, and refer people experiencing mental health and AOD issues.

Consultation feedback also identified the challenges of project based and short-term employment that was occurring due to funding arrangements. This particularly had a great effect on the employment in rural and remote areas.

Description of evidence

The average age of medical practitioners working in remote rural and regional Queensland is 49.4 years old. Thirty nine per cent of this workforce is female, although in very remote communities female practitioners represented only 28 per cent.

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 per cent of the workforce were trained in Australia.

Less than four per cent of practitioners were working in solo practices and 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.35

National data36 indicates the following key characteristics regarding the mental health workforce:

- a low proportion of mental health professional working in rural and remote areas
- an ageing workforce particularly in the disciplines of psychiatry, mental health nursing and Indigenous health workers
- the mental health nurse workforce is predicted to be in significant shortage by 2025, by nearly 8000 workers or nearly 36 per cent of total projected demand.

[13] Identified need:
Insufficient monitoring and evaluation systems and processes

Key issue

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 region. Relationships, partnerships, and collaborative arrangements are being established across the NQPHN region. As these further develop, systems will improve.

Description of evidence

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.
Outcomes of the service needs analysis
[1] Identified need:
Stronger integration and coordination between services and sectors across the whole region

Key issue

Fragmented service systems, including a lack of understanding of mental health within local areas, results in poor coordination of care.

Service planning and coordination needs to include the full range of support responses from self-help, prevention, and 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 Northern Queensland Primary Health Network (NQPHN) commissioning, these are an integral part of community supports and systemic advocacy.

Referral and other system-wide administrative processes are complex and time-consuming, acting as barriers to access.

Description of evidence

Feedback from stakeholder and 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, and 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
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.

• consistency in practices and approaches to mental health is needed as a person receiving support from multiple services can sometimes find the conflicting information they are receiving very challenging
• 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
• a need for localised service mapping identified in many communities and better communication of services
• the bureaucracy surrounding the Access to Allied Psychology Services limits access and flexibility.
Identified need:
Increase availability of services for mild to moderate mental illness through Aboriginal community controlled and primary health care sectors with focus on social and emotional wellbeing and healing

Key issue
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.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:
- social and emotional wellbeing is a better way of communicating, mental health is seen as labelling—social determinants and wellbeing models need to be addressed overall in programs
- culturally inappropriate services, particularly in rural communities where choice of provider is limited
- a need for culturally grounded service frameworks (e.g. social and emotional wellbeing activities including using music, performance, and creative therapies)
- a need for financial counselling (budgeting is a major issue and leads to conflict and stress)
- in a survey of service providers in the NQPHN region, 76 per cent of respondents identified Aboriginal and Torres Islander people as a group most in need of mental health services.

Analysis of local service planning reports and initial service mapping activities highlighted:
- Aboriginal and Torres Strait Islander people in Far North Queensland 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
- strengthen pathways for individual and community healing
- culturally insensitive communication by some services creates tension—some services lack understanding about Aboriginal and Torres Strait Islander cultural and healing practices. Need to implement education to strengthen the cultural competence of government and non-government organisations.

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.
Identified need: Improve mental health system access

Key issue

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.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:
- 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
- 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
- living in a rural or remote community provides limited choice of provider
- accessibility is also limited by the lack of culturally competent services and communities can distrust services and service provision.

Analysis of local service planning reports and initial service mapping activities highlighted:
- web-based mental health resources need to account for culturally/age appropriate content and usability, 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 mental health literacy. However, web-based mental health resources were identified as a good way of engaging young people. In some rural areas though, high usage of telehealth was identified as an issue
- need to expand options re phone supports to improve the continuity for young people—has to be no cost to callers (including from mobiles), no call-backs (by then, moment has passed)
- need for technology in mental health services to increase service access and availability and yet support required for providers to utilise telehealth and web-based mental health resources
- across the lesser populated rural and remote areas, there are very limited mental health or other social support services.
[4] Identified need: Improve access to affordable primary mental healthcare in rural and remote areas

Key issue

There is limited availability and accessibility of affordable mental health services in rural and remote areas. Access to mental health professionals 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.

