Australian Government
Department of Health

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2017-18 MENTAL HEALTH NEEDS ASSESSMENT

CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST PHN

Section 1 – Narrative

The *2017-18 Mental Health Needs Assessment* builds on several sources of information, including:

- The *2015-16 Baseline Needs Assessment* for Central Queensland, Wide Bay, Sunshine Coast PHN, which included extensive community consultations. It was first undertaken in 2015 and reviewed last year.
- Work undertaken under the National Mental Health Service Planning Framework (NMHSPF), for which our PHN was one of the pilot sites.
- Extensive analysis of new data sources available for this exercise, including Queensland Health and Australian Institute of Health and Welfare (AIHW) data on alcohol and other drug (AoD) services delivered across the PHN.
- Consumer journey mapping workshops undertaken in each of the three regional areas in September/October 2017
- Stakeholder and consumer surveys undertaken in early 2017
- Regular feedback received from providers and key stakeholders during our regular Community and Clinical Council meetings and/or in the context of our regional collaboratives.

While drawing on the NMHSPF and the new data available, we used this opportunity to structure the *2017-18 Mental Health Needs Assessment* along the following lines:

- As in the previous needs assessment, we used national evidence to provide context, but wherever possible we have aimed at providing more localised evidence as required to inform strategic and operational plans.
- With the long-term view of informing planning, monitoring and evaluation activities, we have identified key indicators for which we can start assessing trends based on available data. They include, for example, the MBS GP mental health indicators as well as the AoD indicators flagged in the national PHN Performance Framework.
- Specifically for mental health and suicide prevention, we have drawn on the structure and content of the NMHSPF to present available evidence on health needs and gaps. This allows us to better exploit the richness of the NMHSPF and effectively use it as the foundation for our needs assessment and strategic planning for effective implementation of the stepped care model.
- Within the limitations of the current data and in the absence of an AoD framework to be applied, we tried to replicate the NMHSPF structure for presenting the AoD information. So, for example, we have tried to consistently use LGA as the unit of analysis for measuring service levels, since this is the recommended service planning unit for our PHN in the NMHSPF. We have also streamlined our information on social determinants and focused on securing and examining data on AoD services.

We examined a range of quantitative indicators related to determinants of health, health status, service delivery and health system performance. In the ***2017-18 Mental Health Needs Assessment***, we have emphasised service indicators to better capture unmet need. This includes a more detailed analysis of commissioned services data with a view to understand how these services align with patterns of unmet need across the PHN.

Taking into account the paucity of local suicide data, we have analysed emergency department presentations data to unpack at least some trends in regards to suicide attempts and suicide ideation. We undertook a similar approach for AoD, where emergency department data can help to better gauge the levels, trend and distribution of AoD related harm across communities. We also included a detailed analysis of AoD service data that our PHN secured from Queensland Health and the AIHW, which provides us with a better understanding of levels and trends in AoD services in our region .

The *2015-16 Baseline Needs Assessment* involved the (then) newly established Clinical Councils and Community Advisory Councils as critical stakeholders in the process. Processes were developed with

consideration to the potential burden on stakeholders (in some cases the same key people) involved in participating in multiple and overlapping needs assessment and planning activities.

For the *2015-16 Baseline Needs Assessment*, the draft document was presented to each of the six PHN Councils (three Clinical Councils and three Community Advisory Councils). For the *2017-18 Mental Health Needs Assessment*, timelines and the strict confidentiality imposed on the NMHSPF report prevented us from doing so. We opted instead for a stakeholder survey that included Council Members in the sample and which captured their views in regards to health needs, services and system performance issues in the region.

We have also included feedback that Council members as well as other members of the Mental Health, Alcohol and other Drug Regional Collaborative have provided over the year, particularly around health system issues and current priorities. Their feedback has helped us validate findings from the quantitative analysis and provided us with rich information to tease out local issues, which have been duly incorporated in this report.

Since its inception, the PHN has placed paramount importance on the proactive engagement of clients and carers. To inform this report and our joint regional plans, we undertook consumer journey mapping workshops across each regional area in the PHN. These workshops, led by Health Consumers Queensland in September 2017, captured the experiences of clients across the PHN, which have been incorporated in the current document.

Additional Data Needs and Gaps

In compiling whole-of-region, mental health, suicide prevention, drug and alcohol treatment needs assessments, difficulties in sourcing workforce data and information at the local level were pervasive. There were also important gaps, particularly for AoD and suicide prevention.

For AoD, we have no access to local data on drug use prevalence and are reluctant to rely on national or state data. The PHN shows patterns of alcohol use very different to national and state trends, so this is likely to be the case for drug use prevalence.

Detailed data on the type of AoD services delivered and key client demographic characteristics could only be secured through the AIHW in mid-October 2017. However, when triangulating these data and those provided by Queensland Health, there were serious discrepancies for key demographic groups, such as Aboriginal and Torres Strait Islander populations. Since the AIHW data were provided as cross-tabulation tables, we were unable to examine the source of the discrepancy and effectively cross-validate the data. Therefore for this report, we have relied primarily on the AoD data provided by Queensland Health and have only used the AIHW data when patterns did not conflict with our primary data source.

For suicide prevention, data are not available for recent years at local level. This is partly due to confidentiality, and small numbers when looking at LGA level data. Although we utilised available data on emergency department presentations and hospitalisations, critical information for better targeting of services, such as key characteristics of clients, are not available.

As previously noted, we have used standard methods to allocate service levels to LGAs and have aimed at utilising available data. However it would seem sensible that PHNs are able to access deidentified data with detailed information on key demographic characteristic of clients to better understand who is receiving which services and where. This would help address some important evidence gaps such as those related to geographical variability as well as youth and Aboriginal and Torres Strait Islander populations.

In relation to data available on the PHN website, the availability of the portal is certainly helpful and we have mined the available data extensively for this report. However, key datasets such as those related to MBS items are provided at SA3 level, which does not align well with population units for planning (LGAs for our PHN).

We have used standard statistical correspondences for matching SA3 to LGAs (as in the NMHSPF report) and it is well known that they rely on specific assumptions about population distributions that might distort some of our estimates of service distributions. We have attempted to ameliorate these problems through discussions with key stakeholders and insights from the field. Nevertheless, it might be useful in the future to discuss other mechanisms through which PHNs can have access to deidentified data or estimates are produced at the LGA level and for key population groups.

The Executive Leadership Team for the PHN agreed that a restructure of the *2015-16 Baseline Needs Assessment* was required to systematically incorporate findings from the NMHSPF and to provide more detailed analysis to inform the regional plan and strategy development.

We are aware of and understand the strengths and limitations of planning tools such as the NMHSPF, so we have used this information along with other data sources and our knowledge of how the system operates on the ground to provide the best available estimates.

We see strong added value in using the NMHSPF to quantify need and estimate service gaps (i.e. unmet need). This has allowed us to effectively use the NMHSPF to gauge the relative needs of our populations and establish sensible population targets to inform our annual activities and reporting.

Given that the NMHSPF has considerably strengthened and sharpened the focus of this report, our PHN strongly supports its use as the planning framework for mental health.

For suicide prevention, we have used our analysis of suicide rates, hospital admissions and emergency department presentations as included in this report to gauge the relative needs across our LGAs, identify priority groups and establish some broad service targets.

On the above grounds, we would also suggest that a similar framework for AoD – perhaps building on the *Drug and Alcohol Service Planning Model for Australia* – is used for AoD services. This will help us prioritise which services to be delivered to whom and where.

Additionally, we would like to stress that having access to Queensland Health ATODS data was an important step for us to understand recent trends in ATODS services in our region, including the rapid growth of NGO services. Whenever possible, we tried to complement this rich information with that recently provided by the AIHW to our PHN. However, as noted earlier, serious discrepancies in the data prevented us from examining more closely the type of services delivered to key demographic groups.

We hope that in the near future, we are able to have access to full deidentified datasets for AoD. This would allow us to provide the level of detailed analysis required to effectively inform our strategic planning, monitoring and evaluation activities for the sector.

MENTAL HEALTH and SUICIDE PREVENTION

Section 2 – Outcomes of the health needs analysis

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Relatively higher health needs for populations affected by socio-economic disadvantage	The National Mental Health Service Planning Framework (NMHSPF) estimates mental health needs and demand for services based on the average prevalence of mental illness within the Australian population. Selected socio-economic indicators associated with mental illness help us identify those locations within the PHN where relative need of mental services is likely to be higher than predicted by the NMHSPF	**Socio-economic indicators** The *Australian Burden of Disease Study* 2011 study shows a steep socio-economic gradient for mental health. The burden of disease of mental health for the bottom quintile is two times the burden in the highest quintile. When compared to Queensland, the PHN shows higher levels of socio economic disadvantage (i.e. 28% in the bottom Socio-Economic Indexes for Areas (SEIFA) quintile, vs. 20% in Queensland; and annual family income of $62,936 vs. $75,556 in Queensland -2011 data). In the PHN, the population of all the LGAs in Wide Bay as well as Gympie (in Sunshine Coast) and Woorabinda (in Central Queensland) show high levels of socio-economic disadvantage as measured by annual family median income and the SEIFA quintile. Similarly, unemployment rates (as per December 2016) are highest in Wide Bay (9.8%) vs. 6.5% in the PHN and 6.1% in Queensland. However, Gympie also has unemployment rates over 9%. **Geographical location** Populations in rural and remote areas suffer from low access to health services as well as socio-economic disadvantage and high levels of risk factors and chronic diseases. Across the PHN half of all the LGAs in Central Queensland (Banana, Central Highlands and Woorabinda) and one LGA in Wide Bay (North Burnett) have all of their populations living in outer-regional/remote areas. **Aboriginal and Torres Strait Islander** For the Aboriginal and Torres Strait Islander population, the burden of disease related to mental health is 2.4 times the burden of non-Indigenous Australians. The PHN is home to one discrete Aboriginal

