



**Central Queensland Wide Bay
Sunshine Coast PHN
Mental Health and Suicide Prevention:
Health and Service Needs Analysis**

15 November 2021

Contents

Acronyms	3
1. Overview	4
2. Health Needs Analysis.....	1
2.1. Risk and protective factors of mental wellbeing.....	2
2.2. Prevalence of Mental Illness	6
2.3. Mental health conditions for specific population groups	19
2.4. Co-morbidity	41
3. Health Service Needs	44
3.1. Access and Continuity of Mental Health Services	44
3.2. Mental health safety and quality	65
3.3. Mental health workforce	66
3.4. Responsiveness and Appropriateness	68
3.5. COVID-19 impact on Mental Health Services.....	69
4. Triangulation	70
5. Opportunities, Priorities and Options	74
6. Annex: Tables and Charts	83
7. References	86

Acronyms

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
ASR	Age Standardised Rate
CQ	Central Queensland
CQWBSCPHN	Central Queensland Wide Bay Sunshine Coast PHN (the PHN)
CMHS	Community Mental Health Service
DoH	Department of Health
ED	Emergency Department
HHS	Hospital and Health Service
HWQ	Health Workforce Queensland
LGA	Local Government Area
MH	Mental Health
NICE	National Institute for Health and Care Excellence
NMHSPF	National Mental Health Service Planning Framework
NSMHWB	National Survey of Mental Health and Wellbeing
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PPH	Potentially Preventable Hospitalisation
QGSO	Queensland Government Statistician Office
QH	Queensland Health
QLD	Queensland
SC	Sunshine Coast
SCHHS	Sunshine Coast Hospital and Health Service
SEIFA	Socio-Economic Indexes for Areas
WB	Wide Bay
WHO	World Health Organization

1. Overview

Across the Central Queensland Wide Bay Sunshine Coast PHN (the PHN), improving social and emotional wellbeing of the population and addressing mental illness remain key priorities to individuals, carers, communities, and service providers. A large proportion of PHN commissioned services are directed towards mental health and suicide prevention programs. Findings from the National Survey of Mental Health and Wellbeing (NSMHWB) estimated that 45 percent of Australians had experienced a mental disorder in their lifetime, with 20 per cent experiencing a mental disorder in the previous year (1). 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 (2). Estimated projections for 2021 indicate that 17% of the population of the PHN will need some form of mental health services (2). Note that these are pre-COVID estimates.

A complex set of factors including social, economic, and physical environments play an important role in shaping the mental health of an individual (3). Examples of mental health determinants include socioeconomic disadvantage, remoteness, low workforce participation and low educational attainment (3). In addition, homelessness, substance misuse, crime, poor physical health, chronic pain, and domestic violence are often related to poor mental health outcomes. Selected socioeconomic indicators (i.e., SEIFA quintile, unemployment rates, rural/remote population) associated with mental illnesses were analysed for identifying those populations and locations within the PHN where relative need of mental services is likely to be higher than predicted by the NMHSPF.

Some key highlights of the Mental Health Needs Analysis chapter include:

- The PHN showed higher levels of socio-economic disadvantage (27.1% of the PHN population living in the bottom SEIFA quintile, vs. 20.0% in Queensland).
- The PHN areas with higher mental health risk factors (lower SEIFA quintile, unemployment, etc) were Bundaberg, Fraser Coast, North Burnett, Gympie, Woorabinda, and Rockhampton.
- In 2017-18, the rate of people experiencing mental and behavioural problems in the PHN region was slightly higher than QLD (23.1 compared to 22.7 ASR per 100). However, six of the 12 LGAs in the PHN had much higher rates than the QLD rate: Rockhampton presented with the highest rate (ASR 26.5 per 100) followed by Gympie (ASR 25.9 per 100) Bundaberg (ASR 24.8 per 100), Fraser Coast (ASR 24.4 per 100), Gladstone (ASR 24.1 per 100) and North Burnett (ASR 24.1 per 100)
- The rate of people with high or very high psychological distress within the PHN (ASR 13.5 per 100) was higher than the QLD rate (ASR 13.0 per 100) in 2017-18: Wide Bay Region (ASR 14.9 per 100) had the highest rate of psychological distress.
- Suicide was the 9th leading cause of death in the PHN – accounting for 2.2% of all deaths in 2015-2019, compared to the national average of 1.9% (11th rank among causes of death)
- The Aboriginal and Torres Strait Islander population in the PHN region was twice more likely to die of suicide than non-Indigenous people; this ratio was consistent for the period of 2015-19.
- The PHN region had the 5th highest rate (229 per 100,000 people) of intentional self-harm hospitalisation among 31 PHNs across Australia in 2019-20; the PHN rate was 1.6 times higher than Australia rate (143 per 100,000)
- Females aged 0-24 were most at risk of intentional self-harm hospitalisation in the PHN region (253 per 100,000) compared to other age groups and the males of the same age group (94 per 100,000)

In addition to the published data evidence, the PHN community and stakeholder (service providers) survey results also confirmed mental health as one of the key health priorities for the entire region. Youth mental health and suicide prevention were particularly identified as important areas of focus.

An uptake of mental health services and identified service gaps are presented in the Health Service Needs Analysis Chapter.

2. Health Needs Analysis

The World Health Organization (WHO) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (4). A definition used by the National Institute for Health and Care Excellence (NICE) organisation in the UK states that “mental wellbeing is a dynamic state in which the individual is able to develop to their potential, work productively and creatively, build strong and positive relationships with others and contribute to the community” (5). Conversely, “mental illness occurs when a person’s thoughts, feelings or behaviour cause ongoing suffering or an inability to cope with everyday life. Both mental wellbeing and mental illness result from complex interactions between the mind, body and environment (6), thus requiring a comprehensive and integrated approach that allows effective coordination between various levels of care. For Australia, mental illness and substance use disorders were estimated to be responsible for 12% of the total burden of disease in 2015, placing it fourth as a broad disease group after cancer (18%), cardiovascular diseases (14%) and musculoskeletal conditions (13%) (7).

This **health needs analysis** chapter is structured as follows, where possible comparing the PHN and LGA/SA3 level data with national, state/territory data:

- Risk and protective factors of mental wellbeing: Mental health determinants include both risk and protective factors that are crucial in predicting potential mental health priority areas and populations. Unfortunately, there was not adequate data to present the extent of mental health determinants within the PHN. However, we used national and international literature evidence that identifies key risk and protective factors of mental wellbeing.
- Prevalence of common mental disorders including:
 - Mental and behavioural problems
 - Psychological distress
 - Eating disorders
 - Suicide and self-harm
 - Intentional self-harm hospitalisations
- Mental health common conditions (above) for specific population groups: these population groups were identified based on the prevalence of risk factors and common mental health conditions including:
 - Gender
 - Children and young people
 - Older people 65+ years
 - Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
 - Australian defence force personnel
- Co-morbidity: People with mental illness often experience poor physical health and/or adverse health consequences from harmful substance use, leading to reduced life expectancy. We analysed the relevant data to present common comorbidities present among people experiencing mental and behavioural problems.

2.1. Risk and protective factors of mental wellbeing

Social factors affect risk for mental illnesses and substance use disorders, as well as health outcomes of persons with these disorders (3, 8). A complex set of such factors including social, economic, and physical environments play an important role in shaping mental health of an individual (3). Examples of mental health determinants include socioeconomic disadvantage, remoteness, low workforce participation, low educational attainment, and stressors experienced during childhood (3). In addition, homelessness, substance misuse, crime, poor physical health, chronic pain, and domestic violence are often related to poor mental health outcomes (6, 9, 10). Being from Aboriginal and Torres Strait Islander background also extensively increases the risk of mental health concerns (11). This risk is not only associated with socio-economic disadvantage but also with the history that has left deep impact and requires trauma informed care to address it. A knowledge and understanding of the risk and protective factors for the PHN are crucial in predicting potential adverse mental health priority areas and populations.

Selected socioeconomic indicators (i.e. SEIFA quintile, unemployment rates, rural/remote population) associated with mental illnesses were analysed for identifying those populations and locations within the PHN where relative need of mental services is likely to be higher than predicted by the NMHSPF.

- Australian Burden of Disease study shows the burden of mental health and substance use for the most socio-economically disadvantaged to be 1.6 times higher compared with the least disadvantaged in 2015 and the burden of suicide and self-inflicted injuries to be 1.7 times higher for the most socio-economically disadvantaged (7,12).
- When compared to Queensland, the PHN showed higher levels of **socio-economic disadvantage** (i.e., 27.1% in the bottom SEIFA quintile, vs. 20.0% in Queensland) and annual family income of \$73k (PHN) vs \$86k in Queensland (2016), respectively (13).
- The population living in LGAs in Wide Bay (WB) (Bundaberg, Fraser Coast, North Burnett) as well as Gympie (Sunshine Coast (SC)), Woorabinda (Central Queensland (CQ)), Rockhampton (CQ) showed **high levels of socioeconomic disadvantage** as measured by annual family median income and the SEIFA quintile (13). These areas all have higher percentage of socio-economically disadvantaged population compared to the QLD average, where an estimated 20% of the population live in most disadvantaged quintile (See Table A in the Annex for key socio-economic characteristics of the PHN population).
- **Unemployment** (as per Dec 2020) was highest in the WB area (11.8%), higher than the PHN overall average (7.8%) and comparable Queensland average (7.1%) (13). LGAs with higher than 10% unemployment rate include the Fraser Coast (13.1%), Bundaberg (11.0%) and Gympie (10.9%)(13).
- Almost a third (30%) of deaths due to suicide in Queensland were associated with either being unemployed or having experienced recent or pending unemployment (14). Recent research (15) on COVID-19 effects suggests that the economic downturn due to the coronavirus pandemic requires careful monitoring of suicide mortality data for assessing the potential effects of short- and long-term unemployment, amongst other stressors.
- Populations in **rural and remote areas** have poorer access to health services as well as higher levels of socio-economic disadvantage and risk factors compared to the people living in inner regional areas or in major cities. Across the PHN, half of all the LGAs in CQ (Banana, Central Highlands and Woorabinda) and one LGA in WB (North Burnett) had all of their populations living in outer-regional or remote areas (13).
- In Australia, the years of healthy life lost per 1,000 people due to mental and substance use disorders among **Aboriginal and Torres Strait Islander Australians was 2.4 times the rate for non-Indigenous Australians** (23.6 for non-Indigenous; 57.8 for Indigenous) (16). The PHN is a

home to one discrete Aboriginal community, Woorabinda (95% Indigenous), and Rockhampton (7.4%) and North Burnett (6.5%) have a higher proportion of Indigenous population compared to other areas in the PHN region (13).

- The potential for COVID-19 to impact mental health and wellbeing was recognised early in the pandemic (17). The sudden loss of employment and social interaction, the added stressors of moving to remote work or schooling and impacts of 'lockdowns' to prevent further outbreaks have impacted the mental health of many Australians (18).

Table 1 below presents ranking by key social determinants of health that are specifically linked to mental illnesses by PHN LGAs. These include geographic and social isolation, and higher rates of Socio-Economic Indexes for Areas (SEIFA quintiles) and selected demographic age. SEIFA index uses a range of different socio-demographic variables including income, education, employment, occupation, and housing characteristics; hence serves a composite indicator for identifying most and least socio-economically disadvantaged areas (19). These contextual differences between the PHN regions and LGAs and the extent of abovementioned various social determinants across the PHN areas were carefully considered in examining and interpreting the prevalence of mental and behavioural disorders and in estimating the demand for services across the PHN.

Table 1: The PHN LGAs with highest socio-economic disadvantage based on multiple risk factors for harmful use and outcomes of AOD, by LGAs within the PHN.

LGA	Indigenous people		Outer regional, remote, or very remote areas		People living in areas defined as low SEIFA		Young people (15 to 29 years)		Older people (>60 years)		Total Ranking	Overall Ranking (ranked 1-12; 1-worst; 12-least worst)
	%	Ranking	%	Ranking	%	Ranking	%	Ranking	%	Ranking	Total	Ranking
Banana (S)	4.0	8	100	1	17.2	8	16.6	6	21.0	9	32	8
Central Highlands (R)	4.3	5	100	1	14.0	10	18.1	4	13.6	3	23	3
Livingstone (S)	4.4	4	5.4	3	16.5	9	16.3	8	26.1	8	32	8
Rockhampton (R)	7.4	2	2.4	6	39.1	6	21.1	2	20.6	10	26	4
Woorabinda (S)	94.4	1	100	1	100	1	27.7	1	8.5	12	16	1
Bundaberg (R)	4.0	8	4.4	4	49.5	4	16.5	7	31.2	6	29	6
North Burnett (R)	6.5	3	100	1	57.1	3	15.6	9	31.6	3	19	2
Fraser Coast (R)	4.2	6	0.4	7	59.4	2	13.8	11	35.7	1	27	5
Gladstone (R)	4.1	7	13.8	2	21.5	7	18.3	3	17.2	11	30	7
Sunshine Coast (R)	1.9	11	0	8	9.1	11	17.1	5	26.7	7	42	11
Noosa (S)	1.5	12	0	8	5.8	12	13.3	12	33.5	2	46	12
Gympie (R)	3.6	10	4.3	5	46.1	5	14.6	10	31.5	5	35	10

Source: Queensland Government Statistician's Office, Queensland Treasury 2018. Queensland Regional Profiles.

Findings from the **PHN community health survey 2020-21**¹ (20) also indicated that communities across the PHN region identified the need for more accessible and affordable mental health services, especially in rural and remote areas. Survey participants also commonly expressed a need for effective interventions for addressing drug and alcohol use and associated mental health issues through holistic and sustainable long-term strategies. Suggestions included making youth mental health and psychologist services more accessible in most of the LGAs within the PHN (20).

Service providers who completed the **PHN stakeholders' surveys**² across the region also highlighted (21) mental health and suicide as one of the three main concerns, and it was ranked as a top health priority across all LGAs, except North Burnett and Fraser Coast where mental health was ranked as second top priority after social factors (unemployment, housing etc). A summary of top three health concerns by PHN regions as perceived by stakeholders is shown below:

Central Queensland (CQ) area	Wide Bay (WB) area	Sunshine Coast (SC) area
<ul style="list-style-type: none"> • Mental health and suicide • Access to health care services • Alcohol and/or other drugs 	<ul style="list-style-type: none"> • Mental health and suicide • Social factors (jobs, income, housing etc.) • Chronic health conditions / Unhealthy lifestyle choices (diet, physical activity) 	<ul style="list-style-type: none"> • Mental health and suicide • Chronic health conditions • Social factors (jobs, income, housing etc.)

Other factors such as low educational attainment, lack of appropriate support systems, unemployment, decreased physical health and domestic violence were all identified as contributing factors to poorer mental health (21).

¹ 612 completed surveys were used. The survey involved young people and families, adults, older people and people from vulnerable groups including people with a disability, and people from culturally and linguistically diverse backgrounds and LGBTIQ

² 240 completed stakeholders' surveys used in the HNA. There was a fairly even representation across all 3 PHN areas in the PHN stakeholders survey.

2.2. Prevalence of Mental Illness

One in five Australians aged over 16 experience mental illness each year (ABS 1). It is known that mental health experiences are influenced by age, gender, sexuality, social and family situation and cultural background (22). Therefore, people with mental illness are disproportionately represented amongst the following populations:

- Unemployed and those on low incomes, including those on government pensions and allowances as a main source of income.
- People with a history of housing instability and homelessness.
- Aboriginal and Torres Strait Islander Population (this is detailed in Aboriginal and Torres Strait Islander People's Health Needs and Service Analysis document).
- LGBTIQ+.
- Migrants and refugees.
- People from CALD.
- People with a disability.
- People living in rural and remote communities.
- People living with chronic conditions including alcohol or other drug problems.

The Productivity Commission Inquiry report (23) and the Fifth National Mental Health and Suicide Prevention Plan 2017-2022 (24) recognise that these population groups experience higher rates of mental health problems and mental illness than the general population, yet many of them encounter significant barriers which prevent timely access to appropriate supports and services. The Australian Government aims to enable integrated, accessible, and person-centred supports and services that are key to ensuring that these specific population groups experience better mental health and realise their potential (24).

2.2.1. Mental and behavioral problems

Queensland presented with the highest age-standardised rate (22.7 ASR per 100 compared to Australia rate of 20.1 ASR per 100) for mental and behavioural problems among Australian states and territories in 2017-18. Within the PHN, data (25) indicates that:

- Six of the 12 LGAs in the PHN had higher estimated rates than QLD for mental and behavioural problems. Rockhampton presented with the highest rate (ASR 26.5 per 100) followed by Gympie (25.9) Bundaberg (24.8), Fraser Coast (24.4), Gladstone (24.1) and North Burnett (24.1). (See Table 2 below)
- There was no data available for Woorabinda.

Table 2: People with mental and behavioural problems (number and ASR per 100) by LGAs, 2017-18

Location	Estimated number of people with mental and behavioural problems (modelled estimates)	
	2017-18 (persons)	
	Number	ASR per 100*
Banana (S)	2,906	20.8
Bundaberg (R)	23,530	24.8
Central Highlands (R)	5,617	20.9
Fraser Coast (R)	25,437	24.4
Gladstone (R)	14,839	24.1
Gympie (R)	13,330	25.9
Livingstone (S)	8,195	22.3
Noosa (S)	11,494	20.7
North Burnett (R)	2,583	24.1
Rockhampton (R)	20,960	26.5
Sunshine Coast (R)	66,001	21.3
Woorabinda (S)	^	..
Queensland	1,089,817	22.7
AUSTRALIA+	4,842,100	20.1

Source: Public Health Information Development Unit (PHIDU), Social Health Atlas of Australia: Data by LGA, PHIDU, Table: Estimates_chronic_disease

*ASRs higher than the QLD rate are in red

The same data provided by the PHN-SA3 areas are presented in Table B in the Annex for Tables. Gender and age-related prevalence differences are presented in the respective section on mental health conditions for specific population groups. Aboriginal and Torres Strait Islander Population's mental health data and finding are presented in Aboriginal and Torres Strait Islander People's Health Needs and Service Analysis document.

National Mental Health Service Planning Framework (NMHSPF) estimates the numbers of people in the PHN catchment that need mental health (MH) treatment services based on the prevalence of mental illness within the Australian population (2). NMHSPF estimates, along with other available information, serve to determine the broad patterns of need for mental health treatment across different age groups and severity of conditions. Understanding these patterns is crucial for planning the delivery of services across the stepped care model. This information along with the relative differences in **mental health treatment need** helps prioritise those areas, population groups and services with the highest unmet need.

NMHSPF estimates, along with other available information, suggested that across the PHN catchment, 16.7% of the population (or approximately 152,116 people) will need MH treatment of different levels of severity in 2021 (2). Of these, approximately (2):

- 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 had 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% of the PHN population) will need services for severe mental illness.

The above NMHSPF estimates are potentially expected to be higher in the PHN catchment. NMHSPF modelling assumptions, which draw on national level data, are modelled on total population and age groups only. These estimates do not consider the prevalence of other determinants known to be associated with mental illness in high prevalence in the PHN, such as rurality, economically disadvantaged, and Aboriginal and/or Torres Strait Islander populations. However, it must be noted that NMHSPF estimates include all mental health service needs for the entire region, including those delivered/managed by the PHN, Hospital and Health Service (HHS) and all other MH and allied MH service providers. Therefore, the PHN-only service needs require assessment alongside MH services delivered across sectors from a whole of health sector perspective and cannot be done in isolation.

2.2.2. Psychological distress

Psychological distress can be described as unpleasant feelings or emotions that affect a person's level of functioning and interfere with the activities of daily living (11). Psychological distress is often associated not only with poor mental health outcomes but also with poorer physical health outcomes (11, 26).

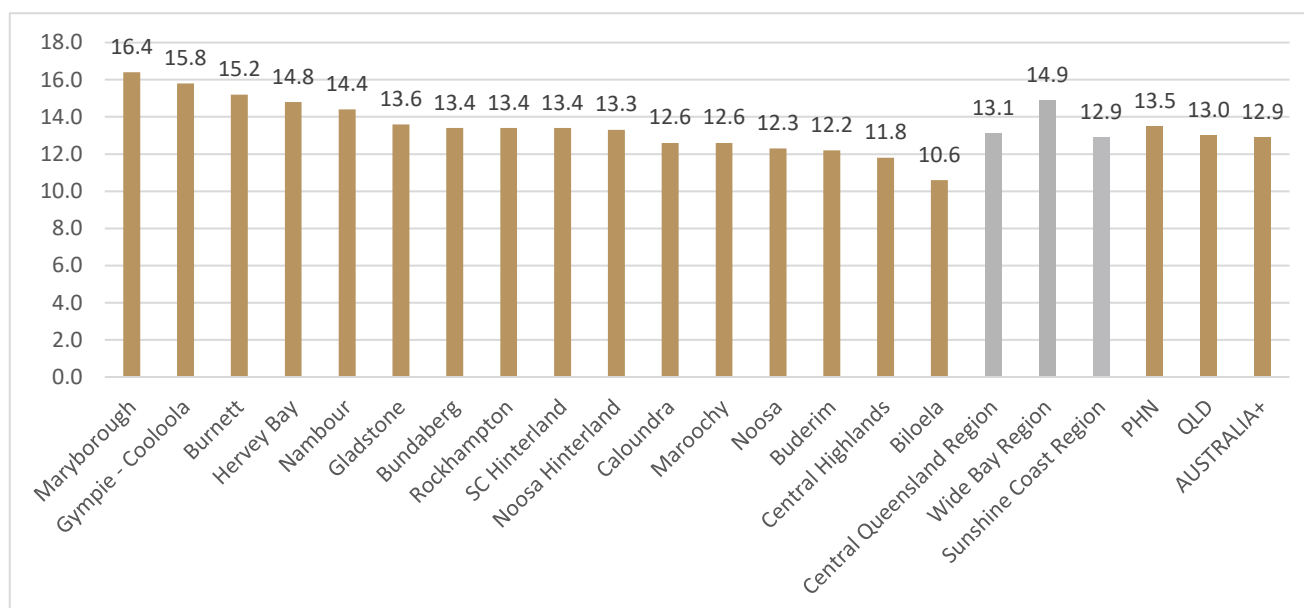
In 2017–18, 13% or 2.4 million Australians aged 18 and over experienced high or very high levels of psychological distress, a 11% increase from 2014–15 (11.7% or 2.1 million Australians) (27). Three in five adults (60.8%) experienced a low level of psychological distress in 2017-18, a decrease from 2014-15 (68.0%) (27). Nationally, Queensland had the highest proportion (ASP 14% Vs 13%-nationally) of adults with high or very high levels of psychological distress among all states and territories in Australia (27).

Overall, there is a ***relatively higher proportion of people with high or very high psychological distress in the PHN region*** compared to the other PHNs in Australia. Psychological distress is disproportional across the PHN region (See

Graph 1 below). Data for 2017-18 indicated the following findings for high or very high psychological distress (25):

- 86,823 people aged 18 years and over are estimated to have high or very high levels of psychological distress (ASR 13.5 per 100 for PHN; ASR 12.9 per 100 for Australia).
- WB region had the highest burden of psychological distress among three PHN regions: (14.9 per 100 compared to 13.9 for CQ and 12.9 for SC) PHN rate of ASR 13.5 per 100.
- 12 out of 16 SA3s in the PHN had higher than the QLD rate (ASR 13.0 per 100).
- The SA3s with the highest prevalence of psychological distress were Maryborough (ASR 16.4 per 100), Gympie – Cooloola (ASR 15.8 per 100), Burnett (ASR 15.2 per 100), Hervey Bay (14.8 per 100) and Nambour (14.4 per 100).
- A higher number of people experienced psychological distress in 2017-18 compared to 2014-15 in the PHN region; the rate increased from ASR 12.3 in 2014-15 to 13.5 in 2017-18.
- Females experienced psychological distress more than the males across all SA3s in the PHN region. Detailed analysis by gender is presented under the subsection on mental health common conditions for specific population groups.