Description of evidence

Feedback from stakeholder and 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 improved 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 mental health, and allied health practitioners providing telehealth
- difficult to attract and retain staff (psychologists, GPs, youth workers etc.) and expensive to get practitioners to outreach
- target groups noted as youth, children with parents with mental health 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 as well as 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:

- in the lesser populated towns and more remote areas, there are very limited to no private psychologists
- the regularity of primary mental health and Queensland Health mental health outreach visits to rural and remote areas is unknown as feedback indicated that scheduled visits did not always occur due a range of reasons.
Identified need:
Early intervention and prevention services for individuals and families at risk

Key issue
Limited early intervention and prevention services across the region.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:
- respondents to the online survey identified early intervention services are most required to meet the needs of people who are missing out on services
- inadequate resources for early intervention
- social services are increasingly required to provide mental health support in rural areas as there is an absence of specialised mental health services
- need to refocus resources on early intervention services for children in out-of-home care (do not meet criteria for Child and Youth Mental Health Services [CYMHS]), families, children and young people, programs supporting culturally strong parenting
- need for expanding school-based mental health literacy, and early intervention and prevention
- Mental Health First Aid (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 Mackay
- 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.
Identified need:
Increased access to the range of mental health and wellbeing services for Torres Strait Islander people

Key issue

Within the Torres Strait there are very limited mental health and wellbeing services, particularly on the outer islands.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:
- lack of services to support people living in the Torres Strait with mental health needs and 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:
- limited understanding of approaches to promote mental health and wellbeing by some service providers
- men have little opportunity for healing, need healing programs and 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.

The service mapping indicates that there is only 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.
[ 7 ] Identified need: Increased services for mild to moderate mental illness

Key issue

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. Travel costs as well as providers willing to provide the services are the biggest barriers.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:

• it is a widely noted issue that there are gaps in services addressing mild to moderate needs for youth and adults (including for older people), and this can be a particular issue within rural, remote, and remote Indigenous areas. Mild conditions are not getting the adequate attention and treatment in a timely manner that would likely prevent escalation
• the mental health needs of the culturally and linguistically diverse (CALD) population also need to be addressed which was a particular concern for communities within the Townsville Hospital and Health Service (HHS) area
• there is no systematic support for non-crisis mental health needs in remote Indigenous communities—non-crisis mental health needs can be hidden within families until acute episodes occur.

Feedback from peak state-wide agencies, local experts, and NQPHN Clinical Councils identified:

• feedback highlighted 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 and remote areas. There are some non-government organisations (NGOs) providing counselling services in the more populated rural areas, but no such services are apparent in the more remote and lesser populated areas.
[ 8 ] Identified need:
Increased treatment and support for people with severe mental illness and complex needs

Key issue
Lack of treatment and support services for people with severe mental illness and complex needs across the region, including in rural areas.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:
- key issue noted across all settings within the region is remote Indigenous, rural and remote, and urban
- Queensland Health (adult, and child and youth) services at capacity and inaccessible, treatment of complex cases hampered by ATAPS’ six session limit, no coordination of care for complex clients, undersupply of crisis intervention, lack of services addressing dual diagnosis, and co-morbidity (including intellectual disability)
- lack of services in rural areas—GPs often not engaged in the care of people suffering from acute psychotic episodes. Explore role of Mental Health Nurse Incentive Program (MHNIP) to support and coordinate care
- insufficient understanding of the need for trauma-focused care
- need increased access to appropriate services at times of critical need, innovative support services and mechanisms for people with complex needs that are disengaged from the service system, increased support for recovery and follow up.

Analysis of local service planning reports and initial service mapping activities:
- there is a need for greater community support for recovery—rural areas in particular struggle with the management of acute psychotic episodes
- the Townsville and Mackay region does not have access to a Partners in Recovery program.
Identified need:
Increase mental health support for children and young people

Key issue

Limited services for children and young people across the spectrum of intervention. This is wide ranging from limited numbers of youth workers, limited outreach by youth agencies such as headspace, very limited respite residential options or supported accommodation for young people with mental health issues and only one six-bed specialised child and adolescent mental health unit in the NQPHN region.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:
- in a survey of service providers in the NQPHN region, 80 per cent of respondents identified youth as a group most in need of improved mental health services
- increasingly complex presentations, increasingly risky behaviours, and self-harming
- bullying can be rife in some areas
- employment is a key issue and most trouble occurs when young people are disengaged from school, family etc.
- issue with ongoing access for those needing more than ten Better Access sessions
- CYMHS reported as being at capacity, inadequate, inaccessible, and criteria too limited
- the accessibility and suitability of existing headspace model for Aboriginal and Torres Strait Islander young people was questioned
- lack of services for young people with complex psycho-social vulnerabilities (particularly LGBTIQ young people and young people from Aboriginal and Torres Strait Islander backgrounds)
- in rural, remote, and remote Indigenous areas there can be limited services for youth—limited referral options and no intermediary services between CYMHS and school based counsellors
- need for youth specific mental health services that are flexible and place based, located in youth friendly services where young people access, out of hours supports, supports for youth post-release, suicide and self-harm prevention/minimisation (including eating disorders), school-based services targeting early intervention/at risk (primary and secondary), secure youth mental health facility in the Cairns region (there is also no facility in Mackay), safe youth gathering spaces, supports for traumatised youth, case management supports, and culturally appropriate approaches
- guidance officers working in rural and regional areas often working across schools and feeling overwhelmed by demands and risk level.
Identified need: Increased access to after-hours services