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		community, Woorabinda, while over 6% of the population in Rockhampton and North Burnett are identified as Aboriginal and Torres Strait Islander.
Relatively higher health needs as identified by higher rates of morbidity associated with mental health	The relatively higher burden of mental health disorders observed across the PHN also helps identifying locations with higher-than-average mental health needs.	In line with the above socio-economic disadvantage, two of the three LGAs in Wide Bay (Bundaberg and Fraser Coast) as well as Gympie in the Sunshine Coast show the highest rates of mental/behavioural problems (2014-15) and high/very high psychological distress (2011-12) across the PHN.
Estimates of prevalence and treatment for the overall PHN population (2021) Identifying population in need of mental health services	Drawing on the prevalence of mental illness within the Australian population, the NMHSPF estimated the numbers of people in the PHN catchment that require mental health treatment services. NMHSPF estimates along with other available information serve to gauge the broad patterns of need for mental health treatment across different age groups and severity. Understanding these patterns is crucial for planning the delivery of services across the stepped care model. This information along with the relative differences in need noted above help us prioritise those areas, population groups and services with the highest unmet need.	NMHSPF estimates along with other available information suggests that across the PHN catchment, 16.7% of the population (approximately 152,116 people as per 2021 estimates) are in need of mental health treatment of different levels of severity. Of these, approximately: • 50,000 (5.4% of the PHN population) will require early intervention and relapse prevention. They represent people who do not yet meet the criteria for a mental disorder and those that previously experienced a mental disorder, but no longer have a diagnosable disorder. • 41,000 (4.5% of the total PHN population) will need a variety of services to treat mild mental illness/disorders, • 33,000 (3.6% of the PHN population) will need services for moderate mental illness/disorders, • 28,372 (3.1%) will need services for severe mental illness. Taking into account the above patterns of disadvantage, and stakeholder feedback, these estimates represent a low case scenario, with higher numbers expected in rural and remote areas – such as those in Central Queensland – and socio-economically disadvantaged areas such as LGAs in Wide Bay; and Gympie in Sunshine Coast.
Estimates of prevalence and treatment for young people (2021) – Identifying population in need of mental health services	Approximately half of all lifetime mental health disorders emerge by age 14 and three quarters by age 24. The negative effects of untreated mental health disorders may have persistent effects later in life.	National data show that one in four young Australians aged 16-24 lives with a mental illness and one in three experiences moderate to high levels of psychological distress. The PHN is home to a large number of young people with an estimated number of 146,799 people aged 12-24 in the year 2021. Mental health problems and disorders account for the highest burden of disease among young people (*Young Australians: their health and wellbeing* 2011 AIHW). Preliminary estimates for youth populations based on prevalence data and the NMHSPF suggest that approximately 26,558 young people (12-24 year olds) will need mental health treatment across the PHN. Of these:

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		• 8,502 will need early intervention/relapse prevention • 6,628 will need services for mild disorders • 5,386 will need services for moderate disorders and • 4,500 will need services for severe disorders These estimates are also likely to be a low case scenario, particularly for young people living in remote and disadvantaged areas, which stakeholders have also identified as a key priority population group.
SUICIDE		
Mortality due to suicide and self-inflicted injuries – Measuring the burden of suicide across the PHN and understanding differences in regional patterns	Deaths by suicide and self-inflicted injuries are high in Queensland and the PHN. There are different patterns across the region, suggesting different target groups. Recent trends at the PHN level show suicide numbers and rates being stagnant. Largest ASR in disadvantaged locations across the two periods for which data are available. Over half of deaths by suicide took place in two LGAs.	**Overall patterns of suicide across the PHN** The Australian Institute for Suicide Research and Prevention (AISRAP) report, *Suicide in Queensland: Mortality Rates and Related Data 2011-2013* (2016) noted that across the PHN for the period 2011-2013, the suicide ASR (per 100,000) was 15.3 in Wide Bay, 14 in Central Queensland and 13 in Sunshine Coast. Similar to Queensland and Australia, males show a much higher suicide mortality rate than females across the three areas. However, different age patterns are observed across the regions. • Older cohorts in Sunshine Coast and Wide Bay. These two regions show the largest proportions of over 55s and the lowest proportions of young people who died by suicide in Queensland. • Younger cohorts in Central Queensland, which has the highest proportion of 35-54 year olds who died by suicide in the state. There are also regional differences in regard to methods. **Trends and more localised estimates** 2010-14 data shows a similar ASR for the PHN with a total of 482 deaths by suicide over this period. The largest population center of the Sunshine Coast LGA accounts for 33% of all suicide deaths in the PHN (158 out of 482). This is followed by Rockhampton (83 out of 482) which accounts for 17% of all suicide deaths. Comparable data for 2008-2012 show similar numbers and ASR for the PHN and similar contributions from Sunshine Coast LGA and Rockhampton.

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		Over the two periods, the largest ASR are observed in Gympie and North Burnett, which almost double the rate in Sunshine Coast LGA. However we should note that rates for Gympie and North Burnett are based on relatively small numbers.
Suicide attempts and suicide ideation – approximate measure of the PHN burden	Actual data on suicide attempts and suicide ideation at local level is hard to come by, but often quoted estimates can be used to gauge the burden across the PHN.	Available studies suggest that for each person who dies by suicide, an estimated 20-25 people attempt suicide. In a given year suicidality prevalence (ideation, plans and attempts) might stand at 2.4% of the population. Our estimates drawing on available suicide rates for 2011-13 and the above, would suggest that in a year approximately 2,834 people would attempt suicide across the PHN (1,267 in Sunshine Coast, 825 in Wide Bay and 742 in Central Queensland). With a 2.4% suicidality prevalence in a given year, we expect that a much higher number, closer to 18,000 across the PHN, would be affected by other issues such as suicide ideation and planning.
Other high-risk groups for suicide prevention – identifying population in need of suicide prevention services	In addition to gender and age considerations, other vulnerable population groups in our PHN include those living in remote areas and young people	Although disaggregated local data are not available, 2011-13 data for Queensland suggest suicide rates are substantially higher in remote areas (26.77 per 100,000), compared to regional (14.85) and metropolitan (12.94). Disaggregated data for young people (under 25 years of age) at local level are not available. National data suggests that one in thirteen 12-17 year olds had seriously considered attempting suicide in the previous 12 months. These rates are significantly higher among young people with major depressive disorders (between 35% to 49%).
Mental Health and Suicide Prevention – Aboriginal and Torres Strait Islander people		
Relatively large numbers of Aboriginal and Torres Strait Islander people in need of mental health and suicide prevention services	The PHN is home to approximately 15% of Queensland's Aboriginal and Torres Strait Islander population. Stakeholders have identified Aboriginal and Torres Strait Islander people as a key priority group for mental health and suicide prevention services, but there is no local available data to quantify the numbers that would require appropriate and effective mental health interventions.	The *Australian Burden of Disease Study* 2011 shows that the disease group causing the most burden among Aboriginal and Torres Strait Islander people was mental and substance use disorders (19% of their total disease burden). Nationally, high or very high levels of psychological distress among Aboriginal and Torres Strait Islander adults are nearly three times the rate of non-Indigenous adults. Drawing on available population data, key assumptions of the NMHSPF and the *Australian Burden of Disease Study* 2011 for the Aboriginal and Torres Strait Islander population, we have estimated that based on 2011 data, between 7,259 to 9,678 Aboriginal and Torres Strait Islander people are in need of mental health interventions across the PHN catchment area.

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Relatively large numbers of young Aboriginal and Torres Strait Islander people in need of effective strategies to strengthen their mental health and wellbeing	Their relatively higher needs are due to a younger demographic structure of Aboriginal and Torres Strait Islander populations, along with disproportionately high prevalence of risk factors and mental disorders.	ABS demographic data for Queensland indicates that children and youth (0-17 years of age) represent 43% of the Aboriginal and Torres Strait Islander population. A similar demographic distribution for the PHN would lead to a population of 11,715 children and young people of Aboriginal and Torres Strait Islander descent. No available data exist at local level, however the *Aboriginal and Torres Strait Islander Health Performance Framework* (2017) highlights that although some gains have been made in areas like education, the relative disadvantage of Aboriginal and Torres Strait Islander young people persists: - Aboriginal and Torres Strait Islander children experience higher rates of high/very high levels of psychological stress, higher levels of concern about suicide and discrimination and one in five reported bullying and emotional abuse as a concern. - In 2011-15 for those aged 15-24 years, the Aboriginal and Torres Strait Islander suicide rate was 3.9 times the non-Indigenous rate.
High rates of suicide and worrying trends	The *Aboriginal and Torres Strait Islander Health Performance Framework* (2017) noted that nationally there has been a significant increase (32%) in Aboriginal and Torres Strait Islander suicide rate between 1998 and 2015. Queensland data suggest a higher burden for both males and females (compared to non-Indigenous) and younger cohorts.	We do not have comparable data to examine levels and trends at local level, but stakeholders across the PHN have identified suicide prevention as a priority issue for the Aboriginal and Torres Strait Islander population At state level, the *Suicide in Queensland: Mortality Rates and Related Data 2011-2013* (AISRAP 2016) report noted: Out of 1914 suicides reported in 2011-13, 6.6% (126) were by Aboriginal and Torres Strait Islander people. The ASR per 100,000 for suicide in Aboriginal and Torres Strait Islander peoples was 1.68 that of all of Queenslanders (23.48 vs. 14.01). This was the case for both males (35.99 vs. 21.32) and females (11.98 vs. 6.94). For Aboriginal and Torres Strait Islander males, the highest rates were observed in the 35-44 years age group (72.14) while in females, the highest rates were in the 25-34 years (25.2). Those under 35 represent 65.9% of Aboriginal and Torres Strait Islander suicides, while only 5.6% were 55 years or older.

Section 3: Mental health and suicide prevention – Outcomes of the service needs analysis

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Service gaps in public sector ambulatory mental health service, which should target those with the most and severe complex needs.	Access to these services is highly variable across the PHN. Those with mild and moderate mental health needs are disproportionately accessing these services.	**Variable access to services** Drawing on various modelling assumptions, it was estimated that current public ambulatory services are sufficient to meet approximately 61% of expected needs of the population for Queensland, vs. 69% for Sunshine Coast, 62% for Central Queensland and 54% in Wide Bay. There is marked disparity amongst LGAs **Services disproportionately used by clients with mild/moderate needs** Limited access to primary care in rural areas discussed below has led to clients with mild/moderate needs accessing services targeted at clients with severe and complex needs. This issue has been consistently raised by stakeholders across Central Queensland. As a result a very low proportion of rural clients in Central Queensland and Wide Bay have a 'standardised marker' of severity of case load (Wide Bay: 16% rural vs. 53% urban; Sunshine Coast: 42% rural vs. 60% urban; Central Queensland: 13% rural vs. 62% urban)
Service gaps in available mental health beds	There is sufficient capacity to provide adult acute inpatient services. However, their utilisation will be compromised by the need for access to: • sub-acute and non-acute services • Acute services for older people, children and young adults.	**Shortages in some specialised services will compromise availability to meet expected mental health bed needs** Across the PHN, current levels of acute adult beds stand at 90% of NMHSPF targets for 2021, which indicates that under the specific assumptions of the NMHSPF, they are sufficient to meet the expected need of bed services. In contrast, only 15% of sub-acute older adult, 44% of non-acute older adult, 45% of community care unit and acute older-adult bed needs will be met.