Graph 1: Persons aged 18 years and over with high or very high psychological distress, by SA3s, PHN Regions, CQWBSC PHN, QLD, Australia 2017-18 (ASR per 100)



Source: Public Health Information Development Unit (PHIDU), Social Health Atlas of Australia: Data by LGA, PHIDU, Table: Estimates_risk_factors_adults

The PHN community health survey 2020-21 data indicates that the majority (96% or 575/ 612) of those who responded to the survey (20) identified that being connected and having access to emotional and social support as being very important (84%) and important (12%). However, in regard to the service, only about 25-30% of the respondents were satisfied with the support services provided in this regard. WB communities (Bundaberg and Fraser Coast LGAs) highlighted a need for a holistic approach in the region to address mental health issues, integrating it with interventions to address broader determinants such as alcohol and other drugs (AOD), child safety, domestic violence, and unemployment (20).

The PHN stakeholders survey: Stakeholders who participated in the survey also highlighted a need for peer-based mental health services, bulk-billed community services, and easier referral for psychological counselling services (21).

2.2.3. Eating disorders

Eating disorders are a group of mental illnesses typically characterised by problems associated with disordered eating or body weight control, and a severe concern with body weight or shape (28). Eating disorders affect up to 9% of all Australians in their lifetime, which increases to 15% for females (29). It causes considerable psychological distress, yet only 25% of Australians with eating disorder are known to the health system (29).

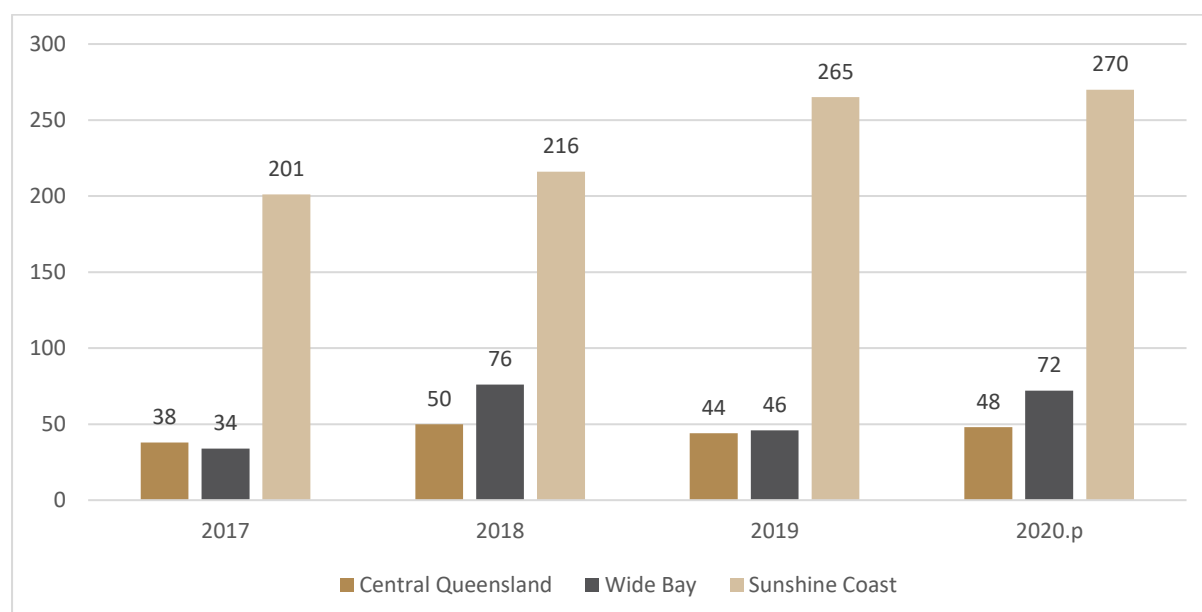
The proportion of females (all ages included) affected by eating disorders were 2.5 times more than the males in 2015-16 (30). In the same year, 95% of Australian hospitalisations with a principal diagnosis of an eating disorder were for females. Females aged 15–24 made up the largest proportion (57%) of these hospitalisations (30).

Nationally, about 132,000 Community Mental Health Service (CMHS) contacts had a principal diagnosis of eating disorders in 2018-19, which is a 57.5% increase from 2016-17. QLD data for eating disorders indicate about 50% increase in CMHS contacts diagnosed with eating disorders during the same period (31).

A proportion of Community Mental Healthcare Service Contacts (CMHC) who had a principal diagnosis of eating disorders were 2.3 % in QLD, same as the Australian average for eating disorders (31). However, this proportion is expected to be higher among younger (12-17 years) females as national data for CMHC indicate that eating disorders were ranked among six commonly reported principal diagnoses for 12-17 years (31).

In the PHN, eating disorders were a concern for the SC region (See Graph 2 below), with episodes of eating disorders highest in Sunshine Coast during 2017-20(32).

Graph 2: Episodes of admitted patient care with *eating disorder* principal or other diagnosis, by HHS of usual residence, public acute facilities, Queensland, 2017 to 2020* *data from 2020 are preliminary



Source: Queensland Health Statistical Services Branch (2021) , Queensland Admitted Patient Data Collection: Eating disorder principal/other diagnosis. Custom data request. 2017 - 2020 calendar years

Queensland Health Statistical Services Branch data for 2017-2020 for episodes of admitted patient care for eating disorder diagnoses (including both principal and other eating disorders) in the PHN HHSs indicate the following:

- SC HHS had much higher number of episodes of eating disorders compared to other two HHS areas during 2017-2020
- The PHN proportion of total eating disorder episodes among QLD HHSs was around 12-13%.
- The highest number of episodes in 2020 was among 0-19 years age group (219 episodes or 56%) followed by 20-29 (17%) age group and 30-39 (15%).
- In 2020, the PHN proportion of 0-19 years age group was higher (56%) than the Queensland proportion for the same age group (50%). The QLD percentage for 20-29 (34%) age group was much higher than the PHN percentage (17%) for the same age group.
- Females experienced eating disorders more than males both in the PHN and QLD during all years. In 2020, the PHN women experienced 8.6 times than the males. However, compared to QLD (7%), the PHN had higher proportion of males with eating disorders (10%) in 2020.

- Eating disorder admissions were consistently high in SCHHS; however, in terms of increase, the WB HHS had the largest increase (2.1 times) between 2017 and 2020.
- All three PHN HHSs had higher average length of stay during 2017-20 compared to the QLD ALOS. See Table below.

Table 3: Admitted patient care with eating disorder principal or other diagnosis, episode count and average length of stay of by HHS of usual residence, public acute facilities, Queensland, 2017 to 2020 *data from 2020 are preliminary

	2017		2018		2019		2020 p.	
HHS of hospital ⁽⁹⁾	Episodes	ALOS	Episodes	ALOS	Episodes	ALOS	Episodes	ALOS
Central Queensland	32	14.4	35	14.7	39	14.5	46	16.7
Wide Bay	27	18.1	38	8.1	39	8.9	61	12.8
Sunshine Coast	165	16.1	220	12.2	235	12.2	266	10.0
Total QLD	2,249	9.7	2,575	9.3	2,646	9.9	3,115	9.4

Source: Queensland Health Statistical Services Branch (2021) , Queensland Admitted Patient Data Collection: Eating disorder principal/other diagnosis. Custom data request. 2017 - 2020 calendar years

The PHN stakeholders survey 2020-21 did not cover issues specific to eating disorders. However, in the previous survey report (2019-20) service providers in Sunshine Coast expressed their concerns about the high prevalence of acute presentations of eating disorders in Sunshine Coast region. An eating disorders clinic was opened at SCHHS in October 2018 as a response to the high prevalence of the condition. Currently, in collaboration with the Butterfly Foundation and SCHHS, the PHN is participating in a trial to deliver evidence based first line treatments for eating disorders in primary care.

2.2.4. Suicide and Self-harm

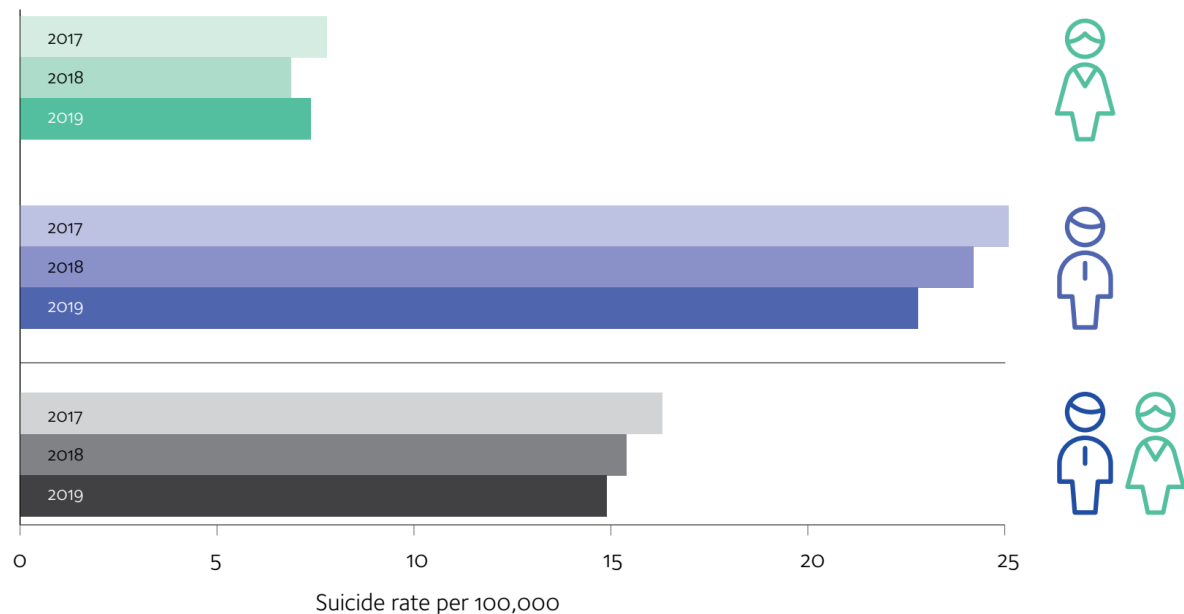
Globally, suicide is the fourth leading cause of death in 15-19year-olds (33). For every suicide there are many more people who attempt suicide (33). Self-harm is any behaviour that involves the deliberate causing of pain or injury to oneself (34). It can be a one-off event or become a repeated behaviour that can be hard to change (34).

According to the latest Burden of Disease study (2015), the second leading cause of total burden of disease in males is suicide, with three other mental health conditions in the top ten (dementia 6th, anxiety disorder 8th, depression disorders 10th) (7). Conversely, suicide was the 15th highest for females, with three other mental health conditions in the top ten (dementia 2nd, anxiety disorder 5th, depressive disorders 6th) (7).

Queensland suicide data (14) for 2017-19 indicated:

- numbers and rates of suicides were highest in males aged 40–49 (crude rate 23.5 per 100,000) and females aged 45-49 (crude rate 13.4 per 100,000) compared to other age groups in Queensland.
- Suicide rates for total QLD residents and males have decreased since 2017 (See Graph 3).

Graph 3: Suicide rate, males, females and total QLD residents, 2017-19 (pooled)

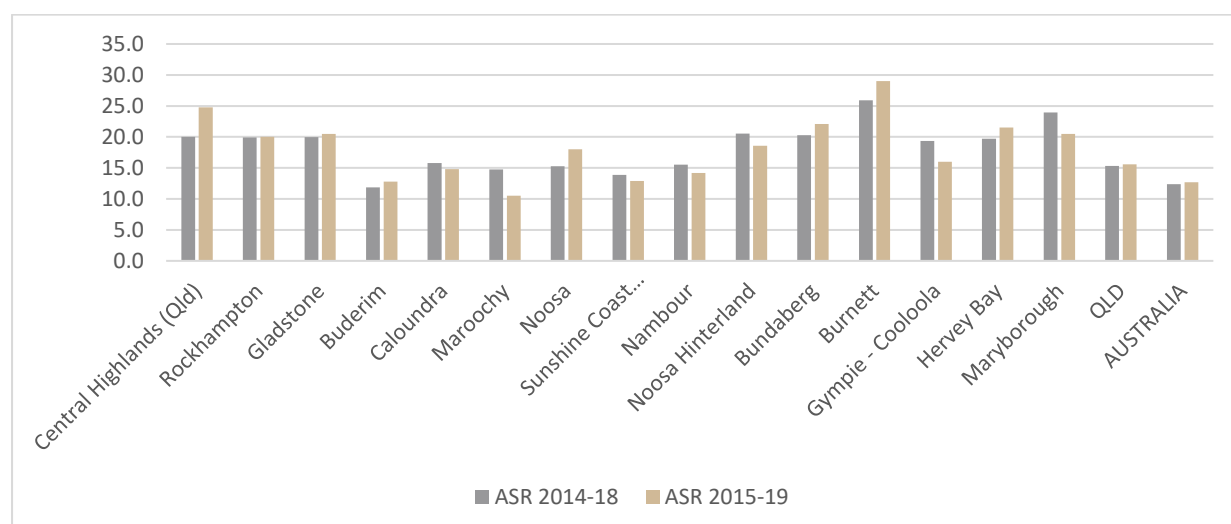


Source: Leske, S., et al., . (2020). *Suicide in Queensland: Annual Report 2020*. Brisbane, Queensland, Australia: : Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University

Queensland (QLD) age-standardised suicide rates for 2014-2018 and 2015-2019 were higher than the national rates of the same period (35).

All eight SA3s (3 in CQ; 5 in WB) with reported age-standardised suicide rates for 2014-18 and 2015-19 within the Central Queensland and Wide Bay regions had higher than the QLD rates (ASR 15.3 and 15.6 per 100,000 respectively) for both pooled years (See Graph 4). However, in the Sunshine Coast region, two out of seven SA3s had higher than the QLD rate (ASR 15.6 per 100,000) in 2015-2019. These were Noosa (18.0 per 100,000) and Noosa Hinterland (18.6 per 100,000) (35).

Graph 4: Age-standardised suicide rate (persons) by SA3, QLD, Australia, 2014–2018, 2015–2019



Source: Australian Institute of Health and Welfare. (2020). Suicide & self-harm monitoring National Hospital Morbidity Database 2014-2018 and 2015-2019

* There were not data provided for Biloela

Table 4 below presents age-standardised suicide rates for SA4 level in two pooled years comparing with rates of the QLD and Australia. Sunshine Coast region had the lower than the QLD rate for both periods (35).

Table 4: Age-standardised suicide rate, by SA4, QLD, Australia (persons) 2014–2018, 2015–2019

Location/SA4	Persons	
	2014-2018	2015-2019
Central Queensland	19.6	20.4
Sunshine Coast	15.0	14.1
Wide Bay	21.5	21.9
PHN	18.2	17.8
QLD	15.3	15.6
AUSTRALIA	12.4	12.7

Source: Australian Institute of Health and Welfare. (2020). Suicide & self-harm monitoring National Hospital Morbidity Database 2014-2018 and 2015-2019; *rates higher than the QLD rate of the same year are in red.

Suicide attempts/Suicidality

Suicidality covers suicidal ideation (serious thoughts about taking one's own life), suicide plans and suicide attempts (36). People who experience suicidal ideation and make suicide plans are at increased risk of suicide attempts, and people who experience all forms of suicidal thoughts and behaviours are at greater risk of completing suicide (36). Actual data on suicide ideation or suicide attempts at local levels are not available, but often quoted estimates are used. Available studies suggest that for each person who dies by suicide, an estimated 20-30 people attempt suicide (37). When this is applied, our estimates, drawing on available data on deaths by suicide for 2015-19 suggest that in a year, approximately 3,663 people would attempt suicide across the PHN (1,485 in SC, 1,093 in CQ and 1,085 in WB) (38).

In a given year, **suicidality prevalence** (this includes ideation, plans and attempts) may stand at 2.4% of the population (36). When using an estimate based on 2.4% suicidality prevalence in a given year,

we expect a much higher number, closer to 20,500 across the PHN, for those affected by suicidality, including suicide ideation, plans and attempts.

Further details of deaths caused by suicide in the PHN LGAs are presented in the Table 5 below. As seen, Central Highlands had the highest suicide rate ratio (1.9) relative to all Australia rate followed by Fraser Coast (1.7), Bundaberg (1.7) Gladstone (1.6) and Rockhampton (1.6).

Table 5: Deaths caused by suicide in 2015-2019, ASR by LGAs, and estimate of suicide attempts, per year

Location/LGA	Number of deaths caused by suicide (2015-19)	Percent of all causes	Crude rate (per 100,000)	ASR (per 100,000)	Rate ratio (relative to all of Australia)	Suicide attempts' estimate, per year*
CENTRAL QLD	219					1093
Banana (S)	11	2.51	15.3	.	.	
Central Highlands (R)	33	6.61	22.7	24.5	1.9	
Gladstone (R)	62	4.36	19.6	20.4	1.6	
Livingstone (S)	32	2.54	17.2	19.1	1.5	
Rockhampton (R)	81	2.51	19.9	20.7	1.6	
Woorabinda (S)						
WIDE BAY	217					1085
Bundaberg (R)	96	2.2	20.2	22.0	1.7	
Fraser Coast (R)	105	1.9	20.1	21.0	1.7	
North Burnett (R)	16	3.2	30.1	.	.	
SUNSHINE COAST	297					1485
Gympie (R)	41	2.0	16.1	16.0	1.3	
Noosa (S)	58	2.7	21.2	19.2	1.5	
Sunshine Coast (R)	198	1.7	12.7	13.1	1.0	
PHN	733	2.2	17.2	17.8	1.4	3663
Queensland (b)	3831	2.5	15.5	15.6	1.2	
Australia	15743	2.0	12.8	12.7	1	

Source: Australian Institute of Health and Welfare. (2021). MORT (Mortality Over Regions and Time) books: Local Government Area (LGA), 2015–2019. Canberra: AIHW.

*This is calculated based on the evidence that each person who dies by suicide, an estimated 20-30 people attempt suicide. We have used 25 as an average. For example: For the PHN 733 suicide cases (2015-19) we estimate potentially $733 \times 25 = 18,317$ suicide attempt during 2015-19; estimate per year $18,317/5 = 3663$

Deaths caused by suicide remained unacceptably high in Queensland and the PHN.

- In 2019, Queensland accounted for 23.6% (or 784 deaths) of the national registered suicides (n= 3,318). In 2018, QLD had the second-highest age standardised suicide rate (ASR 15.8 per 100,000 compared to 12.4 for Australia) of all Australian jurisdictions for registered suicide deaths; however, the rate decreased down to 4th highest in 2019 (ASR 15.4 per 100,000 compared to 12.9 for Australia) (ABS 39).
- National mortality data (40) shows that in 2019, the PHN suicide rate (ASR per 100,000) went down to 14.3 from 19.8 in 2018; this makes the PHN rate lower than the QLD ASR for 2019 (15.4), however much higher than the Australian/national rate of ASR 12.9 per 100,000 (40).

- Suicide was the 9th leading cause of death in the PHN – accounting for 2.2% of all deaths in 2015-2019, compared to the national average of 1.9% (11th rank among causes of death) (41).
- The PHN 2015-2019 deaths data showed an average ASR of 17.8 per 100,000 for the PHN, that is 1.4 times higher than national rate (ASR) of 12.7 per 100,000(41). There was a total of 733 deaths by suicide over this period in the PHN. SA3 and SA4 level data for 2015-2019 indicate the following (See Table 4 and Table 5 above):
- Burnett (WB) had the highest rate (ASR per 100,000) among the PHN SA3s at 29.0, followed by Central Highlands (CQ) 24.8, Bundaberg (WB) 22.1, Hervey Bay (WB) 21.5, and Maryborough (WB) 20.5 and Gladstone (CQ) at 20.5.
- There was no suicide data provided for Biloela.
- Wide Bay region had the highest rate (ASR 21.9 per 100,000) in the PHN, and much higher than the QLD (ASR 15.6) and Australia (ASR 12.7 per 100,000) rates. **Error! Bookmark not defined.**

Disaggregated data for various age groups at PHN and SA3/LGA levels were not available. However, national and state data suggest that living in rural/remote areas, being Indigenous and/or lower socio-economic category were all associated with higher risk of deaths due to suicide.

Nationally, in 2019, suicide rates (ASR per 100,000) were substantially higher in very remote (29.4) and remote areas (20.3), compared to regional (inner 16.8; outer 19.8) and metropolitan (12.6) areas (42). See Graph 5.

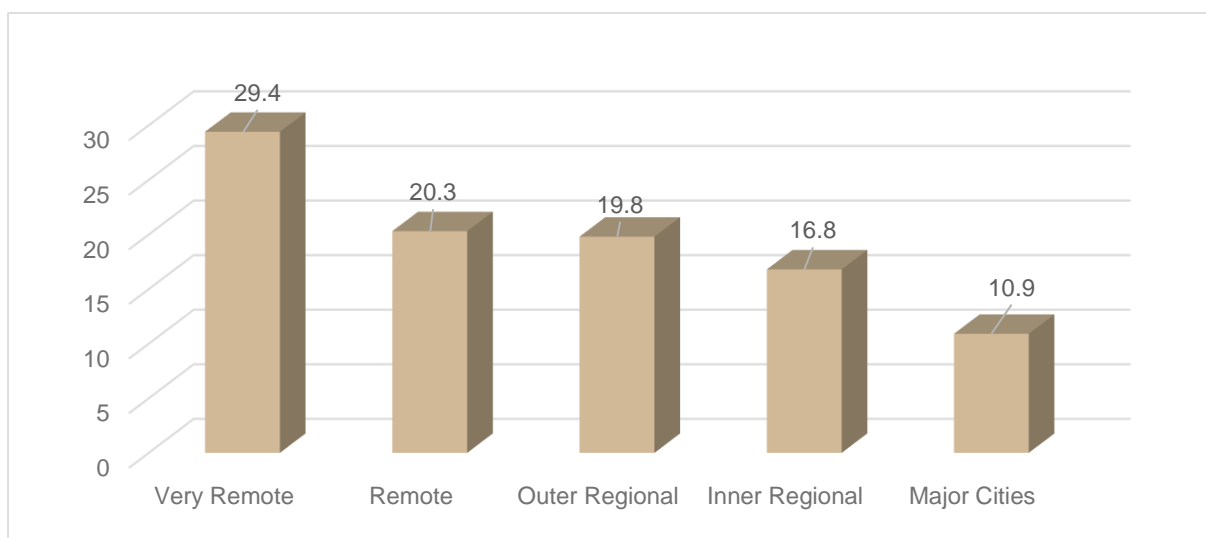
Queensland suicide data for 2017-2019 indicate that males living in outer regional area were most vulnerable followed by males in remote and very remote and inner regional areas (14) See Error! Reference source not found. below.

- 2019 data for Indigenous men and women shows much higher rates (ASR 39.4 and 15.2 per 100,000) than the non-Indigenous men and women (ASR 19.6 and 6.0 per 100,000) (43).

Time series data indicate that both nationally and in Queensland, suicide rates have never been lower for Aboriginal and Torres Strait Islander Australians compared to non-Indigenous Australians (AIHW 14, 43).