Key issue

Within the NQPHN region there are limited after-hours supports in relation to mental health (other than emergency departments). This is particularly relevant in rural and remote areas, where there is evidence of people being forced to drive long distances from rural areas to regional centres with young people in crisis after hours, as they were not accepted at emergency departments in small towns.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:

- need for out of hours regular services noted in some locations across the region to take the pressure off emergency departments
- with increasing drug related problems and growing mental health burden, hospital staff are increasingly wary of mental health related work.

Analysis of local service planning reports and initial service mapping activities:

- there are limited after-hours street services in Cairns, and none identified in the other regional centres, nor the rural and remote areas.
[11] Identified need: 
Ensure effective carer supports are in place

Key issue

Across the region the support services for carers varied depending on the NGO services available.

Description of evidence

Feedback from stakeholder and 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.

[12] Identified need: 
Suicide prevention programs and suicide prevention response protocols in rural areas

Key issue

Lack of suicide prevention programs and services across the region.

Description of evidence

Feedback from stakeholder and 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, 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, have holistic programs of early intervention and prevention (including within schools), appropriate intervention, and post-vention
- our large Aboriginal and Torres Strait Islander populations have suicide specific needs
Identified need:
Stronger support with transitions from prison and rehab back into communities

Key issue
There are no systematic linkages to primary care or other services for prisoners or those exiting rehab returning to communities.

Description of evidence

Feedback from stakeholder and 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
• stakeholder feedback also identified the lack of diversionary programs for young people as an alternative to detention
• problems widely noted with people being released from prison 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 state-wide agencies, local experts and NQPHN Clinical Councils identified:
• Queensland Aboriginal Islander Health Council (QAIHC) identified this as a significant service gap.

Analysis of local service planning reports and initial service mapping activities:
• very limited suicide prevention activities, especially in rural and remote areas.

Service enhancements

• youth, the elderly and drought affected farming communities are also at risk groups
• sometimes delays between seeing GP and psychologist receiving referral
• lack of knowledge regarding developing suicide prevention plans
• suicide prevention needs a regional approach, need for good community protocols around suicide within Aboriginal and Torres Strait Islander communities, need for hospital and primary care staff training in suicide risk assessment and screening for social and emotional wellbeing issues, and culturally appropriate responses.
[14] Identified need:
Increased family support services

Key issue

Families of people with mental health issues provide significant support as carers, and require support themselves. There is a need to increase flexible programs to address the mental health and support needs of families.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:

• current headspace funding does not include provision for family support and Better Access does not always accommodate family therapy
• high rates of children in out-of-home care, and there is lack of support for postnatal and perinatal mental health
• need for parenting programs, family support, family therapy, early childhood services (Torres Strait), need 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).

[15] Identified need:
Mental health promotion

Key issue

Stigma is a key issue impacting access.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:

• address mental health stigma and improve mental health literacy
• need to refocus resources on mental health promotion and early intervention
• need investment in community development and community hubs to prevent social isolation and mental health issues, and as soft entry point to the mental health system
• lack of community education around mental health and wellbeing for communities
• education information needs to be culturally accessible and appropriate.
Identified need: Increase the capacity of GPs to identify and support people with mental health issues

Key issue

GPs are most often the first contact point for people experiencing mental health issues, as it is the closest and easiest form of care available, located near to peoples’ homes and communities. Therefore, GPs need to be supported to have the necessary skills and practice capacity to identify and support people with mental health issues.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:

- the training and support needs to be increased to GPs particularly around mental health screening and assessment, understanding of referral options and pathways, program guidelines such as ATAPS, and mental health care plans
- need for MHNIPs in more GP practices across the region
- need for upskilling GPs in suicide risk assessment and developing a collaborative management plan.

Feedback from peak state-wide agencies, local experts, and NQPHN Clinical Councils identified key reasons for ensuring GPs have capacity to identify and support people with mental health issues include:

- ensures that the population as a whole has access to the mental health care that they need early in the course of disorders and without disruption
- 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.