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	Rates of admission to general hospital non-specialist beds are very high for some populations within the PHN.	Some of these services need to be provided locally, particularly community based sub-acute and non-acute services. **Rates of admission to general hospital non-mental health beds substantially higher in rural areas, particularly in Central Queensland.** Separation rates per 100,000 were 153 in Central Queensland vs. 112 in Wide Bay and 88 in Sunshine Coast. Highest rates were observed in Banana, Central Highlands and Woorabinda (all in Central Queensland) and North Burnett in Wide Bay. High rates of admission to general hospitals reflect the desire to provide local support and the challenges to provide safe transport to major service centers. Specifically, stakeholders in Central Queensland commented that the cost of often having to travel away from home to access specialist services compounds issues of accessibility. Other stakeholders also commented on the need for transport for elderly people to and from their appointments with specialist services
Service gaps in GP MBS mental health services	Notwithstanding the importance of GPs' role in mental health, access to their services is low across the PHN and shows extremely large disparities between rural and urban areas.	There are no recorded structured, focused psychological therapies delivered by GPs across the PHN. Even with under-reporting, this indicates very low access to these services and so a large unmet need for the PHN population. For other GP treatment services (i.e. pharmacotherapy) and planning and review, we found : • PHN rates (130 per 1,000 population) based on patient location (2014-15) are around a third of modelled estimates of required services (380 per 1,000 population) • There is also large variation across the PHN. While the Sunshine Coast LGA shows service rates over 152 per 1,000, rates below 80 are observed in North Burnett in Wide Bay and Banana, Central Highlands and Woorabinda in Central Queensland. Of note, barriers to access these services and in particular mental health plans have been identified by stakeholders in Central Queensland as a priority issue to be addressed. We also examined trends in MBS GP mental health service data, although only data based on provider location is available for 2015-16. The PHN shows similar growth trends to those in Australia. Reassuringly, the fastest annual growth from 2012-13 to 2015-16 is observed for the region with the highest unmet need, Central Queensland (16%), followed by Wide Bay and Sunshine Coast. More importantly the localities where GP mental health services have grown at a fastest pace are also some of the ones with the largest gaps, i.e. Central Highlands/Woorabinda, Banana and North Burnett.

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		However in 2015-16 there are still no recorded services for structured psychological services delivered by GPs in the region.
Service gaps in structured psychological therapy (SPT) services – allied health services	Standard SPT services show relatively low coverage across the PHN. Large disparities across localities, partly due to limited availability of a suitable workforce in rural and remote areas. Low-cost alternatives with greater capacity to scale-up coverage include low intensity services and clinician-moderated web-based interventions. However their coverage is low for the PHN population.	Overall current services including MBS and PHN-commissioned services (discussed below) are delivering approximately 45% of projected standard SPT services required across the PHN. However if we add the requirements of web-based and low-intensity services, current services meet only 24% of estimated need. Specifically looking at MBS data for 2014-15 based on patient location show that while service rates per 1,000 are below 60 for Central Highlands and Woorabinda ,and below 120 in Banana (Central Queensland) and North Burnett (Wide Bay), they are over 255 in the Sunshine Coast LGA. The overall unavailability of mental health services in Central Queensland has also been noted by stakeholders. Stakeholders commented that referrals are often received for psychologists who usually have a wait list or clients can't afford to access. They have also noted other access barriers such as lack of information about services and support available, and stigma and fear around mental illness. The low availability of web-based and low-intensity services was also shown by our service mapping. Only seven (out of 50 providers delivering SPT) offer online services (approximately 30 occasions of service per month), while only one delivers computerised therapy (two occasions of service per month). Mindspot data for June-December 2016 suggest 540 assessments were carried out for clients in the PHN region. In regards to trends, the most recently available MBS dataset for 2015-16 uses provider location and might be less reliable for allied health services. However, it provides some encouraging signs of accelerating growth across the PHN, particularly for areas in need like Central Highlands and Woorabinda in Central Queensland and North Burnett and Fraser Coast in Wide Bay.
Service gaps in structured psychological therapies - service data	The PHN has increased coverage of structured psychological therapies with focus on disadvantaged areas, but large gaps remain.	In 2016-17 a total of 4,720 people received 19,404 ATAPS occasions of services across the PHN. This represents a 15% increase over the previous year. As expected, the largest volume of services were concentrated in the most populated areas, such as the Sunshine Coast LGA. However, when looking at LGA service rates per population for 2015-16 and 2016-17, the largest rates were in areas of high need such as Gympie (Sunshine Coast), Central Highlands (Central Queensland) and Fraser Coast (Wide Bay). Of note, Central Queensland – the regional area with largest service gaps – went from having the lowest service rate per population in 2015-16 (16 per 1,000) to the highest (21.7 per 1000) in 2016-17. This was partly due to considerable efforts to improve communcations with GPs, higher community awareness of ATAPS services, and targeting of high need areas.

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		In addition to the above services, a total of 894 people received 2589 occasions of low intensity services in the PHN in 2016-17. Further efforts are needed to effectively expand coverage to meet the needs of the population.
Service gaps in structured psychological therapies for young people – service data	Low access to specialised youth mental health services across the PHN, particularly in rural and remote areas. Increasing efforts across the PHN to expand coverage during the last year have seen larger numbers of young people accessing youth-specific services.	Preliminary modelled estimates show that approximately $76 million will be required by 2021 to fund staff requirements for delivering services to approximately 26,558 young people in need of mental health services across the PHN. The vast majority of this funding (approx. 70%) will be required to address the needs of the 17% of young clients (i.e. 4,500) with complex and severe mental disorders. Over 22,000 of young clients across the PHN in need of early intervention, relapse prevention and treatment services for mild and moderate mental illness will require approximately $14 million funding. Unfortunately only partial data on services are available for this cohort. However, it is expected that similar gaps as those noted earlier for SPT are observed. For example, In 2016-17, 4,491 clients (22% of the target population) have received youth-specific mental health services across the PHN. This includes both headspace and ATAPS youth services, for which Central Queensland has the highest rate of services (6.25 per 1,000 population) followed by Wide Bay (5.25) and Sunshine Coast (4.42). When looking specifically at headspace data, occasions of service delivered increased from 8250 in 2015 to 11305 in 2016. This is partly due to the new two centres opening in Gladstone in late 2015 FY; and Bundaberg in late 2016 FY. The currently available service rates per 1,000 people indicate that Gladstone has the highest service rate (40.45) followed by Rockhampton (22.98) Sunshine Coast LGA (16.67) and Fraser Coast/Hervey Bay (16.20).
Service gaps - severe and complex needs – mental health nurses in primary care service data	Large gaps in primary care services delivered by mental health nurses to those with severe mental illness/disorders across the PHN.	Services delivered by mental health nurses for supporting people with complex and severe needs complement those provided by GPs and psychiatrists. Modelled estimates suggest that across the PHN, 22 FTE mental health nurses will be required to deliver the required services. Out of these, 10 will be in Sunshine Coast and 6 each in Wide Bay and Central Queensland. These nurses will be expected to deliver 32,907 occasions of service across the PHN. In contrast, commissioned services delivered 4,392 occasions of service in 2015. This represents 13% of relative levels of services. Rockhampton, Bundaberg and North Burnett all show rates of coverage below 5% of that required. This was partly explained due to loss of the workforce in some locations. For 2016-17, Mental Health Nurse Incentive Program (MHNIP) data indicates that 3763 occasions of services were delivered to 1347 clients, the largest proportion of which were delivered in the Fraser Coast

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		LGA (Wide Bay). Consistent with the observed declining trend, the volume of services and clients for 2016-17 is slightly lower than the one reported in the previous year. As a result we expect that current levels of services meet less than 13% of that required. Of note, various locations across the PHN, including Rockhampton, Livingstone and Woorabinda in Central Queensland, as well as Bundaberg (Wide Bay) and Noosa (Sunshine Coast) did not have any records of MHNIP services delivered.
Service gaps - community support services	Totally available funding for community support services seem to be adequate. However, key priority services such as individual support and rehabilitation show substantial funding gaps. Services for complex clients particularly in areas with low access to other primary care mental health services, might not be targeting clients with complex and severe needs.	Modelled estimates show that across the PHN the demand for community support services would require an estimated total funding of approximately $70 million. This will cover 742 FTE staff numbers required to deliver specialised mental health support, targeting individuals with severe and complex needs (i.e. approximately 28,372). The vast majority of this funding (i.e. 75%) is expected to cover demand for individual support and rehabilitation. Data on the community support sector is not readily available, which makes it difficult to assess current service gaps. Estimates suggest that approximately $42.6 million are currently funding community support services across the PHN. This shows a relatively well-funded sector equivalent to 64% of the estimated required for 2021 and over 80% of that required in 2015. However, important gaps are observed for specific programs such as individual support and rehabilitation, which is currently receiving only 33% of the estimated required funding. On the other hand, these services might not be targeting clients with severe needs, particularly in rural areas with low access to other services. For example PIR data suggests that in the Sunshine Coast, the largest proportion of clients has indeed a diagnostic profile consistent with markers of severity such as schizophrenia and/or delusional disorders. However in Central Queensland, the majority of clients have been diagnosed with mood affective disorders.
Service Gaps - suicide prevention and support services primary care service data	Limited coverage of suicide prevention services across the PHN.	Stakeholders have noted that overall there are limited suicide prevention programs available across the PHN, so existing counselling and acute care services provide much of the available care. For example the service mapping identified 35 community organisations delivering suicide related services to approximately 1,160 clients per month. However it also highlighted that only a third of providers offering SPT – including those related to suicide prevention and treatment – operate outside standard business hours. This is in line with the high number of emergency department presentations discussed below. Also of note was the lack of a coordinated approach and service integration across existing services, which further stretches existing capacity. In regards to commissioned services, in 2016-17 we estimated that a total of 400 clients being 1.9% of the target population (i.e. 20,800 affected by suicidality) received suicide prevention services through ATAPS-

Outcomes of the service needs analysis		
		Tier 2, the majority of which were female (62%). The highest service rates were in the Sunshine Coast, followed by Wide Bay and Central Queensland. Although starting from a very low base, efforts in Central Queensland saw rates almost triple during the year. However, Central Queensland clients are still underrepresented.
Suicide/self-harm hospitalisations – primary target population for after-care services	High and increasing rates of self-harm hospitalisations across the PHN, though large variability across LGAs. Low access in rural areas and disadvantaged populations, including those with high suicide prevalence. Similar to suicide numbers, the largest contributor to self-harm hospitalisations is the Sunshine Coast LGA, reflecting its large population base and higher access to services.	In 2013-14 there were 1,787 self-harm hospitalisations across the PHN, with an age-standardised rate (ASR) of 240 per 100,000 (vs 150 in Australia). This was the highest ASR across all PHNs in the country. Self-harm hospitalisations increased to 1,922 in 2014-15 with an ASR of 259 per 100,000, also the highest in the country. Similar increases were observed nationally, with the ASR increasing from 150 to 161 during the same period. There were important variations across LGAs. With available data we are unable to estimate ASR, but population rates per 100,000 indicate they are highest in Gympie (312), Banana (275) and Gladstone (270) and very low for Central Highlands and Fraser Coast (156 and 159). Areas with high suicide prevalence like Wide Bay have hospitalisation rates below the PHN average. In line with suicide numbers and higher service access, the Sunshine Coast LGA accounts for 42% of all self-harm hospitalisations.
Suicide/self-harm-related emergency department presentations - monitoring trends and identifying second-tier of target populations	Increasing rates of emergency department presentations due to suicide attempts and ideation, but limited understanding of what explains the observed increases. Improvements in data recording at emergency department cannot be fully discarded, which might impact future evaluations of population based measures of suicide prevention Very high emergency department presentation rates amongst disadvantaged areas and young people, possibly reflecting their relatively higher rates of suicide and limited access to services. Important for future targeting of services A large number of suicide-ideation emergency department related	**Increasing numbers of emergency department presentations due to suicide attempts and ideation. Comparable data for 2014-15 and 2015-16 and shows**: Over the year, emergency department presentations increased from 2,563 to 3,021, resulting in ASR per 100,000 increasing from 406 in 2014-15 to 482 in 2015-16. Age-standardised rate increases were observed across the board, particularly for Gladstone in Central Queensland (416 vs. 702), Gympie in Sunshine Coast (476 vs. 610) and Bundaberg in Wide Bay (496 vs. 628). Observed increases in emergency department presentations could be explained by increasing health seeking behaviour. For example clients across the PHN have noted that although emergency department might not be the most appropriate service to treat mental health related issues, it was often seen as the 'way to be taken more seriously'. On the other hand, we should ntoe that increasing prevalence of suicidality behaviour as well as improvements in recording of these emergency department presentations might be contributing factors. In this context of increasing trends, serious challenges exist for future evaluation of suicide-prevention initiatives across the PHN. **The most recent data (2015-16) shows high rates in disadvantaged areas**