Table 6, Graphs 5, 6 and Table 6 below present Australian and QLD suicide data by remoteness, Indigenous status, and SEIFA quintiles as these are all important determinants of mental health and wellbeing.

Graph 5: Deaths caused by suicide by Remoteness area, 2019, Australia (ASR per 100,000, person)



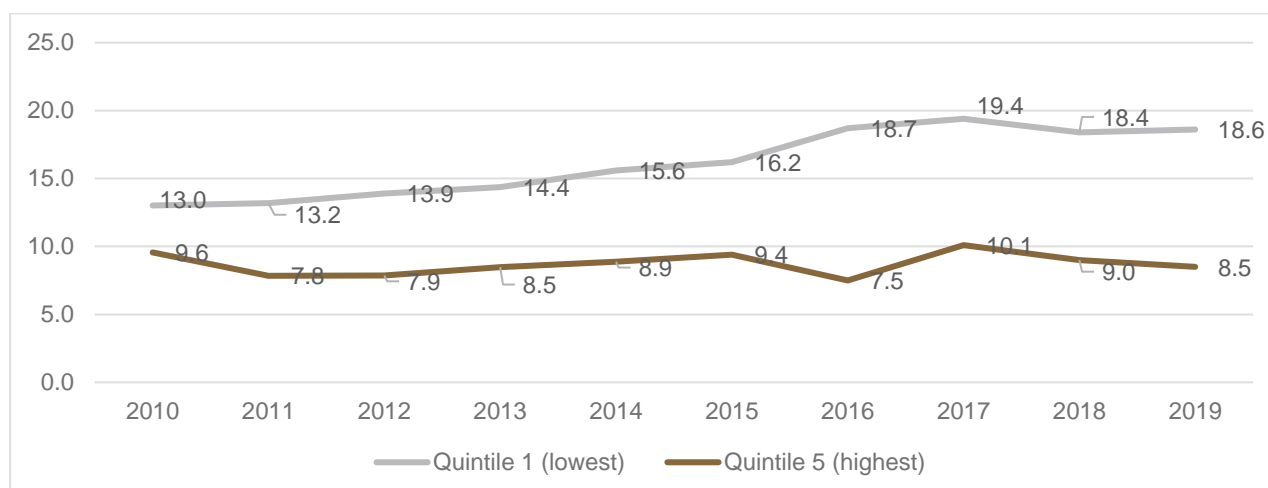
Source: AIHW, 2020. Suicide and Self-harm monitoring, National Mortality Database-Suicide: Table NMD S8: Suicide (ICD 10 X60–X84, Y87.0), by year of registration of death, Remoteness area, 2019

Table 6: Suicide, by year of registration of death, Indigenous status, Australia, 2015 to 2019 (ASR per 100,000, persons)

Indigenous status	Year				
	2015	2016	2017	2018	2019
Indigenous	24.4	23.5	24.1	24.1	27.1
Non-Indigenous	12.8	11.6	13.2	12.4	12.7
Difference (times)	1.9	2.0	1.8	1.9	2.1

Source: AIHW, 2020. Suicide and Self-harm monitoring, National Mortality Database-Suicide: Table NMD S7: Suicide (ICD 10 X60–X84, Y87.0), by year of registration of death, Indigenous status, Australia, 2015 to 2019

Graph 6: Deaths caused by suicide, by SEIFA quintiles, Australia, 2010 to 2019 (ASR per 100,000)



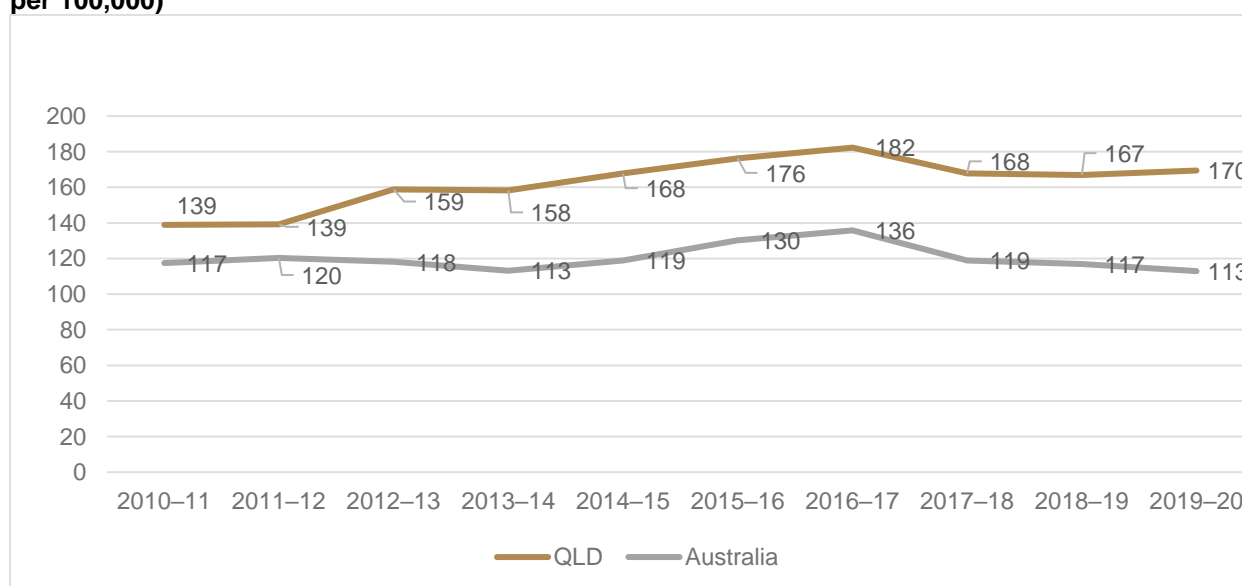
Source: AIHW, 2020. *Suicide and Self-harm monitoring, National Mortality Database-Suicide: Table NMD S12: Suicide (ICD 10 X60–X84, Y87.0), by year of registration of death, socioeconomic area, Australia, 2010 to 2019*

2.2.5. Intentional self-harm hospitalisations

Intentional self-harm is often defined as deliberately injuring or hurting oneself, with or without the intention of dying (44). Intentional self-harm comes in many forms, and affects people from different backgrounds, ages, and lifestyles (44). In 2019–20, there were more than 28,645 hospitalisations due to intentional self-harm in Australia, with the highest proportion (30.2% or 8,636 hospitalisations) in Queensland (45).

In 2019–20, the rate of intentional self-harm hospitalisations was second highest in Queensland (169.5 hospitalisations per 100,000 population) after the Northern Territory (239.9 per 100,000 population) across all states and territories were consistently higher than the national rate and the gap is widening (See Graph 7) (45).

Graph 7: Intentional self-harm hospitalisations, QLD and Australia, 2010–11 to 2019–20 (rate per 100,000)



Source: AIHW, 2021. *National Hospital Morbidity Database, Table NHMD S1: Intentional self-harm hospitalisations, by states and territories, 2010–11 to 2019–20*

Data in the National Hospital Morbidity Database 2019-20 (46) indicate that the PHN region had the 5th highest rate (229.0 per 100,000) of hospitalisation for intentional self-harm across all PHNs in Australia and higher than the national (113.0 per 100,000) and Qld rates (169.5 per 100,000). The PHN and SA3 level data for 2019-20 provide (see Table 7) localised information to enable the PHN to identify and investigate areas requiring more coordination of care to patients at risk of self-harm, by working directly with key primary and secondary health care providers and hospitals.

- In 2019-2020, Burnett had the highest rate of intentional self-harm hospitalisations for both priority age groups (47)
- Population in 25-44 age group were most at risk of self-harm across all SA3s with reported data except Sunshine Coast Hinterland, in which 0-24 years had slightly higher rate than the 25-44 years' age group
- For 0-24 years' age group, Burnett, Bundaberg, Maryborough, and Maroochy all had higher than the QLD rate (207 per 100,000) for 0-24 years
- For 25-44 years' age group Burnett, Bundaberg, Biloela, Maryborough, Hervey Bay had higher than the QLD rate (220 per 100,000) for 25-44 years

Table 7: Intentional self-harm hospitalisations, by PHN Statistical Area 3 (SA3), age, 2019-2020 (rate per 100,000, persons)

Location/SA3s	Priority age groups (persons)	
	0-24	25-44
Biloela	n.p	299
Buderim	94	175
Bundaberg	248	447
Burnett	255	490
Caloundra	153	192
Central Highlands (Qld)	202	211
Gladstone	149	178
Gympie - Cooloola	168	207
Hervey Bay	119	260
Maroochy	209	207
Maryborough	242	292
Nambour	172	218
Noosa	118	n.p
Noosa Hinterland	n.p	n.p
Rockhampton	198	218
Sunshine Coast Hinterland	164	160
CQWBSC PHN	171	229
Queensland	207	220
Australia	136	143

Source: AIHW, 2021. National Hospital Morbidity Database, Table NHMD S10: Intentional self-harm hospitalisations, by Statistical Area 3 (SA3) and age, 2019-20

*rates higher than the QLD rate for the respective age groups are in red

More detailed information by gender and age groups are provided in the relevant subsection under mental health conditions for specific population groups below.

2.3. Mental health conditions for specific population groups

Certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender. The section covers key mental health issues and barriers specific to various population subgroups that require more targeted and tailored approach to address the issues.

2.3.1. Gender

Prevalence of mental and behavioural problems

Overall, women were more vulnerable to mental and behavioural problems compared to men. Queensland men and women estimated to have the highest age-standardised rates (ASR- 20.5 and 24.8 per 100, respectively) of mental and behavioural problems in Australia in 2017-18 (25). The PHN-LGA level data (25) indicates the following (See Table 8)

- 7 out of 11 LGAs with data estimate available for males with mental and behavioural problems have had higher than the QLD rate for male (ASR 20.5 per 100); and all 11 LGAs rates were higher than Australia rate of ASR 17.8 per 100 for men.
- 6 out of 11 LGAs with data estimate available for females with mental and behavioural problems have had higher than the QLD rate for female (ASR 24.8 per 100); and all 11 LGAs rates were higher than Australia rate of ASR 22.3 per 100 for women.
- Rockhampton and Gympie had been estimated to have the highest ASR for both men (24.6-Rockhampton and 24.2-Gympie) and women (28.4-Rockhampton and 27.8-Gympie);
- Noosa rates were lowest in the PHN for both men (ASR 18.4 per 100) and women (ASR 23.0 per 100)
- Woorabinda did not have data to estimate the mental/behavioural problems in the area.

Table 8: Estimated number of males and females with mental and behavioural problems (modelled estimates, 2017-18)

Location/LGAs	Male		Female	
	Number	ASR per 100	Number	ASR per 100
Banana (S)	1,367	18.8	1,541	23.1
Bundaberg (R)	11,057	23.5	12,490	26.1
Central Highlands (R)	2,641	18.4	2,979	23.5
Fraser Coast (R)	11,766	23.0	13,688	25.9
Gladstone (R)	7,030	21.9	7,820	26.5
Gympie (R)	6,251	24.2	7,088	27.8
Livingstone (S)	3,844	20.5	4,356	24.2
Noosa (S)	4,984	18.4	6,516	23.0
North Burnett (R)	1,257	22.8	1,328	25.5
Rockhampton (R)	9,728	24.6	11,248	28.4
Sunshine Coast (R)	28,715	19.0	37,318	23.4
Woorabinda (S)	^	..		
Queensland	489,196	20.5	601,225	24.8
AUSTRALIA+	2,135,000	17.8	2,709,500	22.3

Source: Public Health Information Development Unit (PHIDU), Social Health Atlas of Australia: Data by PHN, LGA, PHIDU, Sep, 2020; Table: Estimates_chronic_disease (Males and Females)*rates higher than the QLD rate for the respective gender are in red.

The same data presented by the PHN-SA3s areas are provided in Table C in the Annex for Tables.

Psychological distress

Nationally, more women than men experienced high or very high levels of *psychological distress* in 2017-18 (14.5% and 11.3% respectively) (25). Similar to other mental health conditions, there is a *relatively higher proportion of women with high or very high psychological distress within the PHN*. The PHN rate for women ranked 5th highest among other 31 PHNs around Australia. The PHN-LGA data for 2017-18 provided by PHIDU (25) indicated higher rates of high or very high psychological distress among women compared to men across all areas (See **Table 9** below):

- Women in Gympie and Fraser Coast showed the highest rate of psychological distress (ASR 17.6- Gympie 17.0- Fraser Coast) in the region compared to the men in the same area (13.9-Gympie and 13.8- Fraser Coast)
- Wide Bay area had the highest burden of high or very high psychological distress for both sexes with all three LGAs have higher than the QLD rates for women (14.5) and men (11.4); however, the rates for women were much higher than the respective rates for men
- Banana and Central Highlands data indicated the lowest rate for women (Banana-12.2 and Central Highlands 13.5) and men (9 and 10.2 respectively)
- Noosa, Sunshine Coast, Livingstone which all had lower (or closer to) than QLD rates for both genders.

Table 9: Estimated number of males and females aged 18 years and over with high or very high psychological distress, based on the Kessler 10 Scale (K10) (modelled estimates, 2017-18)

Location/LGA	2017-18			
	Males		Females	
	Number	ASR per 100	Number	ASR per 100
Banana (S)	489	9.0	622	12.2
Bundaberg (R)	4,261	12.0	5,423	14.8
Central Highlands (R)	1,061	10.2	1,303	13.5
Fraser Coast (R)	5,355	13.8	6,933	17.0
Gladstone (R)	2,823	11.9	3,434	15.4
Gympie (R)	2,708	13.9	3,454	17.6
Livingstone (S)	1,609	11.4	1,993	14.4
Noosa (S)	2,256	10.9	3,101	14.1
North Burnett (R)	543	12.9	603	15.2
Rockhampton (R)	3,658	12.3	4,508	14.8
Sunshine Coast (R)	12,873	11.3	17,768	14.5
Woorabinda (S)	^	..	^	..
Queensland	207,354	11.4	272,248	14.5
AUSTRALIA+	1,035,100	11.3	1,380,000	14.5

Source: Public Health Information Development Unit (PHIDU), Social Health Atlas of Australia: Data by PHN, LGA, PHIDU, Sep, 2020; Table: Estimates_risk factors_adults (Males and Females)

*rates higher than the QLD rate for the respective gender are in red.

Suicide

Over the last decade, the national age-standardised suicide rate for males increased from 17.5 deaths per 100,000 population in 2010 to 19.8 in 2019 (48). Female rates also increased from 5.0 deaths per 100,000 population in 2010 to 6.3 in 2019 (48). Table 10 below shows the difference between the rates for men and women.

Table 10: Suicide rates by gender for PHN regions, QLD and Australia (ASR per 100,000)

Area (year)	Female	Male
National (2019) (i)	6.3	19.8
QLD (2019) (i)	7.4	22.8
PHN (2017-19) (ii)	6.9	27.0
- Wide Bay HHS	6.1	38.3
- Central Queensland HHS	10.2	29.0
- Sunshine Coast HHS	5.8	21.1

Sources: i) Biddle et al (2020). *Suicide Mortality in Australia: Estimating and Projecting Monthly Variation and Trends From 2007 to 2018 and Beyond.*, Centre for Social Research and Methods, Australian National University, Canberra; ii) Leske, S., et al., (2020). *Suicide in Queensland: Annual Report 2020.*, Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University, Brisbane

In 2019, males represented 75.3% of all suicides or 570 suicides, while females accounted for 24.7% or 187 in Queensland (14). This ratio equated to just over three male suicides for every female suicide. In suicide rates, this meant that there were 22.8 male suicides for every 100,000 males in Queensland, 7.4 female suicides for every 100,000 females and 14.9 total suicides for every 100,000 persons (14).

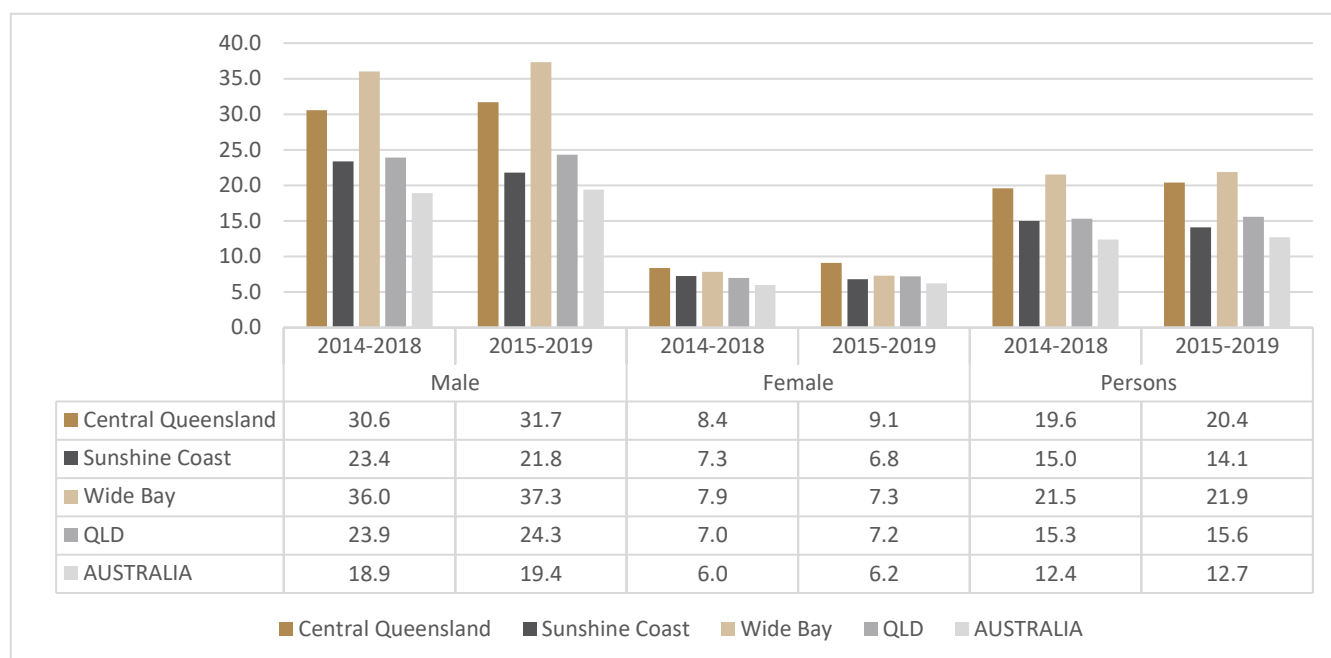
The CQWBSC-PHN 2017-19 suicide data (14) by gender also showed a much higher suicide mortality rate for males (ASR 27.0 per 100,000) than females (ASR 6.9 per 100,000). 2017-19 data by HHS showed the second highest suicide rate for males (ASR 38.8 per 100,000 people) in Wide Bay HHS catchment area in Queensland after Cairns and Hinterland HHS (ASR 39.0 per 100,000). As for females, CQ HHS data showed the highest suicide rate (ASR 10.2 per 100,000) among females within HHS catchment areas in Queensland (14).

Among males, suicide remained as the 8th leading cause of death in the PHN – accounting for 3.2% of all male deaths in 2015-2019 (41). The PHN suicide rate for males (ASR 28.4 per 100,000) remained much higher than the national and Queensland rates for males (ASR 19.3 and 24.3 100,000 respectively) (49) and was 5th highest rate among the 31 PHNs in Australia (41). The PHN female suicide rate (ASR 7.7 per 100,000) was also the 5th highest among the 31 PHNs and 1.2 times higher than the national rate (41). Central Queensland and Wide Bay regions had higher than the national and QLD rates for both genders in both pooled years, in 2014-2018 and 2015-2019 (50). See Graph 8 below.

2015-19 data (38) shows all LGAs in the PHN with male rates reported above the national (19.3) and QLD rates (24.3) for males except Sunshine Coast LGA (20.5), which had a slightly lower rate than the QLD rate. CQ area: Central Highlands (41.1), Gladstone (32.6), Rockhampton (31.8), Livingstone (27.8).

- WB area: Bundaberg (36.1), Fraser Coast (35.8),
- SC area: Noosa (29.0), Gympie (27.5) and Sunshine Coast (20.5)
- Banana, North Burnett, Woorabinda - no ASR reported

Graph 8: Age-standardised suicide rate, by SA4, QLD, Australia and sex, 2014–2018, 2015–2019 (ASR per 100.000)



Source: Australian Institute of Health and Welfare. (2020). Suicide & self-harm monitoring National Hospital Morbidity Database 2014-2018 and 2015-2019

In 2015-2019, suicide was among the 20 leading causes of death for males in all LGAs within the PHN (38) (see Table 11 below). Again, there was no data reported for Woorabinda. Nationally, suicide was not among the top 20 leading causes of death for women. However, among PHN women, suicide was listed among the top 20 causes of death in six LGAs (See Table 12) (38).

Table 11: Suicide as leading 20 causes of death for males, by the PHN, LGAs, 2015-2019

Location	Rank	Deaths	Crude rate (per 100,000)	ASR (per 100,000)*	Rate ratio (relative to all of Australia)
Banana (S)	9	7	18.8	.	.
Bundaberg (R)	9	75	32.1	36.1	1.9
Central Highlands (R) (Qld)	2	29	38.0	41.1	2.1
Fraser Coast (R)	9	82	31.9	35.8	1.9
Gladstone (R)	3	50	30.9	32.6	1.7
Gympie (R)	9	34	26.7	27.5	1.4
Livingstone (S)	7	23	24.0	27.8	1.4
Noosa (S)	7	40	30.1	29.0	1.5
North Burnett (R)	5	16	58.6	.	.
Rockhampton (R)	7	61	30.3	31.8	1.6
Sunshine Coast (R)	8	147	19.5	20.5	1.1
QLD	8	2931	24.0	24.3	1.3
AUSTRALIA	9	11,844	19.4	19.3	1.0

Source: Australian Institute of Health and Welfare (2021). MORT (Mortality Over Regions and Time) books: Local Government Area (LGA), STE, 2015–2019; *Due to small numbers, ASRs cannot be calculated for some LGAs

Table 12: Suicide as leading 20 causes of death for females, by the PHN, LGAs, 2015-2019

Location	Rank	Deaths	Crude rate (per 100,000)	ASR (per 100,000) *	Rate ratio (relative to all of Australia)
Banana (S)	16	4	11.5	.	.
Central Highlands (R) (Qld)	12	4	5.9	.	.
Gladstone (R)	12	12	7.8	.	.
Livingstone (S)	13	9	9.9	.	.
Noosa (S)	13	18	12.7	.	.
Rockhampton (R)	17	20	9.7	10.1	1.63
QLD	18	900	7.2	7.2	1.2
AUSTRALIA	-				1.0

Source: Australian Institute of Health and Welfare (2021). MORT (Mortality Over Regions and Time) books: Local Government Area (LGA), STE, 2015–2019; *Due to small numbers, ASRs cannot be calculated

Intentional self-harm hospitalisations

In 2019-20, women made up almost two-thirds (63% or over 18,000 hospitalisations) of intentional self-harm hospitalisations, nationally (45). Women of all age groups had much higher rates of intentional self-harm hospitalisations than men, except the 65+ age group where men had a slightly higher rate (38.5 per 100,000) than the women's hospitalisation rate (38.0 per 100,000) of same age group.