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 Torres and Cape).³³

Identified need:
Develop and support the primary health care mental health workforce

Key issue
Potential future shortfalls in mental health nurses, psychiatrists, and key allied health professionals. There is a need for task shifting and building a local workforce and alternative service models due to the ageing workforce and low proportion of mental health professionals working in rural and remote areas.

Description of evidence
Feedback from stakeholder and community consultations, and online survey identified the following training priorities:

• screening and assessment
• substance use and dual diagnosis
• trauma therapy
• suicide prevention and better understanding
• utilising Aboriginal and Torres Strait Islander mental health workers
• utilising peer workers and consumer focused care
• how to work in a recovery oriented framework
• culturally appropriate techniques, resources, and approaches
• supporting individuals with complex mental health needs.

Feedback from peak state-wide agencies, local experts, and NQPHN Clinical Councils identified:

• national and state data indicating shortfalls in mental health nurses, psychiatrists, and Aboriginal and Torres Strait Islander mental health workers.

Analysis of local service planning reports and initial service mapping activities:

• attraction and retention of mental health professionals to Mackay and other regional areas is a key issue and impacts on continuity of services

• very limited investment in peer support activities across the region.

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38 Mackay Regional Mental Health Network, Identified Gaps in Services across the Mackay Region.
Identified need:
Increase the capacity of the primary healthcare workforce and other workers in education, emergency, and welfare sector to support people with mental health issues

Key issue

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 and 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 GPs and mental health professionals.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:

- need to build the capacity of primary health care workers to support people with mental health issues
- 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
- need to provide training in screening and assessment, and brief intervention
- Certificate IV in Mental Health to be available for all primary health care staff.

Feedback from peak state-wide agencies, local experts, and NQPHN Clinical Councils identified:

- 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 welfare, community, and education sectors and the growing peer workforce was identified by the National Mental Health Commissions.\(^{19}\)

Analysis of local service planning reports and initial service mapping activities:

- initial mapping on upskilling needs indicated that a suite of training was occurring, though there continued to be a need for more to meet changing needs, stay updated, and address staff turnover.

\(^{19}\) Fact Sheet 12 – What this means for workforce and research capacity.
[19] Identified need:
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

Key issue

Difficulties with retention of staff which impacts on continuity of care and provision of services, was identified as a key service issue. There is a need for strategies to retain workers in the 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
- organisational 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
- development of clearly defined roles and professional boundaries
- strategies to address a shortfall of Aboriginal and Torres Strait Islander workers.

Description of evidence

Feedback from stakeholder and 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 state-wide agencies, local experts, and NQPHN Clinical Councils identified:

- the Indigenous Doctors Association report that causes of staff turnover from Aboriginal and Torres Strait Islander staff are feelings of isolation, high workloads, and lack of cultural capability
- the need to ensure primary health care workers are supported by a mental health specialist was identified by Human Capital Alliance in their report to the National Mental Health Commission.

Identified need: 
Support and expand appropriate services for Aboriginal and Torres Strait Islander people

Key issue

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 mental health workforce is the need to ensure staff are suitably trained and supported.

Description of evidence

Feedback from stakeholder and community consultations, and online survey identified:

- 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
- 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.

Feedback from peak state-wide agencies, local experts, and NQPHN Clinical Councils identified:

- the need for more Aboriginal and Torres Strait Islander mental health workers (identified by National Mental Health Commission and by QAIHC)
- QAIHC also identified the need for formalised training and career pathways.
Identified need:
Need for primary health care organisations to develop and implement structures, policies, and programs that build cultural capability of workforce

Key issue
Many mainstream primary health care organisations need to strengthen the cultural competence of their mental health and social and emotional wellbeing services.

Description of evidence
Feedback from stakeholder and community consultations, and online survey identified:
• need for more Aboriginal and Torres Strait Islander workers in mental health
• need to move the workforce along the continuum from Aboriginal and Torres Strait Islander cultural awareness, to cultural sensitivity, and ultimately to cultural safety.
Moving forward

Service evaluation and quality improvement are an integral component of the Northern Queensland Primary Health Network (NQPHN) commissioning cycle. NQPHN will be using all of the information within this document to inform the commissioning of services to meet the highlighted needs of North Queensland communities.

Following implementation of these new service models, further consultation will be undertaken with communities to ensure that the intended outcomes of these initiatives are being met.

Thank you to all individuals and services who contributed to the preparation of this document. NQPHN looks forward to further engagement with the people of North Queensland to improve the primary health outcomes of our region.