Outcomes of the service needs analysis		
	presentations during standard business hours reflecting limited access to primary care services noted above	Age-standardised rates over 600 per 100,000 people are observed in Gladstone (Central Queensland), Fraser Coast and Bundaberg in Wide Bay and Gympie in Sunshine Coast. Except Gladstone, the other three LGAs also showed some of the highest rates across the PHN in the previous year. This might reflect not only high suicidality rates, but also lower access to primary care services noted above. The lowest rate of emergency department presentations is in the Sunshine Coast LGA , which is partly explained by better access to services. Supporting this, the proportion of Sunshine Coast LGA emergency department presentations amongst the PHN (27%) is lower than the proportion of suicide numbers (33%) and the proportion of self-harm hospital admissions (42%) **The most recent data (2015-16) show very high rates amongst young people, particularly for Central Queensland** In total 165 children under 14 presented to emergency department (5.5%). When looking at only those clients that presented due to self-harm, the proportion of children under 14 stands at 9% (72 out of 794) . Age-standardised rates (per 100,000) of emergency department presentations for 15-19 year olds are: 1,940 in Central Queensland; 1,450 in Wide Bay; and 790 in Sunshine Coast. Although lower, rates of similar magnitude are also observed for the 20-24 age group. **Suicide ideation related emergency department presentations:** Out of the 2230 suicide ideation related presentations across the PHN, 41% (918) took place during standard business hours Monday to Friday 8am-6pm. This is in line with previous findings on limited access to mental health primary care services across the PHN. Our analysis shows that males are also seeking help. They slightly outnumber females presenting to emergency department due to suicide ideation (1136 vs. 1094).
Lack of integration and coordination of services	People with mental illness often experience that their problems are dealt with in isolation, with poorly integrated and coordinated care.	In 2014, the Report of the *National Review of Mental Health Programmes and Services* stressed that across Australia, services are poorly coordinated, delivered in isolation and characterised by funding inefficiencies. Stakeholders and consumers across the PHN have noted the lack of integration and coordination of services. For example some GPs have noted that after referring patients for SPT services, they do not receive further information on client's progress. Other treating clinicians have also stressed that information on their clients' physical health such as chronic disease prevalence and GP management plans is usually absent. Client journeymapping participants called for a holistic approach, with clinical and non-clinical interventions delivered in an integrated manner. Across the three regions, clients noted the lack of continuity of care and follow-up services in emergency department and the community support sectors.

Outcomes of the service needs analysis		
		They have also stressed that notwithstanding the high levels of comorbidity, AoD and mental health services were not integrated and dual diagnosis was often lacking.
Workforce development has been identified as a critical gap for effective scale-up of services.	One of the most important constraints to effectively scale-up services in our PHN relate to workforce. However, limited evidence exists on current levels, gaps and best strategies to address those gaps. They need to be informed by local evidence and best practice.	Current best practice in workforce development strategies emphasises a multi-faceted approach with a strong system focus, targeting individual, organisational and structural factors impacting workforce in general. There is limited information available on the profile of our mental health workforce, how they are addressing current challenges and what has been working/not working across various locations in the PHN. Our PHN is working with NCETA to undertake stakeholder consultations to inform a future workforce development needs assessment.
Mental Health and Suicide Prevention – Aboriginal and Torres Strait Islander people		
Insufficient culturally appropriate services with a holistic approach to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people	- Aboriginal and Torres Strait Islander culture takes a holistic view of health. Their traditions, values and health belief systems need to be taken into account in designing and delivering mental health programs and services.	Our service mapping identified 17 mental health community providers that received funding for delivering services targeting Aboriginal and Torres Strait Islander populations. The survey was not able to capture the extent to which these services are culturally appropriate and adopt a holistic approach. Previous stakeholder consultations noted the need for culturally appropriate services, employment of local Aboriginal and Torres Strait Islander staff and the need for adequate support services. They also stressed that there appears to be limited understanding of what holistic health is for Aboriginal and Torres Strait Islander people and acceptance of the importance of such a holistic approach in delivering services. Stakeholders also stressed the need for more Aboriginal and Torres Strait Islander-specific mental health services which are embedded within the communities they serve. They also noted that Aboriginal and Torres Strait Islander people face barriers in mainstream hospital systems due to racism and the ongoing impact of colonisation.
Insufficient models of suicide prevention services targeted at the Aboriginal and Torres Strait Islander population	Culturally appropriate suicide risk prevention models targeting the Aboriginal and Torres Strait Islander population are currently lacking.	Stakeholder feedback suggests there are important gaps in suicide prevention services targeted at the Aboriginal and Torres Strait Islander population. This is particularly important for Central Queensland, the PHN regional area with the highest proportion of Aboriginal and Torres Strait Islander people (5% vs. 3.1% across the PHN).
Suicide-related emergency department presentations.	Overrepresentation of Aboriginal and Torres Strait Islander populations in suicide-	**Overrepresentation of Aboriginal and Torres Strait Islander populations in emergency department and increasing trends**

Outcomes of the service needs analysis		
Monitoring trends and identifying target groups for follow-up services	related emergency department presentations across the PHN Similar increasing trends to those observed for the total population, but might have also been due to improvements in data recordings. Young Aboriginal and Torres Strait Islander people represent the majority of Aboriginal and Torres Strait Islander suicide-related emergency department presentations.	In line with what was observed for the entire PHN population, there was a substantial increase in total numbers of Aboriginal and Torres Strait Islander people presenting to emergency department due to suicide related issues. They went from 256 in 2014-15 to 337 in 2015-16. For 2015-16, and similar to the overall population, the vast majority (244) presented due to suicide ideation in 2015-16, with the remaining 93 presenting due to self-harm. All Aboriginal and Torres Strait Islander emergency department presentations (337) represent 11% of the total emergency department presentations, although Aboriginal and Torres Strait Islander people make up only 3% of the PHN population. Similar overrepresentation was observed across the region. **The very young** Those aged 15-24 represent 41% of all Aboriginal and Torres Strait Islander suicide related emergency department presentations, with similar distributions for suicide ideation and self-harm. 13% of Aboriginal and Torres Strait Islander emergency department presentations for self-harm were for children under 14 (vs. 8.6% for non-Indigenous).
Service gaps – commissioned services data	Currently low levels of services will need to be expanded in a sustainable manner.	Unfortunately, only 29% of ATAPS clients dislose their ethnicity . Based on this sample, there were 345 Aboriginal and Torres Strait Islander clients receiving ATAPS services in 2016-17 (vs. 339 in 2015-16). Of these, 61% (208 out of 345) received culturally appropriate services. Of note, the number of Aboriginal and Torres Strait Islander clients tripled in Wide Bay in 2016-17 compared to 2015-16. As a result, 60% of Aboriginal and Torres Strait Islander clients were from Wide Bay, followed by Central Queensland (21%) and Sunshine Coast (19%).
Aboriginal and Torres Strait Islander workforce – workforce development needs, including of culturally safe strategies	A more effective sector requires higher numbers of Aboriginal and Torres Strait Islander staff underpinned by culturally safe workforce development strategies	The mental health and AoD workforce consultations currently underway will provide the foundations the PHN to undertake a comprehensive needs assessment and workforce development strategy that targets key issues facing Aboriginal and Torres Strait Islander workers in our PHN and which is aligned with the state framework (*Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026*).

Section 4: Mental health and suicide prevention - Opportunities, priorities and options

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Use the NMHSPF and additional evidence provided here to develop a comprehensive regional mental health and suicide prevention plan	In the context of the regional collaboratives for mental health, suicide prevention and AoD, develop a regional strategic plan that leads regional system reform. To ensure a patient-centred care approach, the plan will draw on consumer/carer journey exercises undertaken in each region.	A regional mental health, suicide prevention and AoD strategic plan 2018-2020 developed and adopted by the Mental Health Drug and Alcohol Council. Regional priorities and actions (aligned with *Connecting care to recovery 2016-2021* Queensland Health) clearly articulated in the plan.	Regional mental health, AoD plan developed and adopted by the regional collaboratives. Local communities and key stakeholders effectively engaged to support the plan and its implementation.	PHN to lead planning in conjunction with HHSs, service providers, consumers and carers.
Development of a coordinated and integrated system for suicide prevention	Adopt a systems community-based approach for suicide prevention across the PHN, targeting areas on their basis of need (i.e. criteria will include numbers and demographics of those affected by suicide, relative differences in suicide rates/attempts and access to mental health services) Commission community-based and multi-tiered suicide prevention activities across the PHN. Services will target those recently discharged from hospitals due to a	Commissioned services are delivered to the identified priority target groups. Fewer suicidality-related emergency department presentations Improved transitions from hospital services to community or home care settings for people affected by suicidality	Proportion of people referred to PHN-commissioned services due to a recent suicide attempt or because they are at risk of suicide followed up within seven days of referral.	PHN will lead commissioning of suicide prevention services. PHN in conjunction with HHSs, service providers, consumers and carers will lead the development of a coordinated and integrated system for suicide prevention supported by the regional plan above.

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	suicide attempt (target group for after-care services), as well as others affected by suicidality (recent attempt that did not lead to hospital admission as well as those affected by suicide ideation).	Improved access to timely and appropriate suicide prevention services across the region. Improved knowledge and confidence among service providers that consumers will receive continuity of care as they transition between services.		
Commission stepped care services across the PHN, supported by a central referral intake.	To facilitate clients accessing the right level/intensity of services according to their need, commission services under a model of central referral intake.	Improved monitoring of unmet need across the PHN leads to innovative strategies to increase service access in priority locations. Central referral intake services collaborate with HealthPathways to improve referrals within the PHN. Central referral intake facilitates referrals for stepping-up/stepping-down clients. Higher uptake of low intensity services.	Improved referral pathways for clients of mental health services across the PHN. Increasing numbers of clients with mild and moderate mental health needs are aware of and use low intensity services provided nationally and/or by commissioned services. Improved outcomes for clients.	PHN to lead in conjunction with service providers and other stakeholders.
Commission mental health services across the stepped care model with focus on identified priority populations	Mental health services across the stepped care model are delivered across the PHN to ensure more equitable access to rural, remote and disadvantaged populations identified in the N/A.	Improved access to appropriate and effective primary care mental health services across the PHN through ensuring that commissioned services target people in rural/remote and disadvantaged locations not able	Proportion or regional population receiving: • Low intensity services • SPT delivered by mental health professionals • Clinical care coordination	PHN to lead planning in conjunction with HHSs, service providers, consumers and carers and commission services in accordance with plans.