The PHN and SA3 level self-harm hospitalisations data for 2019-20 (46, 47) informs the following:

- The rate of self-harm hospitalisations in the PHN were highest for females of 0-24 age groups (253 per 100,000) and for males of 25-44 age groups (125.4 per 100,000) compared to other age groups
- Four SA3s within the PHN had higher than QLD hospitalisation rate (211 per 100,000) for females. These were Burnett (336 per 100,000), Bundaberg (304 per 100,000), Gladstone (219 per 100,000), and Central Highlands (212 per 100,000).
- For males, Bundaberg (206 per 100,000), Maryborough (156 per 100,000), Nambour (156 per 100,000) and Rockhampton (146 per 100,000) rates were higher than the QLD rate (128 per 100,000) for men
- There were no data provided for Biloela for both females and males

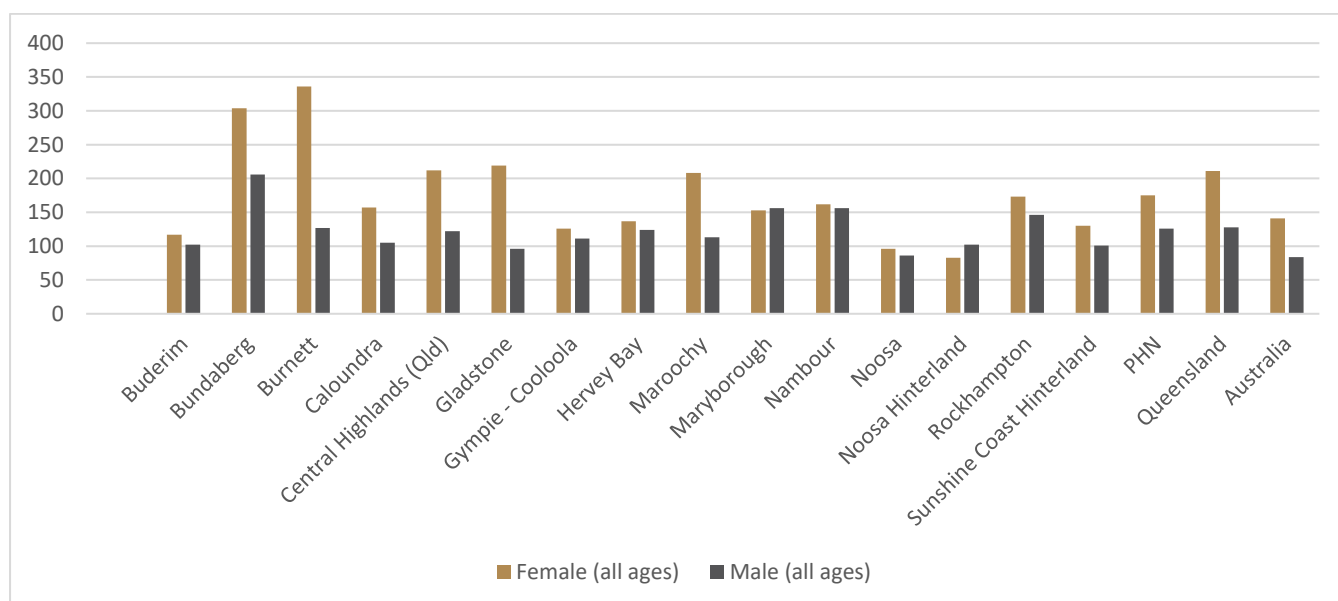
Further details can be seen from Table 13, and Graph 9 below.

Table 13: Intentional self-harm hospitalisations, by age and sex, 2019-20 (number and rate per 100,000)

Location	0-24			25-44		
	Female (all ages for SA3s)	Male (all ages for SA3s)	Persons	Female (all ages for SA3s)	Male (all ages for SA3s)	Persons
Central Queensland, Wide Bay, Sunshine Coast	253	94	171	220	238	229
Queensland	305	112	207	244	195	220
Australia	202	73	136	162	124	143

Source: AIHW, 2021. National Hospital Morbidity Database, Intentional self-harm hospitalisations, by Statistical Area 3 (SA3), PHN, State/Territories, sex and age, 2019-20

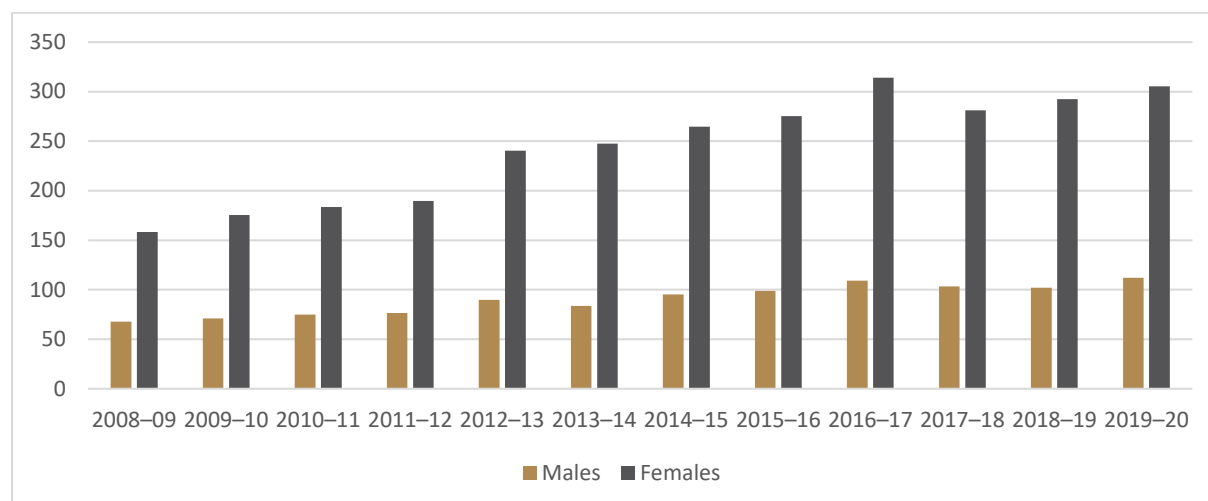
Graph 9: Intentional self-harm hospitalisations, by the PHN Statistical Area 3 (SA3), age and sex, 2019-20 (rate per 100,000)



Source: AIHW, 2021. National Hospital Morbidity Database, Intentional self-harm hospitalisations, by Statistical Area 3 (SA3), PHN, State/Territories and sex, 2019-20

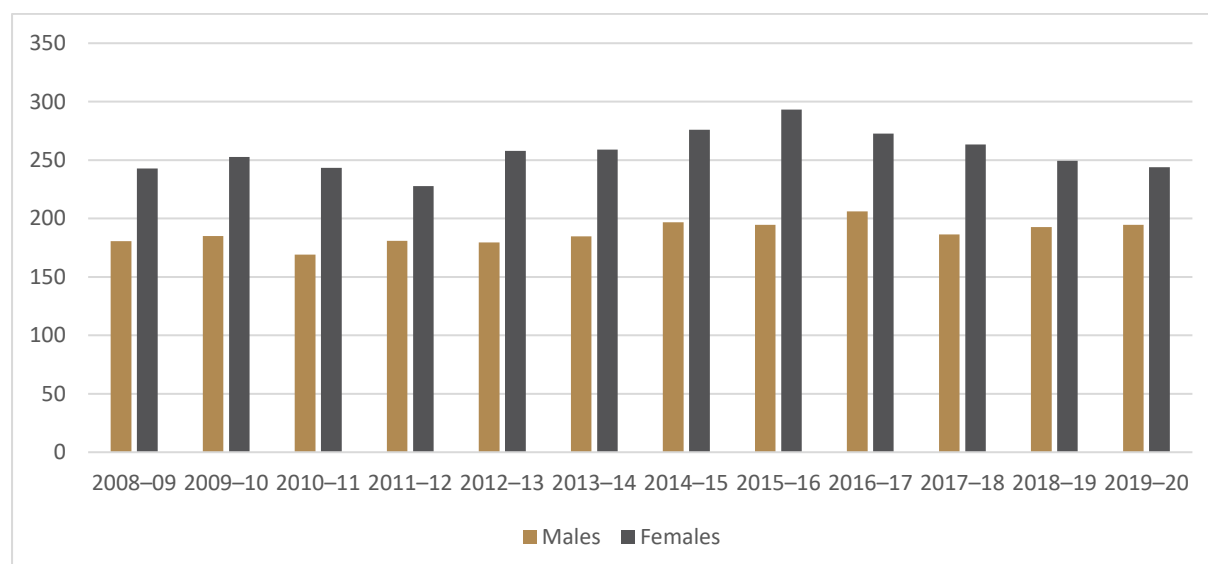
As shown in Graph 11 and Graph 12, QLD rates of self-harm hospitalisations for females were consistently higher than the rates for males for both focus age groups, 0-24 and 25-44 years between 2008-09 and 2019-20 (45). Timeseries rate data was not available at the PHN or SA3 levels.

Graph 10: Rate of self-harm hospitalisations per 100,000 population in QLD, by sex for 0-24 years, 2008-09 to 2019-20



Source: AIHW, 2021. National Hospital Morbidity Database, Intentional self-harm hospitalisations, by State/Territories and sex, 2019-20

Graph 11: Rate of self-harm hospitalisations per 100,000 population in QLD, by sex for 25-44 years, 2008-09 to 2019-20



Source: AIHW, 2021. National Hospital Morbidity Database, Intentional self-harm hospitalisations, by State/Territories and sex, 2019-20

Summary of the issues:

- *Women were more vulnerable to mental and behavioural disorders and psychological distress compared to men at national, regional, and local levels*
- *LGAs with higher than the QLD rate (ASR 24.8 per 100,000) for women with mental and behavioural problems were Rockhampton (ASR 28.4 per 100,000), Gympie (ASR 27.8 per 100,000), Gladstone (ASR 26.5 per 100,000), Bundaberg (ASR 26.1 per 100,000), Fraser Coast (ASR 25.9 per 100,000) and North Burnett (ASR 25.5 per 100,000)*
- *LGAs with higher than the QLD rate (ASR 20.5 per 100,000) for men with mental and behavioural problems were Rockhampton (ASR 24.6 per 100,000), Gympie (ASR 24.2 per 100,000), Bundaberg (ASR 23.5 per 100,000), Fraser Coast (ASR 23.0 per 100,000) North Burnett (ASR 22.8 per 100,000) and Gladstone (ASR 21.9 per 100,000)*
- *The PHN suicide rate for males (ASR 28.4 per 100,000) remained much higher than the national and Queensland rates for males (ASR 19.3 and 24.3 100,000 respectively and is 5th highest rate among the 31 PHNs in Australia)*
- *The PHN self-harm hospitalisation among women were consistently higher than men over the period of 2008-09 to 2019-20*

2.3.2. Young people

Prevalence of common mental health conditions

Nationally, experience of severe psychological distress among young people aged 18-24 increased from 14% in 2017 to 22% in April 2020 (51). According to self-reported data in the Young Minds Matter survey, in 2013–14, 1 in 5 young people experience high levels of psychological distress (51). Respondents to the 2020 Mission Australia Youth Survey reported that 2 in 5 young people (43%) felt stressed in the previous month either all the time or most of the time (51).

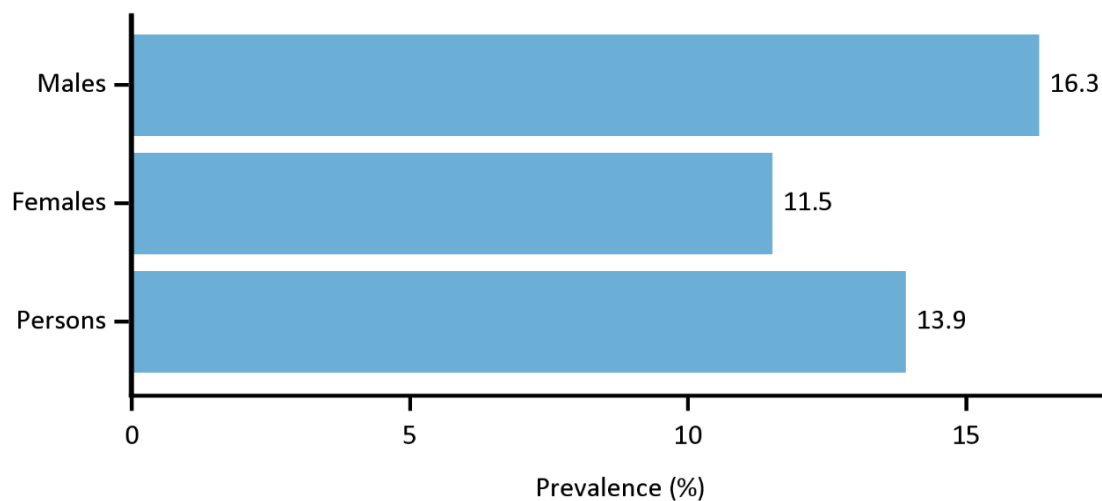
Nationally,

- in 2017-18, of all age groups, young people aged 18–24 were most likely to experience high or very high levels of psychological distress (15.2%) and the females experienced more (18.4%) than the males (12.4%) (27).
- this was also reflected in the Mental Health Services in Australia Database 2018–19 (52): young people aged 18-24 had the second highest rate (103.7 per 10,000) of overnight admitted mental health separations with specialised psychiatric care compared to all other age groups.
- the rates of young people experiencing high or very high levels of psychological distress increased overtime with average annual percent change at around 3.5 for males and 6.1 for females from 2014-15 to 2018-19.

Young Minds Matter Report (53) on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing provides further information on the prevalence of mental disorders in children and adolescents in Australia. It presents the following:

- Almost one in seven (14%) 4–17-year-olds were assessed as having mental disorders in the previous 12 months. This is equivalent to 560,000 Australian children and adolescents.
- Males were more likely than females to have experienced mental disorders in the 12 months prior to the survey (16.3% compared with 11.5%). See Graph 12 below.
- Almost one third (30.0% or 4.2% of all 4–17-year-olds) of children and adolescents with a disorder had two or more mental disorders at some time in the previous 12 mont

Graph 12: Prevalence of mental disorders in 4–17year-olds in the past 12-months, Australia



Source: Lawrence, D., S. Johnson, J. Hafekost, K. Boterhoven de Haan, M. Sawyer, J. Ainley and S. R. Zubrick (2015). *The mental health of children and adolescents: Report on the second Australian child and adolescent survey of mental health and wellbeing*. Canberra: Department of Health.

The survey (53) highlighted the strong relationship between socioeconomic disadvantage and higher rates of mental health problems. Children and adolescents in low-income families, with parents and carers with lower levels of education and with higher levels of unemployment had higher rates of mental disorders and there was also a strong relationship with where they lived as significantly higher rates of mental disorders were found in non-metropolitan areas (53).

The PHN is home to many young people with an estimated number of 164,000 people aged 12-24 years in the year 2021(2). Preliminary estimates for populations of young people based on prevalence data and the NMHSPF suggest that approximately 26,558 young people will need mental health treatment across the PHN (2). Of these:

- 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 lower than actual numbers, particularly for young people living in remote and disadvantaged areas.

Self-harm and suicide

Nationally, the leading causes of total burden for young people aged 15–24 are varied between males and females (51) Suicide and self-inflicted injuries were the leading cause of total mental health burden among young males, whereas anxiety disorders were the leading cause among young females (51, 54) (See **Table 14** below). Nationally, in 2019, there were 461 deaths by suicide among young people aged 15–24, a rate of 14 per 100,000 young people (54).

Table 14: Leading causes of total burden among young people aged 15–24, by sex, 2015

Rank	Males		Females	
	Leading cause	Per cent	Leading cause	Per cent
1	Suicide/self-inflicted injuries	12.8	Anxiety disorders	11.3
2	Alcohol use disorders	7.2	Depressive disorders	8.9
3	Road traffic injuries/motor vehicle occupant	5.7	Asthma	7.1
4	Depressive disorders	5.4	Back pain and problems	6.0
5	Back pain and problems	5.1	Suicide/self-inflicted injuries	6.0

Source: AIHW (2020). *Australia's Health 2020: Health of young people*. Available at: <https://www.aihw.gov.au/reports/australias-health/health-of-young-people>

Queensland data indicated:

- In 2019, about 40% of reported deaths among people aged 15–24 years were due to suicide in Qld (ABS 39). This is an increase by 11 % from 2017.
- ASR for suicide among 15-24 and years in Qld was the highest (17.1) compared to the other State/Territory rates and the National rate (14.1); the rate increased between 2016 to 2019 (ABS 39)

Disaggregated data for young people at local levels (PHN and LGA) were not available.

Young Minds Matter report on the second national survey of 2013–14 data found that around 11% of adolescents (or estimated 186,000) aged 12–17 had ever deliberately hurt or injured themselves without trying to end their life (53). Of those adolescents who had self-harmed, almost three-quarters (73%) had harmed themselves in the previous 12 months. Females aged 16–17 had the highest rates of self-harm, with 17% having harmed themselves in the previous 12 months (53). These further confirm that the risk of self-harm is significantly high among young people.

Intentional self-harm hospitalisation

In 2019-20, the percentage of intentional self-harm hospitalisations was highest among 0-24 years, for all key geographical areas, QLD (31.4%) and for the PHN (34.0%) compared to other age groups (45). Nationally, the percentage of self-harm hospitalisation was higher in major cities and inner regional areas for all age groups including young people. However, the rates were much higher for remote, very remote, and outer regional areas (55) (See **Table 15**). Aboriginal and Torres Strait Islander youth aged under 25 accounted for 41% of all suspected suicides by Aboriginal and Torres Strait Islander Queenslanders in 2019; and those aged under 30 accounted for 60.7%.

Table 15: Intentional self-harm hospitalisations, by remoteness area and age, 2019-20 (rate per 100,000)

Age groups	2019-20 Rate (per 100,000)				
	Inner Regional	Major Cities	Outer Regional	Remote	Very Remote
0–14	34	20	36	34	24
15–19	372	317	506	677	354
20–24	274	224	330	756	252
25–29	227	146	226	297	172
30–34	171	116	206	241	137
35–39	168	106	218	136	130
40–44	146	111	204	378	132
45–49	144	113	182	175	128
50–54	115	99	166	166	112
55–59	90	75	99	80	82
60–64	62	55	66	72	59
65–69	37	41	39	0	41
70–74	31	33	35	0	32
75–79	38	34	29	0	34
80–84	44	46	26	0	44
85+	33	49	31	0	45
Total (all age)	119	102	146	189	113

Source: AIHW, 2021. National Hospital Morbidity Database, Table NHMD S6: Intentional self-harm hospitalisations, by remoteness area and age, 2019-20

The highest rates in 2019–20 was recorded for females aged 15–19 (552 per 100,000 population), followed by females aged 20–24 (340 per 100,000). The rates for young males were lower than those of females (165 and 168 per 100,000 population for males aged 15–19 and 20–24, respectively) (45). (See Table 16).

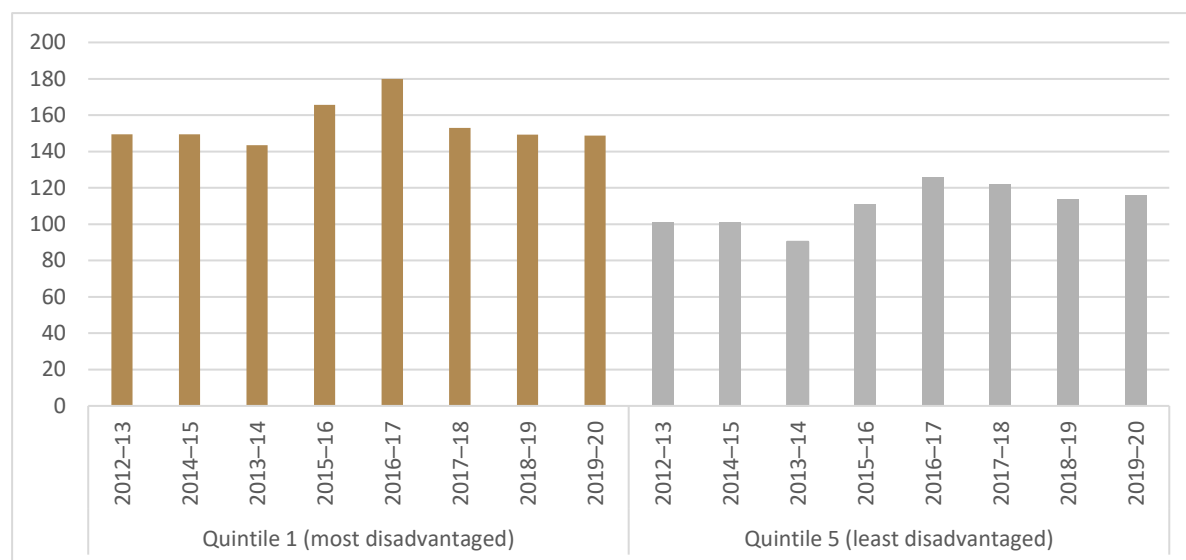
Table 16: Rates of hospitalisations for intentional self-harm are higher for young people (2019-20, per 100,000)

Age groups	Females	Males
15-19	552	340
20-24	165	168
25-44	162	124
45-64	111	82
65+	38	39

Source: AIHW. 2021 Intentional self-harm hospitalisations, by age and sex, Australia, 2019–20

The rate of intentional self-harm hospitalisations was higher for young people (0-24) in most disadvantaged quintile than the least disadvantaged group (149 Vs 116 per 100,000) (45). The gap is slightly reduced between 2012-13 and 2019-20. However, still the most disadvantaged young people are 1.3 times more at risk compared to the least disadvantaged group. See Graph 13 following.

Graph 13: Rates of hospitalisations for intentional self-harm among 0-24 years, by SEIFA quintiles. 2012-13 to 2019-20 (rate per 100,000)



Source: AIHW, 2021. National Hospital Morbidity Database, Table NHMD S6: Intentional self-harm hospitalisations, by socioeconomic area, age and sex 2013-13 to 2019-20

For the PHN, in 2019-20, the rate of intentional self-harm hospitalisations was (46):

- highest for 25-44 years (229 per 100,000) followed by 0-24 age group (171 per 100,000)
- higher among women: females aged 0-24 had the highest rate (253 per 100,000) followed by 25-44 age group males (238 per 100,000)

PHN and SA3 level intentional self-harm hospitalisations data of 2019-20 for 0-24 years informs the following (47): See Table 17. QLD and PHN rates were 207 and 171 per 100,000, respectively and both are higher than the Australia rate (136 per 100,000).

- 4 out of 14 SA3s with hospitalisation rate data available had higher than the QLD rate (207 per 100,000) for the 0-24 years. These SA3s were Burnett (255 per 100,000), Bundaberg (248 per 100,000), Maryborough (242 per 100,000), and Maroochy (209 per 100,000).
- There were no data provided for Biloela and Noosa Hinterland.

Table 17: Intentional self-harm hospitalisations, by Statistical Area 3 (SA3), age, 2019-20 (rate per 100,000)

Location/SA3 Name	Persons	
	(0-24)	(25-44)
Biloela	n.p	299
Buderim	94	175
Bundaberg	248	447
Burnett	255	490
Caloundra	153	192
Central Highlands (Qld)	202	211
Gladstone	149	178
Gympie - Cooloola	168	207
Hervey Bay	119	260
Maroochy	209	207
Maryborough	242	292
Nambour	172	218
Noosa	118	n.p
Noosa Hinterland	n.p	n.p
Rockhampton	198	218
Sunshine Coast Hinterland	164	160
PHN	171	229
QUEENSLAND	207	220
AUSTRALIA	136	143

Source: AIHW, 2021. National Hospital Morbidity Database, Table NHMD S10: Intentional self-harm hospitalisations, by Statistical Area 3 (SA3) and age, 2019-20

The PHN surveys 2020-21 indicate that mental health issues among young people have been identified as a priority across all areas; both community and stakeholders commented that there are not adequate psychologist and psychiatrist services available especially for those living in rural and remote areas and socio-economically disadvantaged areas (20, 21). Service providers in Sunshine Coast raised mental health and suicide attempts as a major concern among young people in Gympie area (21).