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
		to access other primary care services. Services delivered are of good quality and delivered in an efficient way. Rural and remote clients will have better access to primary care and will free up available tertiary resources for clients with high needs.	Average cost of commissioned services: • Low intensity • SPT delivered by mental health professionals • Clinical care coordination Clinical outcomes for regional population receiving commissioned services Low intensity SPT delivered by mental health professionals Reduced number of clients with low/moderate needs are treated in hospital settings in rural areas	
Commission services to improve the mental health of young people.	In addition to commissioned services above, ensure continuity of existing headspace for children and young people in the region and explore opportunities to continue enhancing the geographic reach of existing services.	Improved access to and utilisation of services and programs which address the mental health needs of young people.	Increase availability and utilisation of services tailored to the needs of young people.	PHN to lead in conjunction with service providers – including headspace, HHSs, consumers and carers.
Build a strong monitoring and evaluation framework for mental health and suicide prevention services	Strengthen data management systems to improve monitoring and evaluation of services.	Monitoring and evaluation is built into plans, projects and services. Monitoring and evaluation is used to unpack lessons of what	A robust monitoring and evaluation framework for mental health and SP is developed and implemented.	PHN will lead in conjunction with service providers and other stakeholders in the region.

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	Develop a robust evaluation framework that promotes the use of evidence to inform decision-making by providers, stakeholders and the PHN	works/does not work and has impact on services.	Monitoring and evaluation is supported by strong data management systems.	
Increase GP engagement in mental health, with focus on rural and remote areas	Partner with providers, advocacy bodies, peak and professional bodies to increase participation PSO campaign and support in general practice re implementation of stepped care model and recording of mental health services	Improved recording of mental health services by GPs Higher number of clients with GP mental health plans in the PHN. Increased rates of GP mental health plans in rural and remote areas	Higher coverage of MBS Mental Health services across the PHN Higher rates of GP mental health plans in rural and remote areas	PHN in conjunction with providers, advocacy bodies, peak and professional bodies
Workforce development	Develop a workforce development strategy with a strong system focus that is tailored to the PHN.	A comprehensive workforce development needs assessment is undertaken for the PHN and each regional area to inform strategic planning. A strategic workforce development framework is developed and aligned with the Queensland Workforce Council strategy.	Workforce development needs assessment undertaken. Consultations for the strategic workforce development framework are undertaken. A strategic workforce development framework is adopted and supported by key stakeholders	PHN to lead the development of the strategic framework in conjunction with other key stakeholders.
Mental health and suicide prevention – Aboriginal and Torres Strait Islander people				
Prevention of risk behaviours	Foster and support the development of strategies designed to increase the participation of Aboriginal and	Increased participation of Aboriginal and Torres Strait Islander men in addressing social	Reductions in risk factor indicators among Aboriginal and Torres Strait Islander populations (long term).	PHN in collaboration with Aboriginal Community Controlled Health Services (ACCHSs)

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	Torres Strait Islander men in addressing social and emotional health and wellbeing. Facilitate co-design and implementation of strategies targeting risk behaviours of young Aboriginal and Torres Strait Islander people.	and emotional health and wellbeing. Reduction in risk behaviours among young Aboriginal and Torres Strait Islander people. Improved knowledge and understanding of risk behaviours and implications for long term health outcomes.		
Development of a coordinated and integrated system for suicide prevention to meet the needs of Aboriginal and Torres Strait Islander populations.	Commission community-based suicide prevention activities based on identified needs – with a particular focus on Aboriginal and Torres Strait Islander populations. Develop culturally appropriate referral pathways and systems between HHSs and community-based services to facilitate follow-up care for Aboriginal and Torres Strait Islander individuals following a suicide attempt.	Establishment of a region wide plan for suicide prevention that includes specific strategies to addresses the needs of the Aboriginal and Torres Strait Islander populations. Improved access to culturally appropriate suicide prevention services across the region.	Reduced rates of suicide amongst Aboriginal and Torres Strait Islander people in the region. Other agreed measures to be developed as part of joint planning work with partner organisations.	PHN to lead planning in conjunction with HHSs, ACCHSs, Aboriginal and Torres Strait Islander organisations, service providers, consumers and carers and commission services in accordance with plans.
Increase access to culturally appropriate mental health services for Aboriginal and Torres Strait Islander people	Commission and co-design culturally appropriate, evidence based mental health services within a stepped care approach, that will complement existing services for Aboriginal and Torres Strait Islander people in the region.	Effective engagement with Aboriginal and Torres Strait Islander mental health stakeholders to identify appropriate and effective service delivery options and settings. Improved access to and utilisation of services and programs which	Increased acceptability and access to culturally appropriate mental health services by Aboriginal and Torres Strait Islander people. Decreased rate of hospitalisations for mental and emotional disorders among Aboriginal and Torres Strait Islander populations.	PHN to lead planning in conjunction with ACCHSs, Aboriginal and Torres Strait Islander organisations, HHSs, other local service providers, consumers and carers and commission services in accordance with plans.

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	Work with headspace to continue to provide and increase the availability services to Aboriginal and Torres Strait Islander young people. Continue to invest in capacity building and cultural sensitivity training to service providers to enhance cultural competence and understanding of the historical, cultural and social factors that contribute to poorer mental health outcomes among Aboriginal and Torres Strait Islander populations.	address Aboriginal and Torres Strait Islander mental health issues in culturally-specific ways. Enhanced health outcomes for Aboriginal and Torres Strait Islander people.		
Workforce development of Aboriginal and Torres Strait Islander health workers and increased cultural competency of mainstream services	In the needs assessment and strategy outlined above, address workforce development issues for Aboriginal and Torres Strait Islander workers and ensure strategies adopted are culturally safe. Also include strategies that contribute to the cultural competency of mental health service providers, including those in primary health care.	Specific needs and strategies tailored to the Aboriginal and Torres Strait Islander workforce are identified and adopted, while ensuring alignment with the Queensland *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026.* Increased Aboriginal and Torres Strait Islander mental health workforce in the region.	Workforce development needs assessment undertaken Consultations for the strategic workforce development framework are undertaken and relevant strategies adopted. A culturally safe strategic workforce development framework is adopted and supported by key stakeholders	The PHN, local stakeholders and training institutions, such as universities and the PHN.

ALCOHOL AND OTHER DRUGS –
Section 2 – AoD Outcomes of the health needs analysis

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Links between risk of AoD dependence and social determinants of health	Social determinants of health, including geographic and social isolation and higher rates of socio-economic disadvantage are linked to higher AoD use. The PHN is home to socio-economically disadvantaged communities and rural and remote areas where prevalence of AoD use is likely to be higher.	The *National Drug Strategy Household Survey detailed report* (2013) indicates that people living in remote and very remote areas were twice as likely as people in major cities to drink alcohol in risky quantities, and use meth/amphetamines in the previous 12 months. According to the AIHW report, *Australia's health* 2016, in 2013, the disparity in illicit drug use compared with the general population was greatest amongst populations with socio-economic disadvantages, including Aboriginal and Torres Strait Islander people, people who were unemployed, single people with dependent children and people with a mental illness. For example, compared to the general population, methamphetamine use was 2.7 times as high among unemployed people, 6.1 times as high among people with a mental illness, and 2.4 times as high among single people with dependent children. The same report indicates that amphetamine-related treatment episodes had increased from 24% to 26% in regional and remote areas between 2003-04 and 2012-13. As discussed previously, the populations of Wide Bay, remote and rural areas in Central Queensland, and Gympie in Sunshine Coast are affected by socio-economic disadvantage and higher prevalence of mental illness. Populations with higher prevalence of mental illness also tend to suffer from high AoD misuse prevalence. Indeed, our PIR data suggests that a large number of PIR clients (33% in Sunshine Coast and 40% in Central Queensland) reported alcohol and drug misuse. Stakeholders in the region have identified people in rural and remote areas, youth and Aboriginal and Torres Strait Islander people as the populations in most need of AoD services.
Higher rates of risky alcohol consumption across the PHN catchment	The PHN has higher rates of risky alcohol consumption than Queensland, particularly for young people. While risky alcohol consumption life-time rates for young people have decreased	Queensland Health's Queensland Survey Analytic System (QSAS), Regional detailed data 2015-2016 shows: The PHN catchment had a higher prevalence of alcohol life-time risk (25%) than Queensland (22%). Regional rates were slightly higher in Central Queensland and Sunshine Coast than Wide Bay.

Outcomes of the health needs analysis		
	nationally and in the state, they have remained at previously recorded high levels across the PHN.	Male rates are three times those of females (37 vs. 12) across the PHN, with similar disparities across the three regions. In regards to demographics, people under 29 show the highest rates (30%) of all groups in the PHN. The observed 2015-2016 PHN rate of 30% for young people is substantially higher than the Queensland rate of 23%. - Of note, this rate has remained stagnant since 2011-12. This in contrast to declining national trends as reported in the *National Drug Strategy Household Survey* (2016) and a decrease of 7 percentage points in Queensland during the same period (30% in 2011.12 to 223% in 2015/16). Concerns about alcohol consumption of young people in the PHN have been raised by stakeholders
Prevalence of drug use – Drugs of Concern	Local data on drug use prevalence is not available. We use available service data to examine principal drugs of concern across the PHN. Although service data is affected by service access, it helps to gauge some patterns of drug use in the region when examined in the context of other available information.	The *National Drug Strategy Household Survey* (2016) showed declines in recent use of some illegal drugs, including meth/amphetamines (from 2.1% to 1.4%), hallucinogens (1.3% to 1.0%) and synthetic cannabinoids (1.2% to 0.3%). In contrast, Australians who had misused a pharmaceutical increased to 4.8% in 2016 (vs. 4.2% in 2010). Queensland Health data on AoD services delivered by both community providers and government services for 2013-14, 2014-15 and 2015-16 shows: • Over this period cannabinoids remains the top drug of concern across the PHN, currently representing 47% of episodes, a slight reduction from the 48% observed in 2013-14. It is also the top drug of concern across the three regional areas. Note that in Queensland, cannabinoids displaced alcohol as the principal drug of concern, now accounting for 40% episodes of care. • In the PHN amphetamines currently account for 15% of episodes of care (same proportion as in Queensland). It shows the fastest growth of all drugs of concern with a 2.5 fold increase over the three years (vs. 1.7 fold increase in Queensland). • The growth in amphetamine has taken place across the three regions, though at a much faster pace in Wide Bay, where it increased almost five-fold over the same period. Reassuringly, similar patterns are shown by the AIHW tabulations provided to the PHN in mid-October 2017. The rapid growth in amphetamine services seems at odds with decreasing national prevalence and it is unknown the extent to which it reflects higher severity or heightened concerns and improved services.

Outcomes of the health needs analysis		
		Prescription pharmaceuticals have low representation on episodes of care across the PHN in the Queensland Health data. Similar low shares are observed for AoD counselling and therapy services as reported by HHSs in our catchment. However same HHS data for opioid treatment programs show that in Fraser Coast, Bundaberg and Sunshine Coast HHSs, pharmaceutical drugs such as morphine, codeine and oxycodone represent over 40% of the principal drug of concern, while cannabis is almost negligible. In contrast for Central Queensland HHS, cannabis is the principal drug of concern in 71% of reported opioid pharmacotherapy services, with the remaining 29% of services scattered across 12 different categories. Queensland Police Service data on crime offences indicate that AoD, domestic violence and assault, and rape offences have increased from 23,054 in 2014-15 to 25,631 in 2016-17. This represents an average annual growth of 5.4%. A sharp decrease observed in alcohol-related offences was offset by increases in drug related offences, domestic violence and assault and rape. Specifically when looking at alcohol-related offences, each LGA in the PHN experienced a decrease in rates over the two years. In 2016-17, the highest rates were observed in Woorabinda and Banana, both in Central Queensland, while the lowest rates were recorded in Bundaberg Wide Bay. The highest rates for drug related offences are also observed in Central Queensland (Woorabinda and Rockhampton LGAs), while the lowest rate was in Noosa (Sunshine Coast). As above, Woorabinda also shows a substantial decrease in these crime rates.
Local differences in prevalence of AoD related harm – emergency department presentations as a proxy	In the absence of direct data, emergency department presentations related to AoD are used to capture relative differences in prevalence of AoD related harm in the community. There is marked regional variation with higher rates in Wide Bay. The PHN and particularly Central Queensland show very high rates for young people 15-19, many of which are under the legal drinking age. Differences in age-cohorts for alcohol vs. drugs area also observed	**Local differences in prevalence of AoD related emergency department presentations:** In 2015/16 The largest ASR of AoD related presentations are observed in Wide Bay, in line with their marked disadvantage and high prevalence of mental illness/disorders and suicide rates. Specific LGAs with the highest rates per 100,000, compared to the PHN rate of 1,131 include Fraser Coast (1,645), and Bundaberg (1,475) in Wide Bay and Gympie (1,417) in the Sunshine Coast. These three LGAs also show the highest ASR in 2014-15 and 2013-14. In contrast, Noosa and North Burnett show the lowest ASR in both periods. **What about young people?** Across the PHN, in 2015-16 for those aged 15-19 the age-standardised rate per 100,000 was 2,340, with marked regional variation. Central Queensland shows a rate of 2,910; substantially higher than Sunshine Coast (1,880) and Wide Bay (2,510). The three LGAs in the PHN with the highest rates for those aged 15-19 are all in Central Queensland (Gladstone, Central Highlands and Banana), and show rates above 3,500, i.e. young people in these areas

Outcomes of the health needs analysis		
	Note: For these purposes, we follow the national alcohol indicators project, and included emergency department presentations due to injuries/falls likely to be caused by AoD in our calculations.	will be 1.5 times more likely to present to emergency department due to AoD issues than the average young person in the PHN rate. Of note is Gladstone which also shows the highest rates of suicide emergency department presentations for young people across the PHN. Those aged 20-24 across the PHN, present to the emergency department due to AoD issues at a rate of 2,444 per 100,000 population. The highest rate is observed in Wide Bay (3,350), which is 1.4 times higher than the PHN rate. This is followed by Central Queensland (2,530) and Sunshine Coast (1,910) **Relative differences in the proportion of emergency department presentations due to alcohol vs. drugs** When looking specifically at those emergency department presentations directly coded as alcohol and drugs (i.e. excluding injuries) in 2015-16, the majority (63%) are due to alcohol, with the remaining 37% due to drugs. Of note the highest proportion of drugs emergency department presentations in the Sunshine Coast (42%), possibly reflecting higher drug use prevalence in the area. When comparing those emergency department presentations coded as alcohol vs those coded as drugs, we observe a much younger profile for alcohol and an older profile for drugs. For example 15-19 year olds represent 18% of alcohol coded emergency department presentations vs. 12% of drug coded emergency department presentations. In contrast, the share of emergency department presentations amongst 25-34 year olds is 28% for drugs, twice the share of alcohol (14%).
Drug and Alcohol - Aboriginal and Torres Strait Islander people		
Higher burden of substance use disorders	Aboriginal and Torres Strait Islander people experience disproportionate harm from drug and alcohol use and drug-related problems, which contribute significantly to disparities in health and life expectancy. Very limited available evidence at local level, so we draw on available national evidence.	The *Burden of Disease* study shows that: • Mental and substance use disorders account for 19% of total disease burden for the Aboriginal and Torres Strait Islander population. • The top two risk factors causing the most burden in Aboriginal and Torres Strait Islander Australians were tobacco use and alcohol use. • Alcohol use is the leading contributor to the burden in Aboriginal and Torres Strait Islander males aged 15-44 years and Aboriginal and Torres Strait Islander women aged 15-24 years. The *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-19* indicates that: - Aboriginal and Torres Strait Islander males are hospitalised for conditions to which alcohol makes a significant contribution at rates between 1.2 and 6.2 times those of non-Indigenous males.

Outcomes of the health needs analysis		
		- Aboriginal and Torres Strait Islander females are hospitalised for conditions to which alcohol makes a significant contribution at rates between 1.3 and 33.0 times greater compared to non-Indigenous females (including injuries related to assault). - Deaths from various alcohol-related causes are 5 to 19 times greater than among non-Indigenous Australians. - In Queensland, from 1998 to 2006, two-thirds of Aboriginal and Torres Strait Islander people who died by suicide had consumed alcohol, and more than one-third had used drugs such as cannabis, amphetamines, inhalants or opiates at the time of their deaths.
Dual Diagnosis	Dual diagnosis is likely to be high amongst Aboriginal and Torres Strait Islander people, with prognosis poorer for both conditions together than for either condition alone.	There is evidence of high prevalence of comorbid harmful substance use and mental illness amongst the Australian population, with some estimates suggesting that among those with alcohol-dependence disorder, 20% have an anxiety disorder and 24% an affective disorder. Indirect evidence suggests substantially higher prevalence of dual diagnosis amongst the Aboriginal and Torres Strait Islander population. For example, Aboriginal and Torres Strait Islander men are over four times more likely than non-Indigenous men to be hospitalised due to mental disorders attributable to psychoactive substance use. For Aboriginal and Torres Strait Islander women the rates are three times higher than for non-Indigenous women.
Local prevalence of AoD related harm amongst Aboriginal and Torres Strait Islander populations– emergency department presentations as a proxy	In the absence of local data, as per above, we use emergency department presentations to gauge AoD harm prevalence amongst the local Aboriginal and Torres Strait Islander populations. Over-representation of Aboriginal and Torres Strait Islander populations across the PHN and in each regional area in emergency department presentations due to AoD misuse and AoD related injuries. In contrast to the non-Indigenous populations, the vast majority of emergency department presentations amongst Aboriginal and Torres Strait Islander people are directly related to AoD (coded as such at emergency department)	**Overrepresentation of Aboriginal and Torres Strait Islander populations** In 2015-16 there were 653 Aboriginal and Torres Strait Islander emergency department presentations due to AoD (9.2% of total emergency department presentations vs. 3% of Aboriginal and Torres Strait Islander peoples in the PHN population). Aboriginal and Torres Strait Islander peoples are similarly overrepresented across the three regions: Central Queensland: 12% vs 5% of the population, Sunshine Coast: 5% vs. 1.7% of the population and Wide Bay: 12% vs. 3.6% of the population. In line with the younger profile of the Aboriginal and Torres Strait Islander populations, a lower proportion of over 45s is observed for Aboriginal and Torres Strait Islander emergency department presentations vs. non-Indigenous (22% vs. 30%). **Type of emergency department presentations – AoD coded vs. AoD related injuries** 50% of Aboriginal and Torres Strait Islander emergency department presentations were due to injuries vs. 62% in the non-Indigenous populations. As a result the proportion of emergency department

Outcomes of the health needs analysis		
	and not due to injuries likely to be caused by alcohol. Aboriginal and Torres Strait Islander peoples in the Sunshine Coast area are the only cohort for which drug misuse emergency department presentations outnumber those related to alcohol.	presentations directly coded as AoD at emergency department were much higher amongst Aboriginal and Torres Strait Islander peoples (50% vs. 38%). Of note, in the Sunshine Coast, Aboriginal and Torres Strait Islander people presenting to emergency department due to drug misuse outnumber those presenting due to alcohol misuse (34 vs. 23). In all the other regional cohorts (Aboriginal and Torres Strait Islander and non-Indigenous) drug misuse emergency department presentations are lower than those that are alcohol related. Although numbers are very small to draw firm conclusions, this is in line with other evidence suggesting higher prevalence of drug misuse in the Sunshine Coast area. Overall there are no substantial differences in the percentage of Aboriginal and Torres Strait Islander and non-Indigenous clients that are discharged when presenting to emergency department due to direct drug/alcohol misuse.

Section 3 AoD – Outcomes of the service needs analysis

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
AoD Hospitalisations – Low access to specialised care	Notwithstanding high need across the PHN, there are low rates of overnight hospitalisations due to AoD misuse. A very low proportion of hospitalised clients receive care in specialised psychiatric units with many being treated in general hospitals Local variations in hospitalisation rates across the LGA	For 2014-15, the ASR per 100,000 people of overnight hospitalisations due to AoD misuse across the PHN was 141 (vs. 180 nationally). This is the second lowest rate of the Queensland PHNs and is also lower than the 196 ASR observed across regional areas. The ASR across the PHN has remained the same as in the previous year (2013-14), in contrast with an increasing national trend over the same period (168 vs. 180) Of note, across the PHN around a quarter (26.8%) of all these hospitalisations take place in specialised care. This is lower than the national average (42%) and even lower than the regional rate of 37.6%. This is in line with earlier findings in regards to the relatively large numbers of mental health hospitalisations taking place in general hospitals, particularly in rural areas. When looking at LGA level (population rates per 100,000), we find that areas with high need like Gympie and Gladstone show some of the lowest AoD hospitalisation rates in the region.
AoD Community services delivered by NGO and public providers – Low access particularly in rural areas notwithstanding recent growth	Lower population rates of AoD services delivery than those observed in Queensland. Lower rates in 2015-16 are observed in spite of a rapid growth over the last three years. The NGO sector has expanded rapidly over the last three years, however services are still insufficient to meet current demand. Rural and remote areas are notably underserved.	**Volume of services** In 2015-16, according to Queensland Health data and our own estimates, AoD episodes of care were delivered at a rate of 738 per 100,000 population across the PHN (lower than the 883 per 100,000 population rate in Queensland). This is spite the rapid growth in recent years observed across the PHN as noted below. The Wide Bay population is served at a rate of 801 per 100,000 people vs. 779 in Central Queensland and 679 in Sunshine Coast. AIHW data shows substantially lower rates for our PHN when compared to Queensland. For 2015-16, the PHN rates per 100,000 populatin are just over two-thirds of the Queensland rates. In other words, according to the AIHW data, our PHN population is more disadvantaged in terms of access to services