Summary of the issues for young people:

- Nationally, young people aged 18–24 (2017-18) were most likely to experience high or very high levels of psychological distress (15.2%) and the females experienced more (18.4%) than the males (12.4%)
- The rates for psychological distress increased overtime and the young women aged 18-24 were most affected
- In 2019, about 40% of reported deaths among people aged 15–24 years were due to suicide in Qld
- There is no disaggregated suicide data for young people at local levels (PHN and LGA)
- Nationally, 1 in 10 young people have deliberately injured themselves
- QLD (207 per 100,000) and the PHN (171 per 100,000) rates for self-harm hospitalisation for 0-24 were higher than the national rate (136 per 100,000 people)
- Overall, mental health issue among young people is identified as a top priority across all areas, both by community and stakeholders

2.3.3. Older people 65+years

Prevalence of common mental health conditions

As indicated in the 2017-18 mental health survey data, low and moderate level psychological distress is quite high (85%) among Australian men and women of 65+ years old (27). However, the percentage of high and very high distress level is relatively low (9.9%) among older Australians compared to other/younger age groups (27). An estimate for 2017-18 showed that there were about 75,600 older Australians (65+ years) living with high and very high psychological distress in Queensland (27).

NMHSPF prevalence estimates (2) for mental health needs and demand for services for 65+ people within the PHN area in 2021 suggests the following:

- In the PHN, a total of 52,652 people aged 65+ require various intensity mental health interventions. Of those,
- About 40% (or 20,416) will need early intervention
- 22% (or 11,409) will need relapse prevention
- 21% (or 10,845) will need services for mild disorders
- 10% (or 5,423) will need services for moderate disorders
- 9% (or 4,558) will need services for severe disorders.
- These proportions were similar (equally distributed) across all LGAs

However, these estimates are also likely to be a lower than actual numbers, particularly for older people living in remote and disadvantaged areas.

AIHW 2020 report (56) on aged care needs among residents of Residential Aged Care Facilities (RACF) outlined key facts from 2018-19 data. As of 30 June 2019, there were almost 300,000 people using home care, transitional care, and residential care in Australia. Over 182,000 of those people were using permanent residential care.

- The majority (87%) of residents of RACF had at least one diagnosed mental or behavioural condition
- Depression was the most commonly diagnosed mental health condition; almost half (49%) had a diagnosis of depression
- Dementia was diagnosed in over half of the residents (53%)
- The largest proportion of high care needs was in the cognition and behaviour care (64%) followed by need for care for activities of daily living (60%) or complex health care (52%).

Mental health issues in Residential Aged Care Facilities (RACFs)

Analysis of Aged Care Funding Instrument (ACFI) data for 2018-19 suggested that, across the PHN, there were 3,748 RACF residents with at least one mental or behavioural diagnosis (57). Proportionally, this represents 55% of the total 6,834 residents, lower than the state (59%) and national (60%) proportions, though it was the 3rd highest proportion of the seven Queensland PHNs. Data by PHN regions indicated (57):

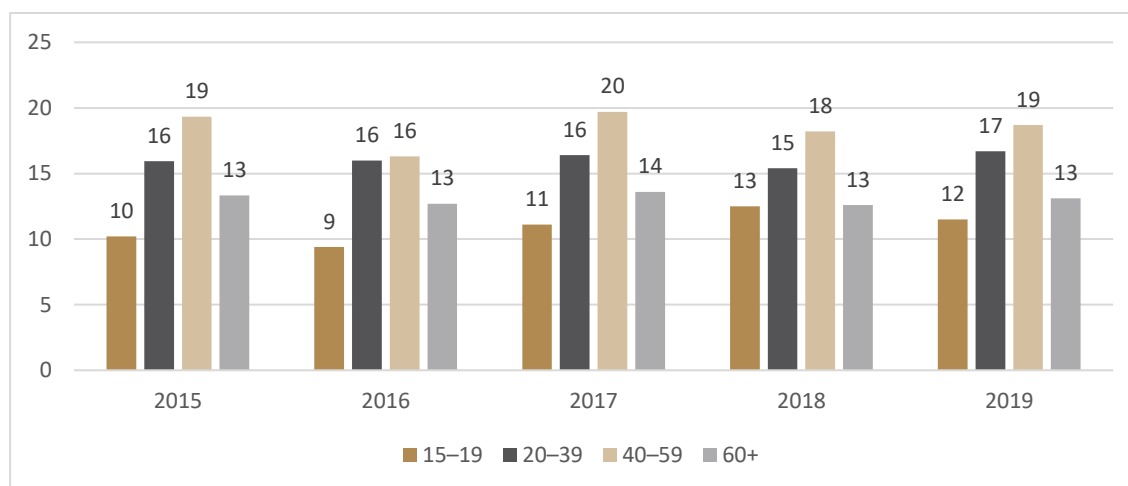
- Sunshine Coast (56 – 70%): Caloundra and Maroochydore SA3s had the highest numbers of permanent RACF residents with a MH and behavioural diagnosis (n 538 and 499 respectively), however Noosa had the highest proportion in the PHN at 70% (n=350).

- Central Queensland (45 – 57%): Rockhampton SA3 had the 3rd highest number of RACF residents in the PHN with a MH and behavioural diagnosis (n=478). Gladstone had the highest proportion in CQ area at 57% (120).
- Wide Bay (41 – 59%): Bundaberg and Hervey Bay SA3s had over 300 RACF residents each with a MH diagnosis. Burnett SA3 had the highest proportion (59%, or n=236), however this area lies across both our PHN (North Burnett LGA) and Darling Downs West Moreton PHN (South Burnett LGA). Applying the proportion to the number of residential places inside our PHN, this equates to approximately 89 people.

Suicide and Intentional self-harm hospitalisations

Suicide was not one of the leading causes of death among older Australians, including older people in Queensland. Age standardised rate for suicide for older population (60+) remained at around 13 per 100,000 from 2015 to 2019 (45). See Graph 14 below.

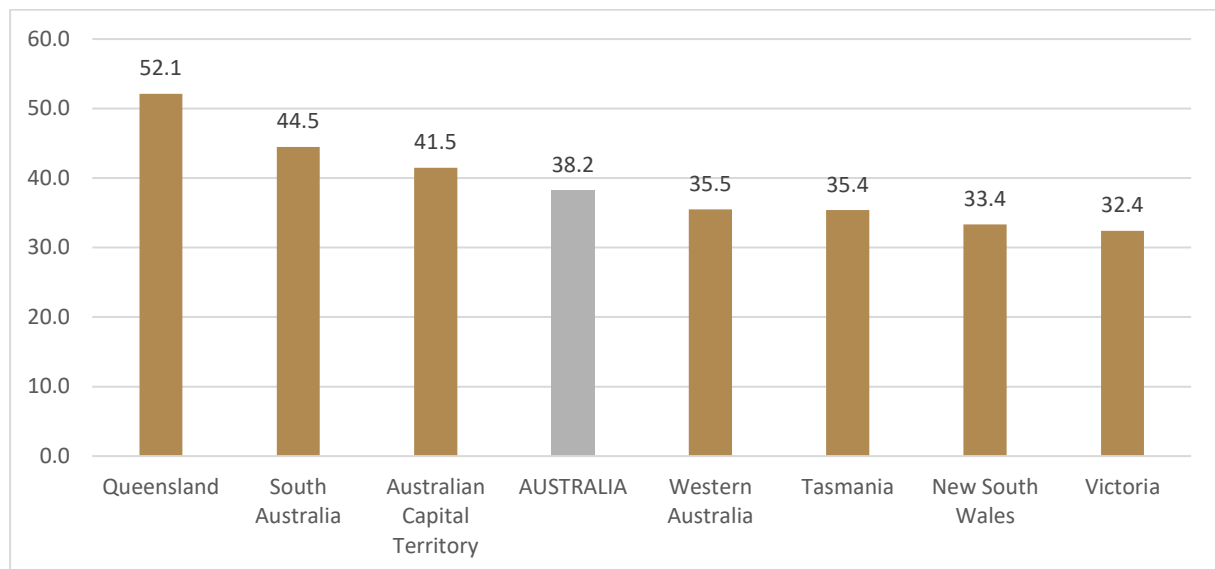
Graph 14: Suicide, by year of registration of death, age groups, Australia, 2015 to 2019 (ASR per 100,000)



Australian Institute of Health and Welfare (2021). "Suicide and Self-harm monitoring, National Mortality Database, 2015-2020.

In 2019-20, self-harm hospitalisation rate was the highest among older people (65+) in Queensland compared to older people living in other regions (45). See Graph 15 below.

Graph 15: Intentional self-harm hospitalizations among 65+ population, by states and territories, 2019–20 (rate per 100,000)



Source: AIHW, 2021. *National Hospital Morbidity Database, Intentional self-harm hospitalisations, by State and Territories, and age, 2019-20*; * there were no data provided for Northern Territory

The PHN population aged 65 years and above had the 3rd highest rate (54 per 100,000) of self-harm hospitalisation among all 31 PHNs in Australia, in 2019-20(46). This is 1.4 times higher than the national rate (38 per 100,000) and slightly higher than the QLD rate (52 per 100,000) for 65+ people.

The PHN community health and stakeholders survey 2020-21 data support these concerns.

Communities within the PHN have raised concerns about the quality of the aged care sector in general and the need for mental health support specific for older people and affordable aged care services (20). Main barriers for receiving mental health and other allied health support for older people were lack of public transport or transport support, lack of service information and inadequate number of local mental health staff. These issues were especially common among communities living in rural and remote areas. Overall, about 97% (592/612) of the respondents of the community survey felt that the need for quality residential care is highly important in their areas; however, only about 23% (142/612) of the respondents were satisfied with the quality of the residential care. A large proportion (40-50%) of respondents representing Bundaberg, Gympie (this includes Kilkivan and Cooloola SA2s), Fraser Coast were dissatisfied with the residential care services; Gladstone had the highest percentage (60% or 33/57) of dissatisfied respondents. Stakeholders listed the following key issues relating to older persons health in the PHN area (21):

- Lack of access to gerontology and other older people's health specialists
- Long wait times for ACAT and therefore packages
- Lack of in-home care and palliative care services
- RACFs sub-standard; not well-trained staff
- Lack of public transport to access centrally based services
- My Aged Care system is very challenging

2.3.4. Aboriginal and Torres Strait Islanders' population

Aboriginal and Torres Strait Islander people are more vulnerable to mental disorder and suicide. Higher presence of health determinants such as socioeconomic disadvantage, remoteness, low workforce participation and low educational attainment among Aboriginal and Torres Strait Islander people further contributes to the higher prevalence of mental health issues and self-harm among them. Indigenous Health Needs Assessment (HNA) document presents Indigenous specific mental illnesses.

2.3.5. Lesbian, Gay, Bisexual, Transgender, Intersex and Queer

Prevalence of common mental health conditions

According to the Australian Human Rights Commission, up to 11% of Australians may have a diverse sexual orientation or gender identity, and more than a third of those do not disclose their LGBTIQ+ status when accessing services (58). Applying 11% prevalence to the PHN population, approximately 90,000 people within the PHN might be representing the LGBTIQ+ community. There is a significant knowledge gap remaining in the mental health outcomes and suicidal behaviours among LGBTIQ people because of lack of inclusion of sexual orientation and gender identity in population health research and planning (59).

National LGBTI Health Alliance Report (59) provides some key statistics on the ***prevalence of mental disorders***, as follows:

- 41% of homosexual/bisexual people aged 16 and older met the criteria for a mental disorder and had symptoms in the last 12 months
- 37% of LGBTI people aged 16 and older reported being diagnosed or treated for any mental disorder in the past three years
- 20% of people in the general population aged 16 years and older met the criteria for a mental disorder and had symptoms in the last 12 months.

The report (59) further highlights the following:

Compared to the general population, LGBTIQ people are more likely to experience and be diagnosed with ***anxiety and depression***, specifically:

- Lesbian, gay and bisexual people aged 16 and over are nearly six times more likely to currently meet the criteria for a depressive episode
- LGB people aged 16 and over are more than twice as likely to currently meet the criteria for an anxiety disorder
- People with an intersex variation are nearly twice as likely to be diagnosed with depression and anxiety
- LGBT people aged 16 and over scored an average K10 score of 19.6, indicating moderate psychological distress compared to general population (aged 16 and over) in Australia score of 14.5 (low psychological distress)

Self-harm and suicide

Evidence suggested that LGBTIQ+ people were at a high risk of suicidal behaviours and had higher rates of suicidality compared to other Australians (14, 59).

Compared to the general population, LGBTI people are more likely to attempt suicide and self-harm in their lifetime (59):

- LGBTI young people aged 16 to 27 are five times more likely
- LGBT young people who experience abuse and harassment are more likely to attempt suicide
- Lesbian, gay and bisexual people aged 16 and over are over six times more likely to have thoughts of suicide
- 77.6% of bisexual people aged 18 and over reported having thoughts of suicide in their lifetime

Yet, currently available suicide data likely underrepresent the actual number of suicides among LGBTIQ+ communities, as they rely on police or coronial reports, disclosure by friends or family, or identification of same-sex relationships to identify sexual orientation or gender identity (14). Between 2017 and 2019, the Queensland Suicide Register (QSR) recorded 36 suspected suicides by people identified as LGBTIQ+ through available data (14).

Moreover, 71% of LGBTI+ people aged 16 to 27 indicated that they did not use a Crisis Support Service (CSS) during their most recent personal or mental health crisis due to potential discrimination (59).

In the PHN community health survey (20) about 5% (29/612) of the respondents identified themselves as LGBTIQ and their main health and wellbeing concerns identified were mental health issues and stigma. They expressed a need for better quality and accessible mental health services.

The PHN Indigenous community health survey (60) informed that majority (17 out of 23 representing all three regions) of those respondents who identified themselves as LGBTIQ indicated that mental health, suicide and chronic conditions were their most urgent health concerns followed by alcohol and/or other drugs (15/17), smoking (12/17) and domestic violence (12/17). Common barriers identified by Indigenous LGBTIQ communities for accessing mental health services included:

- long waiting list
- cost of appointment
- did not feel that service needs my cultural needs
- did not know where to go.

2.3.6. Australian defense force personnel

Prevalence of common mental health conditions

The unique nature of Australian Defence Force (ADF) service can increase likelihood of mental illnesses among service and ex-serving AF personnel (61). The Australian Bureau of Statistics' (ABS) 2017–18 National Health Survey (NHS) estimated almost half (49%) of people who had ever served in the ADF considered themselves to be in excellent or very good health, while 21% considered their health to be fair or poor (27).

Mental health and behavioural conditions were top chronic health condition (44%) experienced by the clients of Department of Veterans' Affairs; these clients were affected twice more than those never served in the ADF (27).

Self-harm and suicide

There is continuing concern about suicide in current serving and contemporary ex-serving ADF personnel. In particular, contemporary ex-serving ADF personnel may face increased risk of suicide. Between 2001 and 2017, there were 419 suicides among current serving, reserve and contemporary ex-serving ADF personnel (62).

After adjusting for age, the rate of suicide compared with Australian men for 2002–2017 was (62)

- 48% lower for current serving men
- 48% lower for men in the reserves
- 18% higher for contemporary ex-serving men

2.4. Co-morbidity

Many people with mental illness experience poor physical health and/or adverse health consequences from harmful substance use, including reduced life expectancy (23). There is a two-way relationship between mental illness and comorbidities, with mental illness often leading to poor physical health and substance misuse, and vice versa (23)**Error! Bookmark not defined.**, hence requiring integrated care for its prevention and treatment.

According to the 2007 National Survey of Mental Health and Wellbeing (the latest available, as of March 2021) (AIHW 1), 59% of adults who experience mental illness in a given year also have at least one physical health problem, compared with 48% of adults without a mental illness. Based on this and the NMHSPF estimates (2) of approximately 152,116 people experiencing mental illnesses in 2021 across the PHN catchment, it is estimated that around 88,200 people with mental illnesses have one or more comorbidities.

As stated in the Productivity Commission Mental Health report (23) both Australian and International evidence indicated that people with mental illness:

- were more likely to be diagnosed with a respiratory disease
- were two to three times more likely to be diagnosed with type 2 diabetes
- were six times more likely to die from cardiovascular disease
- had high rates of chronic pain
- had high rates of overweight/obesity
- were twice as likely to have osteoporosis
- were 50% more likely to have cancer
- were six times more likely to have a dental health issue

Also, there was evidence of a 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 (63). However, there was no national dataset that directly monitors the prevalence of physical illness in mentally ill people, but some information was available from various data sources. These informed the following:

- in 2017-18, 34% of people aged 45 and over with asthma also had mental and behavioural conditions compared to 20% people without asthma (64)
- in 2017-18, 41% of people aged 45 and over with COPD also had mental and behavioural conditions compared to 21% people without COPD (64).
- people being treated for psychotic disorder were more than 3 times as likely to have diabetes, and more than 1.5 times as likely to have a heart or circulatory condition (65).

- Aboriginal and Torres Strait Islander men were 3.7 times more likely than non-Indigenous men to be hospitalised due to mental disorders attributable to psychoactive substance use (66). For Aboriginal and Torres Strait Islander women the rate was 3.5 times higher than non-Indigenous women (66).

Nationally, ABS Causes of Death 2019 data (ABS 39) indicated that **90% of suicides had an associated co-morbid health condition**. Top five conditions included:

- mood disorder including depression (40.6%)
- drug and alcohol use disorders (28.7%)
- psychosocial risk factor associated with problems with spousal relationship circumstances (25.9%)
- suicide ideation (21.7%)
- alcohol and other drugs in the blood (20.9%).

PHIDU data (67) released in 2019 provided (no further updates for comorbidities available as of July, 2021) local level modelled estimates (2014-15) for mental and behavioural problems and commonly occurring comorbidities (See Table 18).

- For the PHN, heart, stroke, and vascular disease (ASR 2.2 per 100) was the most common comorbidity followed by COPD (ASR 1.8 per 100) and type 2 diabetes (ASR 1.4 per 100).
- Co-morbid heart, stroke and vascular disease is highest in Gympie (ASR 3.5 per 100), Fraser Coast (ASR 3.2 per 100), Bundaberg (ASR 2.4 per 100), North Burnett (ASR 2.4 per 100) and Noosa (ASR 1.9 per 100)-all are higher than the QLD rate of ASR 1.8 per 100.
- Co-morbid type -2 diabetes was highest in Fraser Coast (ASR 1.7 per 100), followed by Gympie, Rockhampton, Bundaberg, and North Burnett – all areas had higher than the QLD rate of ASR 1.4 per 100.
- Co-morbid COPD: Fraser Coast, Gympie, Sunshine Coast, Bundaberg, Rockhampton, and Livingstone rates were higher than the QLD rate of 1.6.

Table 18: Estimated number of people aged 18 years and over who had mental and behavioural problems with other associated comorbidities, 2014-15 (modelled estimates)

LGA	Mental and behavioural problems and type 2 diabetes mellitus		Mental and behavioural problems and heart, stroke and vascular disease		Mental and behavioural problems and COPD	
	Number	ASR per 100	Number	ASR per 100	Number	ASR per 100
Banana (S) - part a	9	1.3	9	1.3	11	1.5
Banana (S) - part b	126	1.3	125	1.3	153	1.5
Bundaberg (R)	1,450	1.6	2,279	2.4	1,806	2.0
Central Highlands (R) (Qld)	220	1.2	219	1.3	270	1.5
Fraser Coast (R)	1,751	1.7	3,387	3.2	2,134	2.1
Gladstone (R)	606	1.4	613	1.5	669	1.5
Gympie (R)	756	1.7	1,665	3.5	953	2.1
Livingstone (S)	414	1.3	536	1.7	534	1.8
Noosa (S)	617	1.2	987	1.9	755	1.5
North Burnett (R)	161	1.5	254	2.4	199	1.9
Rockhampton (R)	956	1.6	1,116	1.8	1,195	2.0
Sunshine Coast (R)	3,181	1.2	4,762	1.8	3,921	1.5
Woorabinda (S)	^	..	^	..	^	..
PHN	10,247	1.4	15,952	2.2	12,601	1.8
QLD	48,477	1.4	63,073	1.8	56,138	1.6
AUSTRALIA	277,121	1.6	318,978	1.8	221,358	1.3

Source: PHIDU (2019). *Social Health Atlas of Australia: Selected composite indicators 2014-15 (modelled estimates)*.

The PHN stakeholder survey data findings: PHN stakeholders expressed their concerns about lack of care coordination in the system, especially in the private system, for those clients requiring multidisciplinary care (21). The issue is further complicated by lack of funding and specialist's time for appropriate care coordination for complex clients. Service providers further emphasised a need for better funding for health counselling services to enable providing holistic, sustainable, and ongoing psychological services (21).

3. Health Service Needs

The HNA assesses Mental Health Service needs by following key domains and these domains are consistent with components of the National Health Systems Performance Framework (68):

- Access and Continuity of Mental Health Services: This covers MBS MH services, specialised mental health services, support services, PHN commissioned MH services (Stepped Care, Headspace) and Integration and coordination of MH services
- Mental health safety and quality
- Mental health workforce
- Responsiveness and Appropriateness
- COVID-19 impact on Mental Health Services

In keeping consistency with the Australian Mental Health Services report by AIHW, health services data are presented by MH service type of MH comparing the PHN data with national, State/Territory, and other PHNs and where data permit, across LGAs/SA3s within the PHN region.

3.1. Access and Continuity of Mental Health Services

Mental health services can be broadly divided into following three categories (69):

- Medicare-subsidised services: services provided by General practitioners, Psychiatrists and Psychologists
- Specialised mental health services: provided through Public and private hospitals, Community mental health care and Residential mental healthcare services
- Support services: Disability support services, Homelessness support services and various Mental health programs

A considerable number of mental health services are provided to people with a mental illness each year. Nationally, in 2019-20, 12.4 million Medicare-subsidised MH related services were provided to 2.7 million people or 486 services per 1,000 population. Further, 310,471 presentations to public hospital EDs were mental health-related, accounting for about 4% of all presentations (up from 3% in 2011–12) (69). Community mental health care services provided around 9.7 million service contacts to over 453,000 population (or 386 service contacts per 1,000 population) in 2018–19 (69).

3.1.1. MBS-Mental health services

Medicare-subsidised mental health-related services

There are three types of MBS Mental health services (70):

1. MBS GP Mental Health services
2. MBS-Allied Mental health services include the following subcategory of services:
 - a. Clinical Psychology
 - b. Other Psychology
 - c. Other Allied mental health
3. MBS-Psychiatrist service

These services are provided in various settings such as in hospitals, in consulting rooms, by home visits, over the phone, and by videoconferencing (70). Nationally, the number of people receiving Medicare subsidised mental health-specific services (MBS services) (71) has increased, from 1.4 million (or 6.2%

of the population) in 2009-10 to 2.7 million (10.7%) in 2019-20. The number of services has also increased, from 7.0 million in 2009–10 to 12.4 million services in 2019-20.

In the PHN, a total of 439,088 MBS MH services were provided to 150,617 clients in 2019-20 (71).

- Around 17 % of the PHN population received the service, which is higher than the national level uptake (10.7%).
- Higher proportion of women (10%) in the PHN accessed the services compared with males (7%).
- The highest proportion of people receiving MBS MH services were aged 25-44years (32%) followed by 45-64 years (28%) and 15-24 years (18%), while the lowest proportion (1.4%) of people were aged over 80 years (72).