Outcomes of the service needs analysis		
	As detailed below there are considerable variations in regional availability of services that need to be further explored with local stakeholders.	than suggested by the Queensland Health data above. However, in both datasets, the overall regional patterns are consistent, i.e. the AIHW data also shows higher rates in Wide Bay, followed by Central Queensland and the Sunshine Coast. Importantly when we look at SA3 level data provided by the AIHW, some areas of potentially high need such as Central Highlands/Woorabinda have no registered episodes of care in 2015-16. This reflects an important concern raised by local stakeholders. Also as noted below, the AIHW data shows marked differences across each regional area for specifc services. Some services such as withdrawal management, rehabilitation and case management are delivered at much higher rates in one region vs. the others. Since this dataset was only received in mid-October we have focused mostly on cross-validating the estimates with other data sources, but future work will involve local stakeholders to unpack the drivers of such differences. **Trends based on Queensland Health Data** In 2015-16 there were 6,078 closed episodes of care for AoD services in the PHN. This represents 1.6 times the volume of episodes of care delivered in 2013-14. Over the 2013-14, 2015-16 period, the volume of services across the PHN grew at an annual average rate of 25% (vs. 14% in Queensland) The fastest annual growth rate was observed in Wide Bay (35%), where services almost doubled from 900 episodes of care in 2013-14 to 6,078 in 2015-16. This is followed by Central Queensland and Sunshine Coast whose services grew on average every year 22% and 21% respectively. **Who delivers services?** Similar to Queensland 40% of services across the PHN are delivered by NGOs. However, there are substantial differences in the regions. In Wide Bay and Sunshine Coast around 46% are delivered by NGOs, while only 26% of Central Queensland services are. Of note has been the rapid growth of services delivered by NGOs. They tripled from 806 episodes of care in 2013-14 to 2,435 in 2015/16. This represents an average annual growth rate more than three times that of Queensland (74% in the PHN vs. 22% in Queensland). Taking into consideration the differences in salaries, working conditions, recruitment, retention issues and organisational culture across both sectors, the growing share of the NGO sector has important implications for future workforce development in the region. Notwithstanding this rapid expansion, there is still limited availability of services to address population treatment needs, particularly in rural areas. This has been noted by stakeholders and supported by the

Outcomes of the service needs analysis		
		service mapping undertook in 2016. This identified 14 AoD organisations delivering services across the PHN. However, the majority are small providers with less than 10 AoD treatment staff and operating from large population centres. In regards to future expansion of primary care services, direct stakeholder engagement within the region indicated: • more could be done to encourage GP led ambulatory withdrawal • upskilling of mental health nurses to provide alcohol and other drug services, and • promotion of digital and telephone based alcohol and other drug services for low intensity interventions.
Service gaps in brief intervention and screening services	Across the three regional areas, rates are consistently below those observed in Queensland.	Service mapping indicates there are 11 (out of 14) AoD providers delivering screening/brief interventions across the PHN. According to AIHW data, these providers delivered a total of 2,607 episodes of care during 2015/16. These services were delivered at a rate of 317 episodes per 100,000 population, which is substantially lower than the rate observed in Queensland (455 per 100,000). Service rates were similar across the three regional areas, though slightly higher in the Sunshine Coast region.
Service gaps in drug and alcohol counselling services	Service rates for counselling treatment are similar to those observed in Queensland.	AIHW data for 2015-16 shows that approximately, 2405 episodes of care were delivered across the PHN for counselling services. They were delivered at a rate of 292 episodes of care per 100,000 population across the PHN vs. 288 in Queensland. Rates are larger in Central Queensland (340) and Wide Bay (314) than Sunshine Coast (251). However, it is important to note that as noted earlier low levels of services are recorded for rural and remote areas, with the vast majority of services in Central Queensland concentrated in Gladstone and Rockhampton.
Service gaps in withdrawal management services	In line with stakeholder feedback and our service mapping, the AIHW data shows substantial gaps in withdrawal management services across the PHN. Available data also suggests large regional variabilities that need to be explored in more detail with local stakeholders.	Service mapping indicates that out of the 14 AoD providers in the PHN catchment, six deliver withdrawal management services. Four of them offer these services integrated with rehabilitation and other services and the remaining two deliver them as stand-alone. Inputs from local experts indicate there are barriers to accessing withdrawal management (detox) services beyond GP services.

Outcomes of the service needs analysis		
		These views are strongly supported by the data. In 2015-16, 156 episodes of care for withdrawal management were delivered across our PHN. Our rate of 19 episodes of care per 100,000 population is almost a quarter of the observed Queensland rate of 79 per 100,000 population. There are also regional variations revealed by the available data that need to be examined more closely with local stakeholders. While an area of high need such as Wide Bay shows a rate of 67 per 100,000 population (relatively close to the Queensland rate), rates are much lower in Central Queensland and Sunshine Coast.
Service gaps in rehabilitation services	Important gaps in rehabilitation services are observed across the PHN. Although some data suggests that the vast majority of services are concentrated in the Sunshine Coast region, other data sources suggest that services are also available in Central Queensland.	Stakeholder inputs identified geographic barriers to accessing AoD treatment services. Residential rehabilitation services was identified as a need by local experts, with one or two stakeholders also noting a need for short, medium and long stay options. Service mapping shows that three community organisations (two in Central Queensland and one in the Sunshine Coast) deliver residential rehabilitation services across the PHN catchment. These providers reported 46 beds, 27 of which are in the Sunshine Coast area and the remaining 19 in Central Queensland. The 2015-16 AIHW data shows that a total of 158 episodes of care for rehabilitation services were delivered across the PHN. Most of these services were concentrated in the Sunshine Coast, which shows a service population rate similar to that observed in the state (38 vs. 41 per 100,000 population). This is in line with the above findings. Similarly, the AIHW data support the noted lack of rehabilitation services in Wide Bay. Conflicting information is available in relation to Central Queensland's capacity to deliver rehabilitations services.
Service gaps – Support and Case Management	The PHN is served at a rate substantially lower than the Queensland population, with marked differences across regional areas.	In 2015-16, 116 episodes of care for support and case management services were delivered across the PHN. This represents a rate of 14 per 100,000 population vs. 30 across the State. The data suggests that most of these services are delivered in Central Queensland (77 out of 116 episodes of care). As a result, Central Queensland shows a rate slightly higher than Queensland (33 vs. 30), while services are low in Sunshine Coast (13 episodes of care for a population rate of 3.4 per 100,000). Unfortunately, no other available data exists to validate these findings. As noted earlier, we will need to assess these findings with our stakeholders. This will help us examine the validity of these estimates and understand the potential drivers of such variability .

Outcomes of the service needs analysis		
Service gaps - After-hours and outreach services	Limited availability of services, that need to be taken in the context of the overall lack of services across the PHN.	Service mapping findings demonstrate a gap in availability of after-hours and outreach services, with most providers operating during business hours. Two organisations – one in Wide Bay and one in Central Queensland – deliver AoD services 24/7. Although there are eight AoD providers offering outreach AoD services in the PHN catchment, the capacity to deliver services is limited.
Youth and young adult AOD education, prevention and treatment services	Given the high prevalence of AoD misuse across young people, important gaps in services have been noted.	Reports from Maroochydore, Rockhampton and Hervey Bay Headspace Centres for FY 2015-16 indicate that drug and/or alcohol interventions represent a very small portion of services provided to young people in the catchment (representing between 0.1% and 0.2% across the catchment centres, compared with the national centre average of 1.1%). In Central Queensland, stakeholders indicated concerns about insufficient services for young people whose homes were affected by drugs, alcohol misuse and domestic violence. In the Sunshine Coast area, lack of employment for young people was raised as an issue affecting mental health and wellbeing among young people. Previous consultations with Clinical and Community Advisory Councils in the PHN catchment identified similar concerns as stakeholders in the catchment. Service mapping results also suggest that only five out of 14 AoD providers in the PHN catchment receive funding for delivering AoD services to young people. AIHW data for 2015-16 suggests that over half of AoD services across the PHN were delivered to people under 30 years of age. A slightly lower share is observed in Queensland. However in line with the high prevelance of AoD misuse amongst very young people, our PHN shows the largest share of clients under 20 years of age in Queensland (22.4% vs. 17.9% across the State).
Workforce development has been identified as a critical gap for effective scale-up of services.	One of the most important constraints to effectively scale-up services in our PHN relate to workforce. However, limited evidence exists on current levels, gaps and best strategies to address those gaps. They need to be informed by local evidence and by best-practice.	There is limited information available on the profile of our specialist AoD workforce and the implications of local issues such as the relative share of NGO vs. government sectors and changing patterns in AoD use. Current best-practice in workforce development strategies emphasises a multi-faceted approach with a strong system focus targeting individual, organizational and structural factors impacting workforce in general.

Outcomes of the service needs analysis		
		Our PHN has commissioned the National Centre for Education and Training on Addiction (NCETA) to undertake workforce development needs assessment consultations that will be used to inform our regional strategy and determine priority areas for future action, including assembling the required data.
Fragmented and poorly coordinated services	Fragmentation and poor coordination of the various services receiving AoD clients prevents us from achieving better outcomes for clients in an efficient way.	Feedback to QNADA from statewide NGO AoD service providers identified the need to: - Improve coordination of AoD and related services between sectors. - Coordinate with existing services to avoid overlap and expand capacity to accommodate all individuals in need of treatment. - Co-locate mental health and AoD services as a strategy to improve coordination. As noted under the mental health section, participants at the consumer journey exercise also stressed barriers and challenges imposed by current fragmentation of services, including the lack of dual diagnosis for those clients affected by both mental health and AoD misuse.
Drug and Alcohol Treatment Services- Aboriginal and Torres Strait Islander people		
Service gaps AoD - Community services delivered by NGO and public providers to the Aboriginal and Torres Strait Islander population	In line with their higher need, Aboriginal and Torres Strait Islander clients receive 12% of episodes of care (vs. over 3% of the population). AoD services delivered to Aboriginal and Torres Strait Islander clients have grown at a fast pace across the PHN, but given the initial low number of services, a large unmet need is expected.	**Volume of services** Reflecting their higher need, 12% of episodes of care provided services to Aboriginal and Torres Strait Islander clients in 2015-16 (vs. 10% in 2013-14). This is four times their population share (3.1%). A similar overrepresentation of Aboriginal and Torres Strait Islander clients was observed across the entire PHN region. **Trends** 732 AoD episodes of care for Aboriginal and Torres Strait Islander clients were delivered in 2015-16. This is 1.8 times the volume in 2013-14 (401 AoD episodes of care received by Aboriginal and Torres Strait Islander clients). Similar to overall trends, the fastest growth in services delivered to Aboriginal and Torres Strait Islander clients was observed in Wide Bay, where services delivered in 2015-16 were 2.2 times the volume of services delivered in 2013-14. **Principal drug of concern** In 2015-16, almost half of all episodes of care delivered to Aboriginal and Torres Strait Islander clients (48%) had cannabinoids as the principal drug of concern. This is a slightly higher share than two years earlier (47%).

Outcomes of the service needs analysis		
		Alcohol was the second most common drug of concern, accounting for 22% of episodes of care in 2015/16 (vs. 26% in 2013/14). Amphetamines now accounts for 13% of all episodes of care and increased two percentage points over the same years. **Who delivers services** In 2015-16, 56% of all AoD services are delivered by public providers vs. 44% by NGOs. It is important to note the growing importance of the NGO sector, which accounted for only 17% of all episode of care to Aboriginal and Torres Strait Islander clients two years earlier. As noted earlier, given workforce development differences across public and community sectors, this has important implications for future workforce development in the region. Unfortunately serious discrepancies between the AIHW data and the Queensland Health data prevented us from undertaking a more detailed analysis of the AIHW data in regards to the type of services received to the Aboriginal and Torres Strait Islander population across our PHN.
Lack of culturally appropriate services	Culturally competent services are required to ensure the engagement of Aboriginal and Torres Strait Islander people and successful reductions in alcohol and other drug related harm. The resource implications of providing culturally competent and effective AoD services for Aboriginal and Torres Strait Islander populations should be given due consideration.	Similar to mental health services, AoD services need to be grounded on a holistic concept of health and wellbeing, reinforce Aboriginal family systems of care, support and responsibility, place culture as a central core component of the service. Stakeholders in the PHN identified a lack of culturally responsive service provision, including lack of support services for Aboriginal and Torres Strait Islander families experiencing drug and alcohol misuse within their family. A majority of funding is provided to mainstream services, many of which struggle to engage with Aboriginal and Torres Strait Islander clients, who feel uncomfortable receiving services from these organisations. Although local evidence is not available to examine the cost implications of delivering culturally competent and effective AoD services to Aboriginal and Torres Strait Islander clients, previous work on the Drug and Alcohol Service Planning (DASP) Model adaptation suggested that the additional costs of delivering the required care to Aboriginal and Torres Strait Islander clients are about two to three times as much as non-Indigenous clients. Costs are greater because of the need to include additional elements such as specific care components (i.e. return to country/community), as well as other elements such as better engagement with families and more intensive assertive follow up.

Outcomes of the service needs analysis		
Aboriginal and Torres Strait Islander Workforce – Workforce development needs, including of culturally safe strategies	Insufficient Aboriginal and Torres Strait Islander AoD workforce has been identified as a critical gap to be addressed. This is in addition to the above issue of overall constraints in AoD workforce across the PHN and the lack of a sound evidence base to inform effective strategy development.	The service mapping shows that two out of 14 AoD providers that participated in the service mapping reported Aboriginal and Torres Strait Islander health workers amongst their AoD treatment staff. A comprehensive mental health and AoD workforce development needs assessment will be needed to provide the evidence required for a workforce development strategy aligned with the state framework and which targets key issues facing Aboriginal and Torres Strait Islander workers in our PHN, including the need for higher numbers .

Section 4 AoD – Opportunities, priorities and options

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Sector Engagement and Strategy Development in the context of the regional plan for mental health and AoD services described above.	Work collaboratively with HHSs, QNADA, specialist drug and alcohol treatment providers in the region, Aboriginal and Torres Strait Islander organisations and service providers, consumers, other government agencies and welfare organisations to further develop a comprehensive regional AoD plan based on best available evidence.	PHN secures access to ATODS data to further identify levels of services, gaps and priority populations and locations. Regional plan developed and broad support exists for priorities and strategies identified in the plan.	Regional plan for AoD developed in the context of the regional collaboratives for mental health and AoD and supported by the best available evidence Formalised partnerships/ collaborations established with local key stakeholders	PHN to lead planning in conjunction with a range of relevant stakeholders. Stakeholders to provide the PHN with access to required ATODS data to inform planning and monitoring of services.
Increase local availability of withdrawal management and support services	Engage further with local AoD service providers regarding opportunities and barriers to increasing local or home-based withdrawal management and support services. Commission appropriate withdrawal management and support services within the PHN region.	Increased delivery of withdrawal management services in the PHN catchment.	Increased coverage of withdrawal management services in the PHN catchment	PHN to lead commission services in conjunction with other stakeholders.
Increase access to other AoD services with focus on rural/remote and other underserviced populations.	Increase access to transitional rehabilitation to community services, particularly in rural/remote areas	Improved access to AoD services, especially in rural areas.	Proportion of PHN population with access to AoD services	PHN to commission services in conjunction with other stakeholders.

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Integration and coordination of care	Work with mental health and AoD providers to improve dual diagnosis and the delivery of integrated care. Identify GPs with an interest in AoD across the PHN and engage them as champions to facilitate GP education on AoD.	Improved dual diagnosis rates for mental health and AoD clients More integrated and coordinated care for AoD clients	Referral into specialist treatment from other health services in the PHN catchment Improved rates of dual diagnosis	
Workforce development	Develop a workforce development strategy with a strong system focus that is tailored to the PHN.	A comprehensive workforce development needs assessment is undertaken for the PHN and each regional area to inform strategic planning. A strategic workforce development framework is developed and aligned with the Queensland Workforce Council strategy. In line with the DoH Performance framework development strategies include training and support for health professionals	Workforce development needs assessment undertaken Consultations for the strategic workforce development framework are undertaken. A strategic workforce development framework is adopted and supported by key stakeholders. Quality Improvement – evidence of support for health professionals, number of education/training modules delivered.	PHN to lead the development of the strategic framework in conjunction with local training institutions and other stakeholders.
Drug and Alcohol Treatment Services- Aboriginal and Torres Strait Islander people				
Prevention of risk behaviours	Foster and support the development of strategies designed to increase the participation of Aboriginal and	Increased participation of Aboriginal and Torres Strait Islander men in addressing social and emotional health and	Reductions in risk factor indicators among Aboriginal and Torres Strait Islander populations (long term).	PHN in collaboration with Aboriginal Community Controlled Health Services.

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	Torres Strait Islander men in addressing social and emotional health and wellbeing as well as risk factors associated with harmful substance use. Facilitate co-design and implementation of strategies targeting the lifestyle behaviours of young Aboriginal and Torres Strait Islander people.	wellbeing as well as risk factors associated with harmful substance use. Reduction in risk behaviours among young Aboriginal and Torres Strait Islander people. Improved knowledge and understanding of risk behaviours and implications for long term health outcomes.		
Workforce Development of Aboriginal and Torres Strait Islander health workers and increased cultural competency of mainstream services	In the needs assessment and strategy outlined above, address workforce development issues for Aboriginal and Torres Strait Islander workers and ensure strategies adopted are culturally safe.	Strategies to increase cultural competency of AoD workforce included. Specific needs and strategies tailored to the Aboriginal and Torres Strait Islander workforce are identified and adopted, while ensuring alignment with Queensland's *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026*.	Workforce development needs assessment undertaken Consultations for the strategic workforce development framework are undertaken and relevant strategies adopted. A culturally safe strategic workforce development framework is adopted and supported by key stakeholders	PHN to lead the development of the strategic framework in conjunction with local training institutions and other stakeholders.
Co-create locally based solutions	Collaborate with Aboriginal and Torres Strait Islander organisations to Improve access to and delivery of high quality AoD services that effectively engage the Aboriginal and Torres Strait Islander population. Includes better	Established collaborations with Aboriginal and Torres Strait Islander organisations to deliver culturally appropriate and effective services.	Continuous and sustainable growth of service utilisation by Aboriginal and Torres Strait Islander status	PHN in collaboration with ACCHOs and commissioned service providers.

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	identification of treatment pathways for Aboriginal and Torres Strait Islander population. Collaborate with organisations to ensure that current growth in services for Aboriginal and Torres Strait Islander people across the PHN continues in a sustainable manner.	Improved access to AoD services across the PHN.	Formalised partnerships/ collaborations established with local key stakeholders	
Increase access to culturally appropriate AoD services for Aboriginal and Torres Strait Islander people	Continue working with Aboriginal and Torres Strait Islander organisations and communities to identify specific AoD needs and service gaps for Aboriginal and Torres Strait Islander people. Commission culturally appropriate, evidence based services that will complement existing services for Aboriginal and Torres Strait Islander people in the region. Continue to invest in capacity building and cultural sensitivity training to service providers to enhance cultural competence and understanding of the historical, cultural and social factors that contribute to harmful substance use among Aboriginal and Torres Strait Islander populations.	Effective engagement with Aboriginal and Torres Strait Islander stakeholders to identify appropriate and effective service delivery options and settings. Improved access to and utilisation of services and programs which address Aboriginal and Torres Strait Islander harmful substance use issues in culturally-specific ways. Enhanced treatment outcomes for Aboriginal and Torres Strait Islander people.	Increased acceptability and access to culturally appropriate mental health services by Aboriginal and Torres Strait Islander people. All commissioned services are culturally appropriate	PHN to lead planning in conjunction with ACCHSs, Aboriginal and Torres Strait Islander organisations, HHSs, other local service providers, consumers and carers and commission services in accordance with plans. PHN to deliver cultural sensitivity training to service providers.

Section 5 MENTAL HEALTH, SUICIDE PREVENTION and ALCOHOL AND OTHER DRUGS- Checklist

This checklist confirms that the key elements of the needs assessment process have been undertaken. PHNs must be prepared, if required by the Department, to provide further details regarding any of the requirements listed below.

Please attach checklists for any Activities under other Schedules to the Standard Funding Agreement if required.

Requirement	✓
Governance structures have been put in place to oversee and lead the needs assessment process.	✓
Opportunities for collaboration and partnership in the development of the needs assessment have been identified.	✓
The availability of key information has been verified.	✓
Stakeholders have been defined and identified (including other PHNs, service providers and stakeholders that may fall outside the PHN region); Community Advisory Committees and Clinical Councils have been involved; and Consultation processes are effective.	✓
The PHN has the human and physical resources and skills required to undertake the needs assessment. Where there are deficits, steps have been taken to address these.	✓
Formal processes and timeframes (such as a Project Plan) are in place for undertaking the needs assessment.	✓
All parties are clear about the purpose of the needs assessment, its use in informing the development of the PHN Annual Plan and for the department to use for program planning and policy development.	✓
The PHN is able to provide further evidence to the department if requested to demonstrate how it has addressed each of the steps in the needs assessment.	✓
Geographical regions within the PHN used in the needs assessment are clearly defined and consistent with established and commonly accepted boundaries.	✓
Quality assurance of data to be used and statistical methods has been undertaken.	✓
Identification of service types is consistent with broader use – for example, definition of allied health professions.	✓
Techniques for service mapping, triangulation and prioritisation are fit for purpose.	✓
The results of the needs assessment have been communicated to participants and key stakeholders throughout the process, and there is a process for seeking confirmation or registering and acknowledging dissenting views.	✓
There are mechanisms for evaluation (for example, methodology, governance, replicability, experience of participants, and approach to prioritisation).	✓