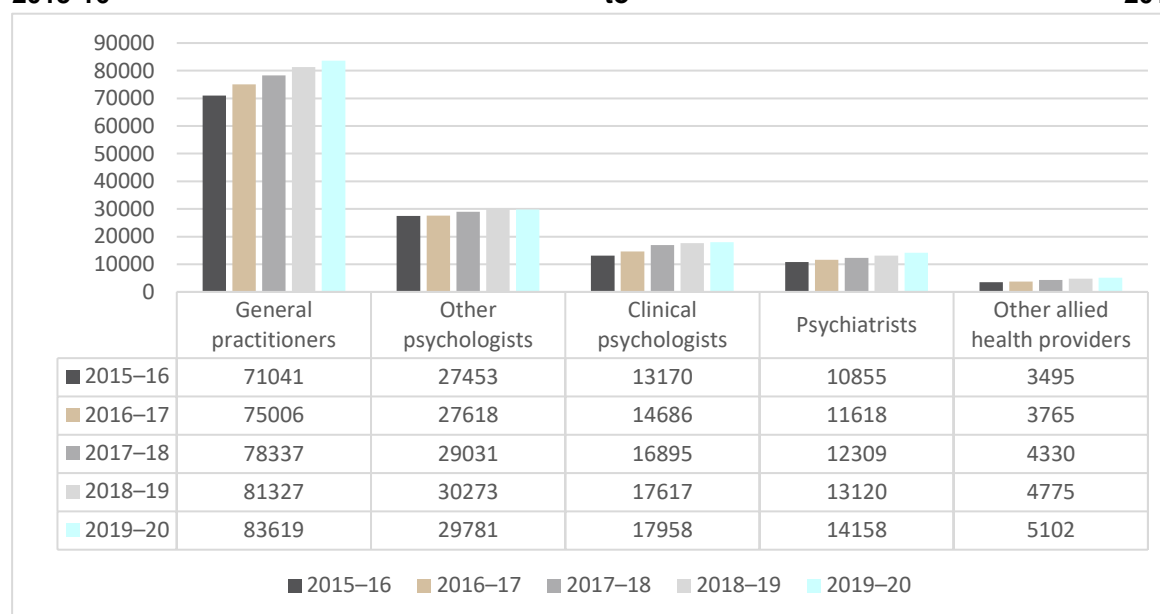
In 2019-20, an extent and pattern of uptake of different types of MBS mental health services by the PHN population (71) was similar to those Australian population's service uptake:

- 10% (or 83,619 people) of the PHN population received the services from general practitioners
- 3.4% (or 29,781 people) from psychologists
- 2.0% (or 17,958 people) from clinical psychologists
- 1.6% (or 14,158 people) from psychiatrists
- 0.6% (or 5,102 people) from other allied mental health professionals

Comparing these numbers against the service needs estimates in the NMHSPF, overall, MBS-mental health services provided within the PHN respond relatively well in connecting people to services for their mild mental illness, presuming that the majority of these services are delivered by GPs. However, there is a need for improving access to people requiring services for their moderate and severe mental illnesses provided by psychiatrists, psychologists and allied mental health professionals.

The number of people accessing various types of MBS-MH services have increased from 126,014 in 2015-16 to 150,617 in 2019-20. The largest increase has been related to the number of people receiving other allied MH services (46% increase), followed by people using clinical psychologists (36% increase), psychiatrists service (30% increase) and GP MH services (18% increase). People receiving other psychologist's services had a minimal increase (8% increase only) (72). See Graph 16 below.

Graph 16: Number of people accessing MBS-MH services in the PHN region, by service type, 2015-16 to 2019-20



Source: Australian Institute of Health and Welfare. (2021). Medicare-subsidised mental health-specific services, by PHN, 2015-16 to 2019-20

However, it is to be noted that an individual may receive services from more than one provider type. The number of people reported here as receiving services from GPs is limited to services billed against mental health-specific MBS item numbers, which is a sub-component of GP mental health-related activity. It is not clear that how many additional people receive GP mental health-related care that is billed as a consultation against generic GP MBS item numbers; the results of the 2015-16 the Bettering the Evaluation and Care of Health (BEACH) survey suggests that this number is quite substantial (71). Therefore, the above numbers potentially are underestimates of GP provided MH services being provided.

MBS GP mental health services in the PHN population

General practitioners play a major role in providing MBS MH services within the PHN population. In 2019-20, the highest proportion of MBS mental health services delivered within the PHN were by GP MH services (32.3%) followed by other psychologist service (28.3%), psychiatrist (17.7%), clinical psychologist (17.3%) and other allied mental health (4.5%) (71). This ratio is similar to national MBS mental health service distributions (72).

MBS data of 2019-20 (71) indicated 141,698 mental health services provided by GPs to 83,619 patients across the PHN region. The PHN rate for MBS GP services was higher (162 per 1,000 people) than the Queensland rate (157 per 1,000) and the national rate (149 per 1,000) (71). Nevertheless, despite the need for primary mental health services, access to these services was varied across the PHN and showed large disparities between rural and urban areas.

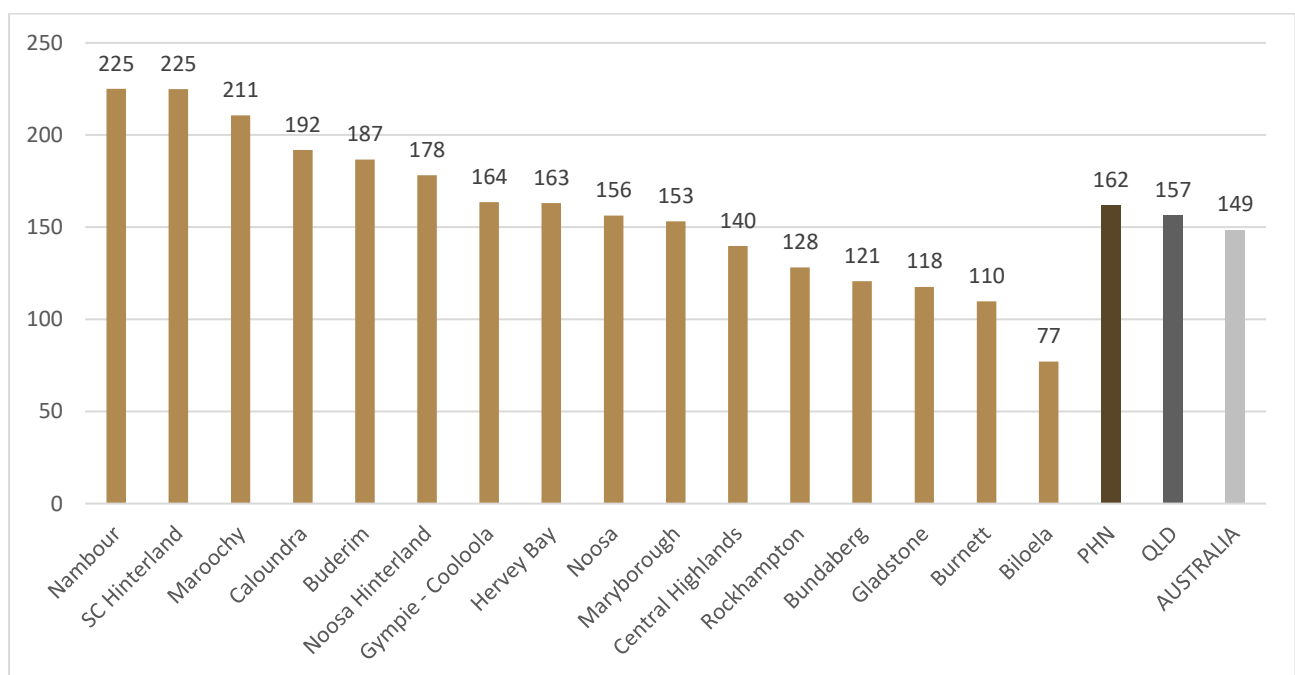
GP Mental Health service uptake for 2019-20 within the PHN shows AIHW (Australian Institute of Health and Welfare) (72) (See Graph 17 below):

- The overall PHN service rate was 162 per 1,000, which is less than the half of modelled estimates of required **GP Mental health** services (380 per 1,000 population) (2). Nevertheless, the service

rate is increasing continuously to meet the growing demand for the service; the PHN GP-MH rate was 112 per 1,000 in 2014-15.

- A large variation across the PHN-SA3s still exists; relatively lower service utilisation rates were seen in Burnett (110 per 1000) Gladstone (118), Bundaberg (121) and Rockhampton (128) despite its higher prevalence of mental health disorders among people living in these areas.
- Regional service rates were lowest in CQ (77– 140 per 1,000) yet CQ has a relatively higher burden of mental disorder in the PHN, after Wide Bay area. All LGAs within the CQ region had lower than the PHN (162) and QLD rate (156.5); SC LGAs had the highest service uptake rates (156 – 225 per 1,000) within the PHN; this can be explained its relatively urban or semi-urban location, hence better availability of the services rather than the higher demand compared to other two areas; the prevalence data showed that SC area had the lowest burden of mental disorder within the PHN.
- Both outer regional SA3 areas (Biloela-77.1 and Central Highlands-139.8) and 5 out of 9 inner regional SA3 areas, namely Bundaberg, Burnett, Gladstone, Maryborough, Rockhampton had lower than the QLD service rate (156.5 per 1,000). However, all major cities-SA3s, except Noosa (156.3) had higher than the QLD rate. Sunshine Coast Hinterland (224.9) and Nambour (225.0) had the highest rate in the PHN.

Graph 17: MBS-GP Mental Health services provided in 2019-20, by SA3 areas (services per 1,000 population)



Source: Australian Institute of Health and Welfare. (2021). Medicare-subsidised mental health-specific services, by PHN area and SA3 area and provider, 2019–20

Trends in MBS GP mental health service data over the last few years continued to show growing trends within the PHN with some disparities. The PHN data indicated the number of people receiving MBS GP-Mental health services continuously increased from 57,310 in 2013-14 to 83,619 in 2019–20 (71, 72). The percentage of the PHN population receiving mental health services from GPs was 7.1% in 2013-14; this increased to 10% in 2019-20. The service rate increased from 117.4 per 1,000 people in 2013-14 to 161.8 per 1,000 in 2019-20 (71, 72).

In terms of annual improvement in the use of GP mental health MBS items from 2018-19 to 2019-20, the highest SA3 improvements were observed in Central Highlands (40.8%), Sunshine Coast Hinterland

(12%) and Maroochy (8.5%). However, despite the largest increase in service uptake in Central Highlands, the area still needs to increase the number of services to meet the MH needs in the area. Service uptake rate change went backwards in a number of areas: Biloela (-6%), Gladstone (-1%) and Maryborough (-0.3%) (71, 72); which needs to be addressed as these areas, specifically, Maryborough and Gladstone, presented a higher burden of mental illness. Biloela has the lowest service rate (77.1) in the region with service availability limited in the area, as evidenced by community and stakeholder surveys.

According to Mindspot data (73), only 40.3% of respondents (116/288) from the PHN who received an assessment in 2017 had a GP who they would speak to about mental health. The assessment performed in 2016 had a slightly higher percentage (46%); hence a decrease by 6% has occurred despite the increasing need for GP MH services.

MBS-allied mental health services in the PHN population

MBS Allied MH services are provided by clinical psychologists, other psychologists and allied mental Health professionals. MBS data for 2019-20 (72) indicated that 219,871 mental health services provided by allied mental health professionals to 52,840 patients across the PHN region. The proportion of patients who received services from **various allied mental health professionals** in 2019-20, were as follows:

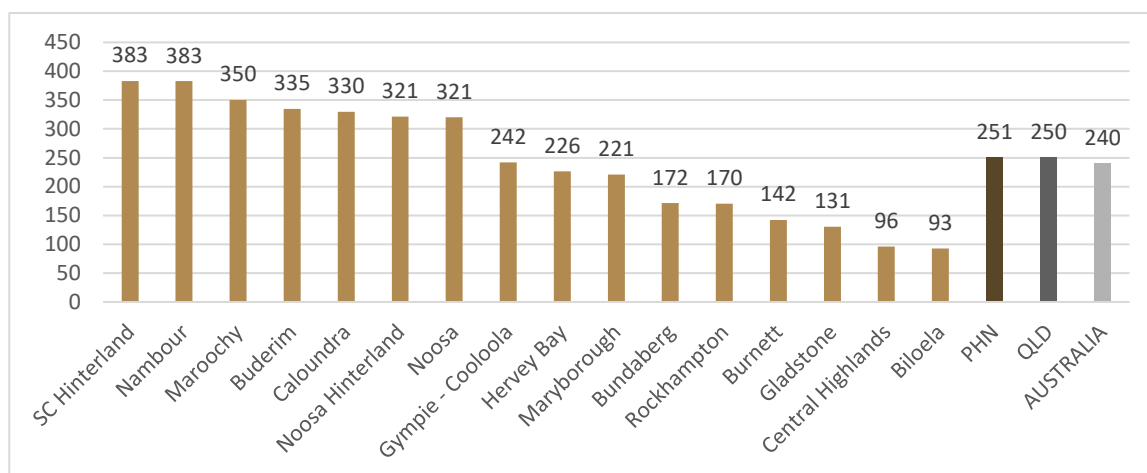
- 29,781 (or 3.4% of the PHN population) received services from psychologists
- 17,958 (or 2.1% of the PHN population) from clinical psychologists
- 5,102 (or 0.6% of the PHN population) from other Allied Mental Health professionals.

The PHN rate for MBS allied mental health was 250.8 per 1,000 in 2019-20, this is a slight decrease (-2.2%) from 256.5 per 1,000 population in 2018-19, however higher than the national rate (240.2 per 1,000) for 2018-19 (71, 72).

However, large disparities across localities continue to exist in MBS allied mental health service use in 2019-20 (71, 72):

- Similar to MBS GP mental health service, the lowest service rates were seen in two outers regional SA3 areas, Biloela (92.7 per 1,000) and Central Highlands (96.2 per 1,000); other SA3s with lower than the QLD rate of 249.7 per 1,000 people were Gladstone (130.7), Burnett (142.2), Rockhampton (170.3), Bundaberg (171.5), Maryborough (220.8), Hervey Bay (226.3), Gympie – Cooloola (242.0). See Graph 18 below.
- Regional service rates were lowest in CQ (92.7-170.3 per 1,000) followed by WB (142.2-242.0 per 1,000); all SA3s in CQ and WB region had the lower than the QLD and the national rates, except only Gympie-Cooloola (242.0) which had a slightly higher rate than the national rate. However, SC had the highest rate (320.5– 383.1 per 1,000) in the PHN region. All SC SA3 service rates were higher than the QLD and national rates. These service rates do not effectively correspond to the prevalence of mental illness in the region, with Wide Bay and CQ experiencing much higher burden of mental health illness compared to SC yet having much lower service rates. Limited access and availability of Allied MH services in regional areas contribute to the lower service rates in CQ and WB areas.
- Overall, for the majority (9 out of 16) of the SA3s, allied MH service rate changes went backwards in 2019-20 compared to the rates observed in 2018-19; remained similar in four SA3s (Caloundra, Central Highlands, Maroochy and Sunshine Coast Hinterland); only three SA3s (Burnett, Gladstone, and Bundaberg) had some increase.

Graph 18: MBS Allied MH services provided in 2019-20, by SA3 areas (services per 1,000 population)



Source: Australian Institute of Health and Welfare. (2021). Medicare-subsidised mental health-specific services, by PHN area and SA3 area and provider, 2019–20

Nevertheless, overall PHN data indicated the number of people receiving MBS allied MH services continuously increased from 33,932 in 2013-14 to 52,840 in 2019–20. The percentage of the PHN population receiving allied mental health services from allied health practitioners was 4.2% in 2013-14; this increased to 6.0% in 2019-20. The service rate increase was 33%, from 188.5 per 1,000 people in 2013-14 to 250.8 per 1,000 in 2019-20 (71, 72). However, disparities in access and availability of the service within the PHN remains a concern.

MBS-Psychiatrist service

The percentage of Australians receiving services from psychiatrists was 1.3% in 2008–09, increasing to 1.7% in 2019–20 (71). About 1.6% of the PHN population received services from psychiatrists in 2019-20 (71), similar to the national rate. The PHN data for 2019-20 indicates (71, 72):

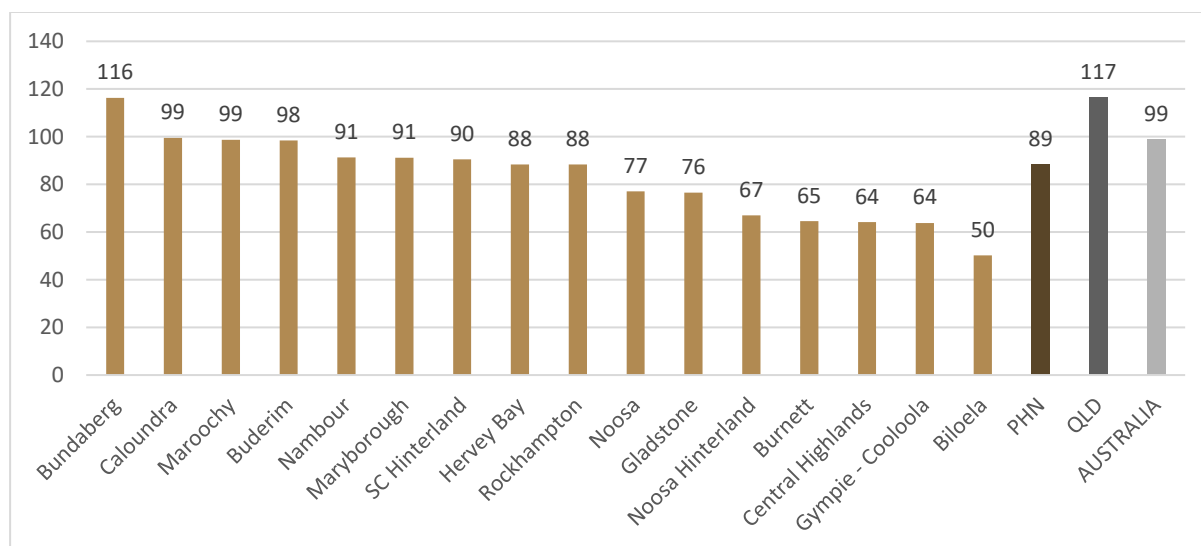
- Rate of psychiatrist services was 88.5 per 1000 (Qld-116.6 and National-98.7 per 1,000) despite having higher demand for psychiatrist service within the PHN as estimated in the NMHSPF (2)
- 77,520 psychiatrists' services provided to 14,158 patients
- Steady increase in the number of patients receiving MBS psychiatrist service; about 30% increase from 2015-16 to 2019-20
- Gradual increase in the number of psychiatrist services provided; from 65,188 in 2015-16 to 77,520 in 2019-20.

Overall, the PHN had a very low rate of psychiatrist service uptake. The PHN rate is lower than the QLD and national rate despite its higher rate of psychological distress (71): See Graph 19 below.

- All SA3s had lower than the QLD rate; only two SA3s (Bundaberg-116.3 and Caloundra-99.5) had higher than the national rate (98.7)
- Two outer regional areas had the lowest service rates Biloela (50.2 per 1,000) and Central Highlands (64.1 per 1,000); although these areas are not with the highest rate of mental illnesses, the current service uptake is not meeting the demand

- Gympie – Cooloola (63.8), Burnett (64.5) Gladstone (76.5) and Rockhampton (88.3) had lower service uptake despite the higher prevalence of mental disorder in these areas indicating immediate need for service uptake in these locations.
- Other areas with lower than the PHN service rate (62.4 per 1,000) include Gympie – Cooloola (43.2), Burnett (46.2). Gladstone (51.3), Noosa Hinterland (53.4), Noosa (54.4), Hervey Bay (59.4) and Rockhampton (60.2).

Graph 19: MBS-Psychiatrist MH services provided in 2019-20, by SA3 areas (services per 1,000 population)



Source: Australian Institute of Health and Welfare. (2021). Medicare-subsidised mental health-specific services, by PHN area and SA3 area and provider, 2019–20

However, despite a relatively lower service rate overall, the PHN data indicated an increased uptake of psychiatrist services from 2015-16 to 2019-20; the number of services provided increased by about 20% and number of people receiving the service increased by 30% (72).

In terms of improvement in the uptake of psychiatrist services from 2015-16 to 2019-20, the highest SA3 improvements were observed in Gladstone (80%), Biloela (77%), Central Highlands (76%) followed by Bundaberg (46%), Maryborough (43%), Hervey Bay (38%), Rockhampton (36%), Burnett (13%), and Nambour (10%). SA3s with less than 10% improvements were Gympie-Cooloola (9%). Sunshine Coast (4%), Maroochy (2%) and Caloundra (1%). The service rate changes went backwards in three SA3s: Noosa (-13%), Buderim (-3%), and Noosa Hinterland (-1%) (72).

The PHN community health survey data findings: About one third of the PHN community health survey 2020-21 respondents (176/612) needed to see mental health professionals in the last 12 months but could not. Common reasons that prohibited their engagement included cost (including the travel cost), lack of local doctors and Covid19 restrictions (20). Emerald clients specified that that they could not see a MH specialist due to unavailability of face-to-face appointments. Further, Gin-Gin clients commonly expressed a need for bulk-billing GP services in the area. Communities from rural and remote areas also raised their concerns about lack of affordable local mental health services (20). The most in-demand services named across the PHN were mental health counselling, especially, young people and children's counselling and psychologists services. More specifically, the respondents representing communities in Banana, Central Highlands, Gladstone, and Fraser Coast supported a need for more locally available mental health specialists and AoD counselling.

PHN service providers survey: Majority of the service providers (about 85-90% of the respondents) across the PHN agreed that there is an inadequate number of psychologists, psychiatric and psychosocial services in the community (21). Mental health and suicide prevention services were one of the most commonly reported (75% or 170/228) service areas identified as having gaps/needs across the PHN, as well as in each region individually.

3.1.2. Specialised mental health services

Specialised mental health services are provided through **public and private hospitals, community mental health care and residential mental healthcare services.**

In 2018-19, mental and behavioural disorders were third common cause for hospitalisation in Australia among young people (both males and females) aged 15-24 years (74).

Available mental health beds

Across the PHN, existing levels of acute adult beds stand at 90% of NMHSPF targets for 2021, indicating that under the specific assumptions of the NMHSPF, they are sufficient to meet the expected need of mental health 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 based on the same assumptions and estimates. Some of these services need to be provided locally, particularly community based sub-acute and non-acute services to meet the local demand (2).

Mental health admission rates in 2017/18 per 100,000 were 1,770 in SC, 771 in WB and 770 in CQ, which all were low when compared to the QLD rate of 2,131 per 100,000. Highest rates were observed in all three LGAs in SC (Gympie 1,147, Noosa, 1,671, Sunshine Coast LGA 1,793 per 100,000) and Rockhampton (CQ) 1,233 per 100,000(75). This indicates that there is a potentially unmet MH bed needs in Wide Bay and Central Queensland, as these regions had higher rates of people with high and very high psychological distress.

Greatest improvements in MH hospital admission rates from 2015/16-2017/18 were seen in Banana (46%) and Central Highlands (33.1%). The largest reductions were seen in Gladstone (39.5%), Fraser Coast (22.9%), and Gympie (22.8%) (75).

Mental Health related Emergency department (ED) presentations

Nationally, 3.8 % of all ED presentations were MH related, compared to 4.1% in QLD in 2019-20 (76). The proportion of MH related ED presentations in public hospitals in Australia and in QLD increased by about 1 % (average annual change) over a four-year period from 2015-16 to 2019-20 (76).

In 2019-20, there was a total of 12,550 MH-related presentations by the PHN population, which accounted for about 3.7% all ED presentations (up from 3.0% in 2015–16) (76). The proportion of MH-related presentations by Aboriginal and Torres Strait Islander people sat at about 12% (76); a relatively higher representation of Indigenous people compared to the 3.5 % of the PHN population that identify as Aboriginal and Torres Strait Islander. The national rate for MH related presentations by Aboriginal and Torres Strait Islander people was about 6% in 2019-20AIHW AIHW (Australian Institute of Health and Welfare) (76).

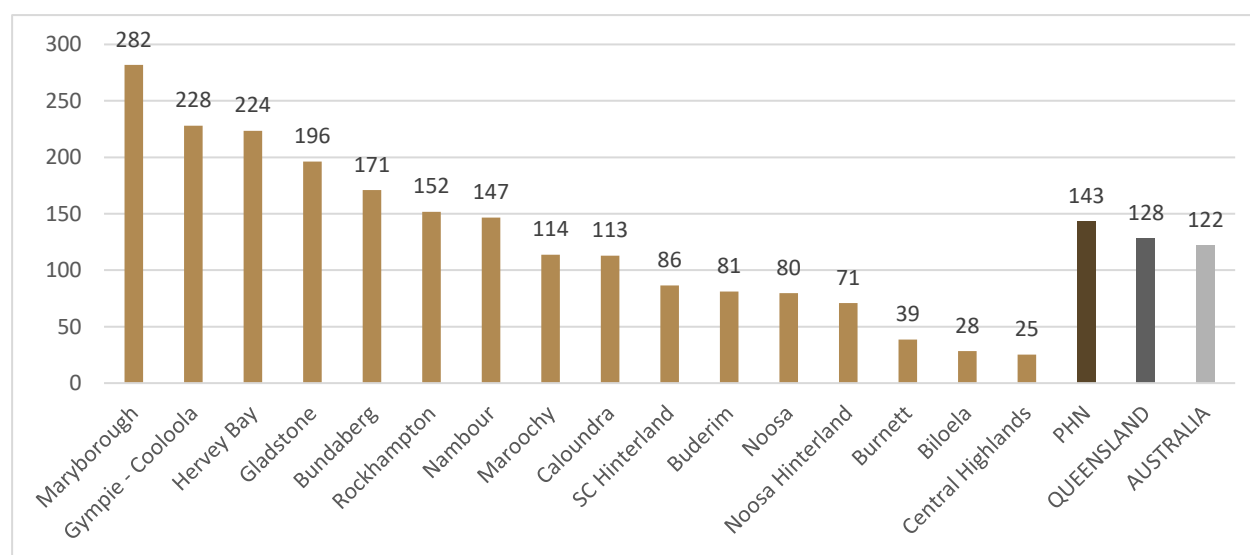
The PHN average annual percentage change rate for MH-related ED presentations was about 7.8% during 2015-16 to 2019-20, much higher than the change in Queensland (2.0%) and Australia (1.6%) (76). During the same period, large variations across PHN SA3s (based on the patient SA3s) were seen, as follows (76):

- SA3s with highest increase of average annual percentage change rate: Gladstone (14.8%) Gympie – Cooloolool (14.3%), Maryborough (13.9%), Hervey Bay (10.5) and Bundaberg (10.1%)

- Two SA3s shown decreases: Biloela (-30.6) and Noosa Hinterland (-10.6%)
- SA3s with small to medium increases and lower than the PHN (7.8%) average change are: Buderim (0.1%), (0.3%), Maroochy (2.6%), Caloundra (5.6%), Noosa (7.3%), Bundaberg (1.6%), Burnett (4.8%), Rockhampton (6.1%), Sunshine Coast Hinterland (5.5%), and Central Highlands (7.5%).

The percentage of MH-related presentations were higher than the QLD percentage (4.1%) in five SA3s in 2019-20. These include Noosa (6.4%), Noosa Hinterland (4.4%), Maryborough (4.2%), Maroochy (4.2%), and Hervey Bay (4.1%) - all in the Sunshine Coast region, except for Maryborough. These suggest that despite the increased uptake of MBS MH services in the PHN, there are still unmet needs for MH services provided at the primary care. Graph 20 below compares the rates for MH related ED presentations.

Graph 20: PHN-SA3 rates for MH related ED presentations per 10,000 population, 2019-20



Source: Australian Institute of Health and Welfare. (2020). *Mental Health Services in Australia, 2020: Services provided in public hospital emergency departments 2019-20*.

The PHN stakeholders survey 2020-21 respondents (service providers) commented that under-resourced MH services leads to higher use of medication and potentially avoidable presentations to ED. They highlighted a need for bulk-billed counselling and psycho-social services, and community mental health services, especially for those living in rural and remote areas (21). Ongoing mental health support, funding for after-hours services and rehabilitation services were also highlighted as priority actions in addressing mental health and AoD issues (21). A mental health professional servicing the Sunshine Coast area further commented that communicating with acute mental health services are generally difficult as they seem reluctant to accept responsibility of high-risk clients to practitioners in the area. This reinforces a need for improved communication and collaboration between service providers.

About 1 in 4 respondents represented in the **PHN community health survey** (20) indicated they visited ED because GP was not available, or the wait list was too long. Unavailability of after-hours services was also one of the most mentioned reasons that clients visited ED (20).

Overnight admitted mental health patient hospitalisations

Overnight mental health-related hospitalisations (also referred to as separations) occur in public acute, public psychiatric, or private hospitals. These hospitalisations can also occur on a general ward and are classified as either with or without specialised psychiatric care (70).

- Nationally, the rate of overnight separations with specialised care has doubled between 2006–07 and 2017–18 for females aged 12–17 years (52).
- Mental Health Services in Australia Database for overnight admitted mental health-related care 2018–19 showed (52) that in the PHN public and private hospitals, 8,416 overnight mental health-related hospitalisations (or separations) occurred, equating to 95,876 patient days. However, the PHN separations per 10,000 population were the second lowest (98 per 10,000) after ACT PHN (95 per 10,000) in 2018-19 among 31 PHNs within Australia.
- Rockhampton SA3 had the highest rate for overnight admitted mental health-related patient days (1,514 per 10,000 population) within the PHN followed by Maroochy (1,488 per 10,000), Nambour (1,459 per 10,000), Sunshine Coast Hinterland (1,290 per 10,000), and Caloundra (1261 per 10,000), and these rates were all higher than the QLD (1,248 per 10,000) and national rate (1,214 per 10,000 population) (52).
- Nationally, in 2018-19, women had a higher rate (71) of overnight admitted mental health-related hospitalisation per 10,000 population than men (65); the rate for Indigenous Australians (140.9 per 10,000) was more than double the rate for non-Indigenous Australians (64.3 per 10,000) (52). These demographic data are not available for the PHN and LGA/SA3 levels.

Further details can be seen in Table 19 below.

Table 19: Overnight admitted mental health-related population rates of separations and bed days, with and without specialised psychiatric care, by Statistical Area 3 (SA3) area, PHN, 2018–19

SA3 name	Separations	Patient days	Separations per 10,000 population	Patient days per 10,000 population
Central Highlands (Qld)	159	1,173	54	396
Rockhampton	1,293	17,967	109	1,514
Biloela	116	859	82	604
Gladstone	522	4,273	83	679
Buderim	507	6,103	86	1,032
Caloundra	941	11,116	107	1,261
Maroochy	743	9,023	123	1,488
Noosa	414	4,866	92	1,080
Sunshine Coast Hinterland	509	6,816	96	1,290
Nambour	544	6,720	118	1,459
Noosa Hinterland	195	2,255	84	965
Bundaberg	803	6,841	89	759
Burnett	610	4,713	123	948
Gympie – Cooloola	487	5,923	95	1,150
Hervey Bay	586	6,148	99	1,033
Maryborough	410	4,347	89	945
PHN	8,416	95,876	98	1,111
QLD	37,051	630,547	73	1,248
AUSTRALIA	171,286	3,057,433	68	1,214

Source: AIHW, *Mental Health Services in Australia, Overnight admitted mental health-related care 2018-19 Table ON 11: Overnight admitted mental health-related population rates of separations and bed days, with and without specialised psychiatric care, by Statistical Area 3 (SA3) area, 2018–19*

Community Mental health care services

Mental illness is often treated in the community and hospital-based outpatient care services provided by state and territory governments. Collectively, these services are referred to as **specialised community**

mental health care (CMHC) services (70). An increase in the uptake of community mental health care could serve as an indication for improved continuity of care. Nationally, the community MH service contact rate increased from 373.9 per 1,000 population in 2013–14 to 385.5 in 2018–19 (77). The most frequently recorded principal diagnoses for patients receiving service contacts in QLD were schizophrenia (30.6% of all contacts), schizoaffective disorders (7.7%) and depressive episodes (6.8%) (77).

In 2018-19, the rate of CMHC service contacts in Queensland was 401 per 1,000 population, which is higher than the national rate (386 per 1,000) and the third highest (after ACT and SA) among all states territories (77). The highest rate of service contacts was observed among young people aged 12-17 years (807 per 10,000) followed by 25-34 years (572 per 1,000) and 18-24 years (565 per 10,000) in Queensland (77). The pattern was the same across all states and territories. Aboriginal and Torres Strait Islander patients received community mental health care services at around 3.6 times the rate of non-Indigenous patients in Queensland and 3.5 times in Australia in 2018-19. Males (425 per 1,000 population) had a higher rate of service contacts than females (377 per 1,000) in 2018-19 in Queensland as well as nationally (Males 393; Females 366) (77). However, young females aged 12-17 years (females-996 compared to males-628 per 10,000) and 18-24 years (females-581 compared to males-550 per 10,000) had much higher rates than the males in QLD, as well as across all other states and territories.

There was no PHN level CMHS data available; however national and QLD level data stated above can provide some context to the service in terms of its uptake and trend over the years, common reasons (or principal diagnosis) of receiving the service and key target population. This information can effectively inform PHN level community MH services planning.

The PHN community and stakeholders survey 2020-21: The respondents of both community health and stakeholders' surveys highlighted a need for public or bulk-billed community mental health services to provide ongoing and sustainable mental health support (20, 21). Peer-based support and youth mental health services were highly sought-after services especially, in the Gympie area, as indicated by service providers in the Sunshine Coast area.

Residential mental healthcare services

Residential mental health care (RMHC) services provide overnight specialised mental health care in a domestic-like environment, and these services may include rehabilitation, treatment or extended care (70).

Nationally:

- 8,045 episodes of RMHC care were provided to 6,375 residents with an average of 46 residential care days per episode in 2018-19 (78). The most frequently recorded principal diagnoses for patients receiving RMHC were schizophrenia (25.1% of all contacts), followed by personality disorders (13.2%), schizoaffective disorders (8.8%) and depressive episode (8.4%) in 2018-19.

In Qld (78):

- 947 episodes of RMHC care were provided to 868 residents with an average of 87 residential care days per episode in 2018-19; the average residential care days per episode was the second highest in Australia.
- The rate of residential care days was 162.5 per 10,000 in 2018-19; this is higher than the national rate of 147.2.

In PHN (78):

- 341 episodes of RMHC care were provided to 312 residents in 2018-19.
- The rate of episodes per 10,000 was 3.9; this is higher than the national rate (3.2) and much higher than the QLD rate (1.9)

The recent most available data at the PHN level by AIHW (78) were for 2017-18 and 2018-19. The rate (rate per 10,000) of residents receiving RMHC was increased from 1.8 in 2017-18 to 3.6 in 2018-19 (108% increase); the rate of episodes of care from 2.1 to 3.9 (88% increase) (78). The PHN rate (3.9) of episodes of care was higher than the Qld rate (1.9 per 10,000) and the national rate (3.2 per 10,000).

The provision of RMHC services differed between SA3s in 2018-19, with Gladstone reporting the highest rates of episodes of care (11.6 per 10,000 population) and residents (10 residents per 10,000 population) followed by Bundaberg (9.9 for episodes; 9.1 for residents) and Buderim (8.11 for episodes and 7.10 for residents) (78). 10 out of 16 SA3s in the PHN had less than ten episodes and residents; these areas include Biloela, Burnett, Central Highlands, Gympie – Cooloola, Maroochy, Maryborough, Nambour, Noosa, Noosa Hinterland, Sunshine Coast Hinterland (78) (See Table 20 below). This may not necessarily suggest that these areas had less demand for RMHC services; rather, patients in these areas had limited access to RMHC or received services in areas where services were accessible because both prevalence data and survey findings suggested that these areas, especially Burnett, Gympie-Cooloola, Maryborough and Maroochy had higher needs for mental health services.

Table 20: Residential mental health care episodes and residents, by Statistical Area 3 (SA3), 2018–19 (N and rate per 10,000)

SA3/Location	Episodes of Care		Residents	
	Number	Rate (per 10,000 pop)	Number	Rate (per 10,000 pop)
Biloela	0	0.00	2	0.00
Buderim	48	8.11	42	7.10
Bundaberg	89	9.88	82	9.10
Burnett	6	0.00	6	0.00
Caloundra	14	1.59	13	1.48
Central Highlands (Qld)	4	0.00	4	0.00
Gladstone	73	11.59	63	10.00
Gympie - Cooloola	3	0.00	3	0.00
Hervey Bay	13	2.18	11	1.85
Maroochy	8	0.00	8	0.00
Maryborough	9	0.00	8	0.00
Nambour	6	0.00	6	0.00
Noosa	0	0.00	1	0.00
Noosa Hinterland	3	0.00	3	0.00
Rockhampton	61	5.14	60	5.05
Sunshine Coast Hinterland	5	0.00	4	0.00
PHN	341	3.9	312	3.61
QLD	947	1.9	868	1.7
AUSTRALIA	8,045	3.2	6,375	2.5

Source: Australian Institute of Health and Welfare. (2020). *Mental Health Services in Australia: Residential mental health care 2018-19*.

Data by **demographics** suggested that in Queensland, the highest rate of episodes observed among people aged 25-34 (3.8 per 10,000) years followed by 18-24 (3.6 per 10,000) years and 35-44 years (3.5 per 10,000) (78). Men (2.2 per 10,000) used the service 1.5 times more than the women (1.5 per

10,000) in 2018-19 (78). Aboriginal and Torres Strait Islander patients (5.7 per 10,000) received RMHC services at around 2.4 times the rate of non-Indigenous patients (2.4 per 10,000) in Australia in 2018-19 (78).

Mental health related prescriptions

Mental health-related medication prescribing provides additional insight into the burden of mental health, particularly at the community level. In our PHN, there were 1,760,657 mental health-related medication prescriptions prescribed (subsidised and under co-payment) to 189,052 patients in 2019–20 (79). Rate of prescriptions per 1,000 population was 2,010; this is higher than the QLD (1,757 per 1,000) and the national rate (1,597 per 1000) (79).

The majority (88%) of prescriptions in Queensland were provided by general practitioners. The most common medications prescribed were (79):

- anti-depressants (73.0%),
- anxiolytics (9.1%),
- antipsychotic (8.9%),
- hypnotics and sedatives (4.8%) and
- psychostimulants (4.1%).

The rates of mental health related prescriptions in various areas in the PHN generally align with the prevalence of self-reported mental health and behavioural issues in various SA3s (79). SA3 level MH related prescriptions data 2019-20 (79) indicated the following:

- Majority of the SA3s (13 out of 16 SA3s) in our PHN had higher than the QLD rate (1,757 per 1,000) for MH prescriptions
- In Maryborough 25 % of the population received MH prescriptions; rate of prescriptions was the highest in Maryborough (2,411 per 1,000) followed by Hervey Bay 24.1% and 2,269 per 1,000 and Bundaberg 23.6% and 2,282 per 1,000 population
- Lowest rate of patients and prescriptions were reported in Central Highlands (15.5% and 1,320 per 1,000) and Biloela (16.9% and 1,528 per 1,000)

Across the PHN, females received about 1.3-1.5 times more MH-prescriptions than the males.

3.1.3. Support services

Support services include disability support services, homelessness support services and various mental health programs are delivered by non-Government organisations (70).

Psychiatric disability support services

Psychiatric disability support service landscape is changing. These changes involve (80):

- The NDIS is being rolled out in the PHN region
- National Psychosocial Support (NPS) services commenced in April 2019 and will continue recurrently. NPS assists people with a severe mental illness who have reduced psychosocial function and who are not supported by the NDIS.

- Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs), Day to Day Living (D2DL) services ceased on June 30, 2019 and are now a part of the National Psychosocial Support Transition (NPS-T) which commenced 1 July 2019. As part of this, PHNs now fund the former PHaMs, D2DL and PIR providers to transition clients to NDIA, Continuity of Support (CoS) or elsewhere.
- The Continuity of Support program provides flexible and responsive psychosocial support to people who are not eligible for the NDIS and previously accessed services under:
 - *Partners in Recovery*
 - *Support for Day-to-Day Living*
 - *Personal Helpers and Mentors*
 - *National Psychosocial Support Transition.*

CoS services have started to commence from September 2019 and have varied commencement dates depending on the NPS-T activity in each area.

Nationally, AIHW estimated that around 2-3% of Australian people live with a severe mental illness (81). Around 8.8% (64,000) of those will be eligible to access the NDIS under the psychosocial disability stream.

In the PHN:

Approximately 490,000 adults were aged between 18-64 years. Of these, 16,900 adults (18-64) live with severe mental illness (2).

- Within that we estimate 2,200 (0.45% population) had very high needs, 4,900 (1%) lived with severe persistent and 9,800 (2%) live with severe episodic mental illness.
- Based on national rate we can estimate that 8.8% (1,500) will be eligible for NDIS and are likely to come from the severe and complex cohort.

Of the remaining 15,400 we estimate that:

- The population with severe persistent mental illness (4,900) is likely to be serviced by the Hospital and Health Services (HHS) Continuity of Support (CoS) program.
- The remaining 9,800 with severe episodic mental illness would need psychosocial support at some time.
- The new national psychosocial support measure will provide funding for people with severe mental illness and psychosocial functional impairment who are not more appropriately supported through the NDIS, or services provided through the HHS.

As reported in the PHN, 12-monthly performance report (80), in 2019-20, 666 clients received PHN commissioned psychosocial support services under the NPS, which is about 44% of the people who require psychosocial support services. The average wait time for accessing the services is two weeks, and a client accesses the services for 14.8 weeks, on average. Despite the unmet need for servicing more NPS clients who require psychosocial support (over 800), the PHN report indicates that the PHN already overreached its capacity (NPS capacity in the PHN region is 405), thus requires to increase its NPS service capacity (80).

The data in the PHN report (80) indicates that 119 clients received services through CoS service, and a client accesses the services for 23.6 weeks, on average. As per the above-mentioned estimates, the population with severe persistent mental illness (4,900) would need to be serviced by the HHS's CoS

program. Yet, the current data indicates only 119 clients received the services through CoS, suggesting there is an urgent need to increase uptake of the CoS services in the PHN.

Homelessness support services

Governments fund various agencies across Australia to provide Specialist Homelessness Services (SHS), including accommodation and other non-accommodation services (70).

Nationally, 88,338 or 396 clients per 100,000 population had a current mental health issue in 2019–20, which is about one-third of the 241,966 national SHS clients aged ten and over (82, 83). Almost half of SHS clients with a mental health issue accessed accommodation services (48.5% or 42,887 clients), at a rate of 192 clients per 100,000 population. A further 49.2% (43,444 or 194 clients per 100,000 population) received other support services, while 2.3% (2,007 clients) did not receive a service or referral to service in 2019-20 (82). In QLD, there was 11,682 SHS client with mental health issues in 2019-20; the higher proportion (54.3% or 6,338) of SHS clients with a mental health issue received accommodation support compared to those who received other support services (44.3% or 5,177), and 1.4% (167) clients did not receive service or referred to a service.

ABS Census of Population and Housing homelessness data (84) showed that more than 3,000 homeless people live in the PHN. Based on the national ratio (one-third of SHS clients had MH conditions), we can estimate that the PHN will have about 1,000 SHS clients with a current mental health issue, over 50% (or over 500) of which require accommodation services.

Mapping of the homeless people within the PHN is presented in Table A in the Annex: Tables and Charts.

3.1.4. PHN commissioned MH services (Stepped Care, Headspace)

As part of the National Mental Health reform, the PHN team designed, commissioned, and implemented a Stepped Care approach within the region. The approach chosen has six service streams from low intensity to severe and complex needs. Further, a centralised intake and triage service run by a commissioned non-government organisation (NGO) to process and allocate the incoming referrals.

- **Stream 1: Low Intensity MH services** – It provides early intervention and mental health care services for those at risk of mental illness, mild mental illness, or as a transition out of care.
- **Stream 2: Child and youth-** focuses on consumers 0-24 years of age and provides services across the spectrum of mental health severity needs (excluding acute services)
- **Stream 3: Psychological Therapies (underserviced)** – provides psychological therapies especially to rural/ remote consumers and underserviced groups
- **Stream 4: Severe and complex** – provides clinical care coordination activities for consumers with severe and/ or complex requirements
- **Stream 5: Suicide prevention aftercare** – provides treatment and care coordination to consumers exiting acute services following a suicide attempt
- **Stream 6: Indigenous-specific** – provides social and emotional wellbeing services for Aboriginal and/or Torres Strait Islander consumers

In FY2019-20, the PHN commissioned Stepped Care mental health services (all streams combined) provided (excluding headspace) 37,099 occasions of services related to 6,850 number people being 4.7% of the estimated population (146,424) requiring treatment from any MH service provider (not just PHN) (85). (See Table 21)

- S3 Psychological therapies was the most utilised service stream, accounting for about more than one third of the clients (n= 2,601 of 38%); and the service contacts at 27.4% (n=10,181).
- The second most common stream was S1 Low intensity (client n=1,995 or 29.1%), however these clients attended the fewest service contacts on average (3.0); this can be expected as these are the clients with least severity
- Third most common stream was Stream 4-Severe and Complex (client n=1,073 or 15.7%). These clients had second highest number of average service contacts (6.1)
- S6 Indigenous-specific services (16.2% of the total OOS) had the fewest clients (n207); however, with the highest attendance rate per client (average 28.9 service contacts/OOS per client).
- Total number of clients receiving the Stepped Care service in FY2019-20 has been increased by 59% and the service contact (or OOS) by 77% compared to the service provided in 2018.

Headspace service uptake was also increased. It serviced higher number of young people (n=4,504; n=24,743 OOS) than the Stepped Care S2 Child and Youth services (n=888 clients; n=4,226 OOS)

- Average number of service contacts per headspace clients was higher (5.5) than S2 Child & Youth services (4.8)
- The clients receiving headspace service was increased in 2019-20 by 18% and service contacts by 63% compared to Q3 2018 suggesting significant increase in the client contact with the service.

Table 21: Activity summary: Number of clients, occasions of service contacts, by service stream, FY2019-20

Service Stream	Clients(n)	Clients(%)	OOS (n)	OOS (%)	Average OOS per Client
S1 Low intensity	1,995	29.1%	6012	16.2%	3.0
S2 Child & youth *	888	13.0%	4226	11.4%	4.8
S3 Psych. therapies	2,601	38.0%	10,181	27.4%	3.9
S4 Severe & complex	1,073	15.7%	6537	17.6%	6.1
S5 Suicide Aftercare	761	11.1%	4151	11.2%	5.5
S6 Indigenous-specific	207	3.0%	5992	16.2%	28.9
TOTAL**	6,850	100.0%	37,099	100.0%	5.4

* Excludes headspace

** The PHN total for clients is not additive as one client may present across multiple service streams.

The service data were explored by locations (LGAs), various streams and the extent it covered treatment/target population in the region.

The highest percentage of services (55%) was provided to Sunshine Coast region followed by Central Queensland (28.4%) and Wide Bay (16.6%) (Table 22). This can be expected as the difference in the population size and ease of access to the services could impact the service uptake. However, MH prevalence data suggest that Central Queensland and Wide Bay regions have much higher burden of MH illnesses compared to Sunshine Coast region and the overall MH service rates were also lower in those regions despite their higher demand. This pattern was also seen in the Stepped Care services.

Table 22: Number of clients, and service contacts, by client location FY2019-20, (all streams combined)

Client Location	Clients (n)	Clients (%)	Service Contacts (n)	Service Contact (%)	Average number of services per client
CENTRAL QLD	2,578	37.6	10,553	28.4	4.1
Banana (S)	214	3.1	780	2.1	3.6
Central Highlands (R)	220	3.2	828	2.2	3.8
Gladstone (R)	248	3.6	1,069	2.9	4.3
Livingstone (S)	299	4.4	1215	3.3	4.1
Rockhampton (R)	1585	23.1	6,638	17.9	4.2
Woorabinda (S)	12	0.2	23	0.1	1.9
WIDE BAY	1,445	21.1	6,168	16.6	4.3
Bundaberg (R)	637	9.3	2,391	6.4	3.8
Fraser Coast (R)	562	8.2	2,369	6.4	4.2
North Burnett (R)	246	3.6	1408	3.8	5.7
SUNSHINE COAST	2,827	41.3	20,378	54.9	7.2
Gympie (R)	673	9.8	7,888	21.3	11.7
Noosa (S)	264	3.9	1575	4.2	6.0
Sunshine Coast (R)	1,890	27.6	10,915	29.4	5.8
TOTAL*	6,850	100	37,099	100	5.4

* The PHN total for clients is not additive as one client may present across multiple service streams.

* Headspace service is not included

Table 24 below summarises number of clients for S1, S3 and S4 streams and the client utilisation rates as a proportion of treatment population - based on estimates from the National Mental Health Service Planning Framework (NMHSPF) tool. Treatment population is the number of people within a normal population that is estimated to require that type of mental health treatment. The summary of this analysis below (Table 23) provides top three highest and lowest service rates.

Rate of service utilisation across all three streams exhibited regional variation. Whilst rate of service utilisation for S1 Low Intensity services was lower in North Burnett and Banana; it was highest for S3 Psychological Therapies and S4 Severe & Complex services. This could represent either higher acuity populations in North Burnett and Banana, or delayed health seeking behaviour (treatment begins only once a condition has worsened).

Table 23: Rate of service utilisation per 1000 treatment population within service streams (top three highest and lowest ranking LGAs)

Service Streams	Highest (LGAs)	Lowest (LGAs)
S1 Low Intensity	Rockhampton, Gympie, Central Highlands	Fraser coast, Gladstone, North Burnett
S3 Psychological Services	North Burnett, Rockhampton, Banana	Fraser Coast, Gladstone, Central Highlands
S4 Severe and complex	Banana, Rockhampton, North Burnett,	Central Highlands, Bundaberg, Sunshine Coast

Source: Central Queensland Wide Bay and Sunshine Coast Primary Health Network, Analysis of Stepped Care for Mental Health services 2019-20 (PHN commissioned services) 2021.

Note: Woorabinda excluded as the client numbers were too small (S1) or no clients (S3; S4) reported

Table 24: Number of clients by service streams as a proportion of estimated treatment population, FY2019-20

REGION	S1 Low Intensity			S3 Psychological Therapies			S4 Severe & Complex		
	Clients	Treatment Population updated ¹	Service rate per 1,000 treatment population	Clients	Treatment Population ²	Service rate per 1,000 treatment population	Clients	Treatment Population ³	Service rate per 1,000 treatment population
CENTRAL QLD	1011	22,688	44.6	716	8,168	87.7	409	7,033	58.2
Banana (S)	25	1,416	17.7	65	510	127.5	116	439	264.3
Central Highlands (R)	111	2,870	38.7	83	1,033	80.3	10	890	11.2
Gladstone (R)	85	6,341	13.4	66	2,283	28.9	51	1,966	25.9
Rockhampton* (R)	783	8,151	96.1	502	2,934	171.1	232	2,527	91.8
Woorabinda (S)	7	101.6	68.9	0	36.576	0.0	0	31.496	0.0
WIDE BAY	238	21,388	11.1	760	7,700	98.7	306	6,630	46.2
Bundaberg (R)	155	9,586	16.2	370	3,451	107.2	19	2,972	6.4
Fraser Coast (R)	71	10,671	6.7	188	3,842	48.9	256	3,308	77.4
North Burnett (R)	12	1,060	11.3	202	382	529.4	31	329	94.3
SUNSHINE COAST	746	43,675	17.1	1125	15,723	71.6	358	13,539	26.4
Gympie (R)	185	5,245	35.3	174	1,888	92.2	79	1,626	48.6
Sunshine Coast* (R)	561	32,843	17.1	951	11,823	80.4	279	10,181	27.4
TOTAL	1995	87,679	22.8	2,601	31,564	82.4	1073	27,180	39.5

Source: Central Queensland Wide Bay and Sunshine Coast Primary Health Network, Analysis of Stepped Care for Mental Health services 2019-20 (PHN commissioned services) 2021.

* SUNSHINE COAST (R) INCLUDES Noosa (S), AND ROCKHAMPTON (R) INCLUDES Livingstone (S) to accommodate estimates produced when those LGAs were amalgamated

1 NMHSPF estimates: Includes people with early signs and symptoms but that do not meet criteria for a mental disorder, those who have previously but no longer

2 NMHSPF estimates: Includes people in need of treatment for a mental disorder with moderate impact on function requiring treatment from any MH service provider (not just PHN)

3 NMHSPF estimates: Includes people in need of treatment for a mental disorder with severe impact on function requiring treatment from any MH service provider (not just PHN)

Higher rate of service utilisation in North Burnett LGA compared to other LGAs for S3 Psychological Therapies (202 clients translates to 529.4 per 1,000 treatment population) possibly has skewed the overall results for Wide Bay. (Table 24 above)

Low rates of service utilisation for S4 Severe and Complex services within Bundaberg (6.4 per 1,000) and Central Highlands (11.2 per 1,000) require further investigation as these rates demonstrate very low access given sizeable population within these LGAs and higher estimated mental health burden.

About 3.4% of the 0-24 population in the PHN received S2 Child and youth mental health services. Preliminary estimates for populations of young people based on prevalence data and the NMHSPF suggest that approximately 26,558 young people (or approximately 10 % of the total youth population) will need mental health treatment across the PHN. Stepped Care S2 Child and Youth and Headspace services together serviced 5,392 (or 2% of the PHN youth population) youth population in the PHN contributing significantly in meeting demand for youth MH services in the region.

Table 25: Number of S2 Child and youth service clients as a proportion of total young population in the region, by LGA

REGION	S2 Child & Youth**		
	Clients	Population (0-24)	Per 1,000
CENTRAL QUEENSLAND	359	77,516	4.6
Banana	5	4,647	1.1
Central Highlands	9	10,353	0.9
Gladstone	35	22,160	1.6
Livingstone	67	11,513	5.8
Rockhampton	238	28,325	8.4
Woorabinda	5	518	9.7
WIDE BAY	164	58,370	2.8
Bundaberg	137	27,436	5.0
Fraser Coast	23	28,014	0.8
North Burnett	4	2920	1.4
SUNSHINE COAST	365	127,550	2.9
Gympie	137	14,846	9.2
Noosa	18	14,364	1.3
Sunshine Coast	210	98,340	2.1
The PHN Total*	888	263,436	3.4
PHN total (S2+Headspace)	5,392	263,436	20.5

Source: Central Queensland Wide Bay and Sunshine Coast Primary Health Network, Analysis of Stepped Care for Mental Health services 2019-20 (PHN commissioned services) 2021.

*excludes headspace

Table 26 below presents number of S5 clients, average service contacts per client, and rates of service utilisation for S5 stream based on Emergency Department (ED) presentations as the target population, making this a much smaller denominator. Overall, 761 clients received S5 services representing 24.1% of the 3,164 suicide-related emergency department presentations that were completed and discharged (240.5 per 1,000 target population). Whilst referral direct from the hospital post-suicide attempt is not the only referral pathway, it is the expected pathway, therefore using suicide-related ED presentations as proxy for target population is justified.

SC area had the highest average client access rate per 1,000 target population in the PHN (SC 383.4; CQ 243.2; WB 73.3; PHN 240.5). Among the PHN LGAs, Fraser Coast (51.8), North Burnett (90.9), and Gladstone (96.7) LGAs had the lowest service rates per 1,000, yet these areas have higher risks of suicide related deaths in the PHN. This suggests expanding the suicide prevention and after care service in these areas.

Suicide aftercare was the most utilised service stream in Noosa (467.4 per 1,000) and Livingstone (440.9) and Sunshine Coast LGAs (430.0 per 1,000). This is of significance in Noosa considering its highest suicide mortality within Sunshine Coast region.

Table 26: Number of Suicide Aftercare clients as a proportion of estimated target population, by client's location, FY2019-20

Region	S5 Suicide Aftercare				Suicide Mortality ² (ASR per 100,000)
	n of clients	Average OOS per client	Target Population ¹	Clients per 1,000	
CENTRAL QLD	329	3.7	1,353	243.2	
Banana (S)	5	3.4	19	263.2	n/p
Central Highlands (R)	24	3.5	77	311.7	24.5
Gladstone (R)	41	5.2	424	96.7	20.4
Livingstone (S)	41	2.6	93	440.9	19.1
Rockhampton (R)	218	3.6	749	291.1	20.7
Woorabinda (S)	0	n/p	5	0.0	n/a
WIDE BAY	62	2.5	846	73.3	
Bundaberg (R)	36	1.6	344	104.7	22.0
Fraser Coast (R)	25	3.5	483	51.8	21.0
North Burnett (R)	1	n/p	11	90.9	n/p
SUNSHINE COAST	370	7.5	965	383.4	
Gympie (R)	32	5.0	181	176.8	16.0
Noosa (S)	43	7.5	92	467.4	19.2
Sunshine Coast (R)	295	7.8	686	430.0	13.1
Total*	761	5.5	3,164	240.5	<i>Australia, ASR 12.7 per 100,000</i>

Source: Central Queensland Wide Bay and Sunshine Coast Primary Health Network, Analysis of Stepped Care for Mental Health services 2019-20 (PHN commissioned services) 2021.

1 Number of suicide-related Emergency Department presentations in 2018, where departure status = completed and discharged, by LGA

2 AIHW, 2021. Mortality Over Regions and Time (MORT) books by PHN and LGA (2015-2019)

The PHN stakeholders survey 2020-21 respondents 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. Most respondents (71%) disagreed or strongly disagreed that the health care system is effective in improving psychosocial outcomes of clients. However, respondents from the Sunshine Coast area highlighted how programs such as the NDIS and the PHN Stepped Care are working well to increase access through increased availability of services including quantity, choice, and affordability.

3.1.5. Integration and coordination of MH services

People with mental illness often experience that their problems are dealt with in isolation, with poorly integrated and coordinated care (86). The Report of the National Review of MH programs and services (86) stressed that across Australia, services were poorly coordinated, delivered in isolation and characterised by dramatic funding inefficiencies. Results for our PHN from the 2016 Survey of Health Care for patients aged 45 and over who had visited a GP in the preceding 12 months show (87) that:

- Around 39% reported that their usual GP practice always seemed informed about care provided by an allied health professional for emotional or psychological health, compared to 48%, nationally.
- About 20% reported that their GPs never informed about it compared to 18%, nationally.

The PHN community and stakeholders survey 2020-21: Majority of the issues highlighted in the previous years' PHN stakeholder surveys undertaken as part of the PHN HNA 2019-20, such **as lack of integration and coordination of services, continuity of care** remained to be important areas for improvement across the PHN. In the PHN stakeholder survey of 2020-21, service providers also expressed a need for appropriate community level mental health services; they noted that existing mental health services provided through PHN, and the hospitals are inadequate for our community and often not appropriate to the person seeking longer term service and supports (21). The PHN communities across all three regions also emphasised a need for clear and effective patient referral system, follow-up care and better integrated care between community level care, primary care professionals and specialists at the hospital (60).

3.2. Mental health safety and quality

The National Mental health services report (88) presents a rate of seclusion and restraints as an indicator for the safety and quality of MH services. In 2019-20, the rate of seclusion events (this is calculated as the number of seclusion events per 1,000 bed days for public sector acute specialised mental health hospital services) for the hospitals within the PHN was relatively higher. Bundaberg (13.0), Maryborough (12.2), and Rockhampton (10.0) hospitals have rates than those for QLD (10.1) and Australia (8.1). This indicates a need for better MH management in primary care through improved GP MH care and allied MH care as well as broader service coordination effectiveness. National, state and PHN public hospitals data also suggest that remote and outer regional hospitals have higher rates of seclusion events compared to hospitals in a major city and inner regional areas (88). This further confirms that populations in rural and remote areas have poorer access to mental health services, hence the higher rate of complications such as seclusion and restraints.

The PHN stakeholders survey 2020-21: Stakeholders across the PHN highlighted a need for continuity of mental health services, user-friendly and easier referral for counselling services, more after-hours services, and peer-based mental health services (21).

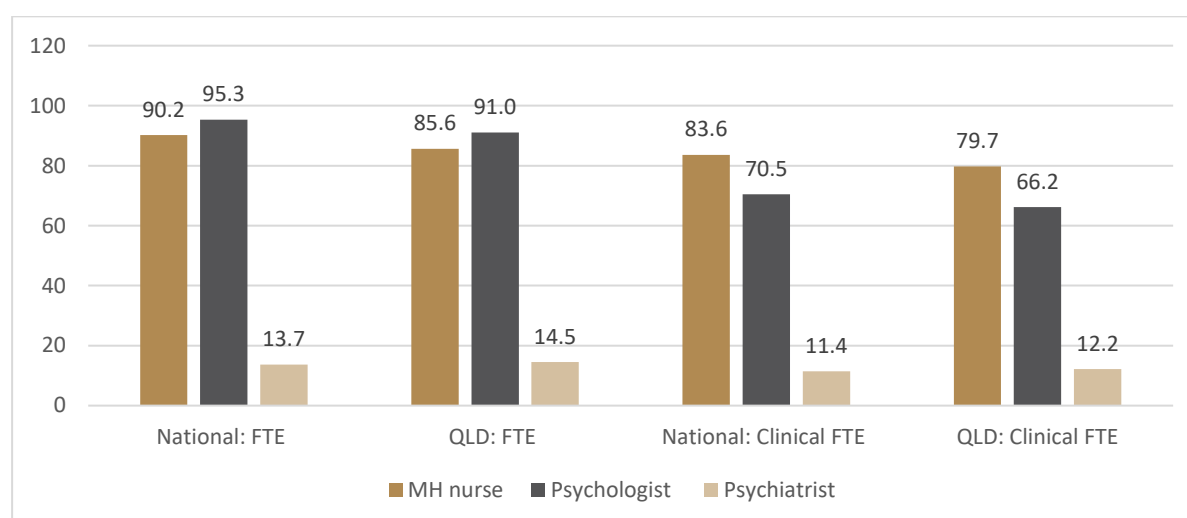
The **PHN, Your Experience of Service (YES) survey** findings indicated that most of the respondents (91% or 61/67) felt safe and always welcomed using the mental health services. About one in three respondents (176/612) of the **PHN community health survey** indicated that they needed to see an MH specialist in the last 12 months but could not see the specialist. Key reasons were mainly lack of specialists in the area and COVID restrictions; however, some quality and safety-related reasons mentioned were not being able to see the same doctor, i.e. continuity of care, absence of face-to-face appointments (namely, in Emerald), and a few clients from Gympie also indicated that referral process was not straightforward, and they did not feel supported and listened by their referring GPs.

3.3. Mental health workforce

As reported in AIHW data, in 2019, rates for FTE and clinical FTE (per 100,000 population) for employed psychiatrists in QLD were 14.5 and 12.2, respectively; this is slightly higher than the national rates (13.7 and 11.4) (89). However, regarding MH nurses (FTE 85.6 and clinical FTE 79.7) and psychologists (FTE 91.0 and clinical FTE 66.2) in QLD the rates were lower than the national rates for MH nurse (FTE 90.2 and clinical FTE 83.6) and psychologists (FTE 95.3 and clinical FTE 70.5) per 100,000 population (89).

MH workforce data (2019) for QLD and Australia are presented in Graph 21 below (89).

Graph 21: Employed MH nurse, psychologist and psychiatrist, rates for QLD and Australia, 2019 (FTE per 100,000 population)



Source: Australian Institute of Health and Welfare. (2021). *Mental health services in Australia—Mental Health Workforce data 2019*.

There were limited data available on the profile of PHN MH workforce, how they were addressing current challenges and what has been working/not working across various locations in the PHN. According to the Health Workforce Queensland report 2021(90), commissioned by the PHN, top three areas with workforce shortage for primary care in the PHN region was psychology, speech pathology and occupational therapy. GP and ATSI health workers also had high workforce gap ratings which also contributed to the shortage of MH services provided by these professionals. This impacts not only the ability to provide mental health/psychology services, but also the ability for clients to get a GP mental health plan – a key requirement for accessing services.

HWQ report (90) provided mean workforce gap ratings (See

Table 27 below). Means in 'bold' are values of 60 or higher, and indicative of a possible serious gap (90).

Table 27: Mean workforce gap ratings for the CQWBSC-PHN region and each HHS

	CQWBSC Region Total	Central Queensland HHS	Wide Bay HHS	Sunshine Coast HHS
Type of workforce	M (Rank)	M (Rank)	M (Rank)	M (Rank)
Psychology	74.91 (1)	78.89 (1)	75.28 (1)	66.61 (3)
Speech Pathology	73.86 (2)	77.94 (3)	71.78 (3)	69.11 (1)
Occupational Therapy	73.41 (3)	78.20 (2)	72.23 (2)	65.41 (4)
Social Work	69.29 (4)	75.07 (5)	62.95 (5)	68.57 (2)
General Practitioner	68.58 (5)	76.00 (4)	69.57 (4)	51.94 (9)
ATSI Health Worker/Practitioner	62.08 (6)	68.24 (6)	58.44 (6)	54.32 (7)
Diabetes Education	60.44 (7)	64.61 (7)	55.31 (9)	59.29 (5)
Nutrition and Dietetic	57.33 (8)	61.90 (8)	54.09 (11)	53.61 (8)
Dentistry	55.57 (9)	61.58 (9)	54.83 (10)	46.17 (10)
Exercise Physiology	55.08 (10)	60.30 (10)	56.40 (7)	43.64 (11)
Nursing/Midwifery	55.07 (11)	59.37 (11)	48.95 (14)	55.70 (6)
Podiatry	53.26 (12)	58.93 (13)	55.44 (8)	35.72 (14)
Sonography	50.54 (13)	58.98 (12)	50.10 (13)	35.18 (16)
Physiotherapy	49.86 (14)	55.43 (15)	50.18 (12)	35.54 (15)
Audiology	49.65 (15)	58.64 (14)	45.35 (16)	37.28 (13)
Radiology	46.90 (16)	54.87 (16)	47.60 (15)	30.11 (17)
Optometry	40.86 (17)	46.10 (17)	35.51 (18)	38.19 (12)
Pharmacy	32.88 (18)	33.42 (18)	36.00 (17)	25.83 (18)

Source: Health Workforce Queensland. (2021). Health Workforce Needs Assessment Summary Report: Central Queensland Wide Bay Sunshine Coast PHN. June 2021, Health Workforce Queensland: Queensland.

HWQ data (90) disaggregated by LGAs showed that the gaps in services were reported to be particularly high in Emerald and surrounds; Gladstone and surrounds; Gympie and surround; and Bundaberg and surrounds. The areas with no or very few MH service providers (not a head count of MH professionals) included Banana (0), North Burnett (0), Central Highlands (1) Livingstone (1) and Gympie (2).

Gladstone (3) and Bundaberg (3) also did not have adequate MH service providers despite the increasing demand for the service in these areas as informed by other data sources such as mental health prevalence data and community and stakeholders' survey data.

Areas with no Psychology service provider include Banana and North Burnett; apparently these areas were serviced by 1-2 visiting psychologists occasionally visiting the area. The main service gap areas identified in the HWQ report were mental health, psychology, alcohol, and other drug (AOD) and dental services. Key barriers of accessing these services included lack of acute care services/service providers, poor transport facilities and affordability of these services.

The PHN community health and stakeholders survey 2020-21: Inadequate MH workforce shown in HWQ data is strongly supported by the findings of the PHN community health surveys of 2020-21. Communities in rural areas (i.e Gin-Gin, Banana, Emerald) expressed a need for locally available psychologists and allied mental health professionals (20). Clients from Gladstone also indicated that the health service in Gladstone cannot meet the growing mental health demands of the population in the area (20). **Service providers** across the PHN highlighted a need for more funding for the counselling and psycho-social services and after-hours mental health services (21). As informed by the previous HNA consultations, the PHN is continue working with The National Centre for Education and Training on Addiction to undertake stakeholder consultations to inform a future workforce development needs assessment.

3.4. Responsiveness and Appropriateness

Patient experience or service survey results can serve as a proxy indicator for responsiveness and appropriateness of the MH services in addition to the qualitative survey collected from the consumers and stakeholders. Your Experience of Service (YES) survey gathers information from mental health consumers about their experiences of care. The state level report presents consumers experience data for admitted care and ambulatory care for 2018-19 (91), as follows:

- In admitted care 53% in Queensland (was 47% in 2017-18) reported a positive experience of MH service compared to 70.1% in NSW and 53.0% in Victoria
- In ambulatory care Queensland had the highest proportion of consumers with a positive experience of MH service (80.9%), followed by NSW (78.7%) and Victoria (76.5%)

YES survey at the PHN level was sent to 511 eligible participants in Nov 2020 and received responses from 68 clients (13% response rate) received services from various providers/programs. Majority (60% or 41/68) of the respondents were recipients of the Stepped Care program which is a key mental health program managed by the PHN; rest of the respondents were recipients of the various other support mental health services such as CoS and NPS. About half the respondents did not complete the client demographics questions, therefore, we cannot present data by age, gender, location, and cultural and ethnicity backgrounds. Nevertheless, the survey data suggests following important findings about overall PHN commissioned mental health program' responsiveness and appropriateness:

- Majority (93% or 62/67) of the respondents felt always (88%) or usually (5%) welcomed using the service and 91% (or 61/67) felt safe using the service; however, few numbers (less than 5%) of clients responded that they rarely felt safe using the service.
- 91% (or 59/65) responded that they always or usually had access to the service when they needed it. Almost all respondents (39/40) who received Stepped Care services stated that they always had access to the services
- However, about 72% (or 47/65) of the respondents indicated that they always had opportunities for their family and friends to be involved in their support or care; about 11% (or 7/65) responded these opportunities were provided rarely or sometimes only. There were few numbers (less than 10%) of clients representing Stepped care, NPS and New access stated that they were never provided with these opportunities.
- 78% (or 51/65) indicated that they were provided with right information or advice to manage their physical health. However, about 22% (or 14/65) of the clients representing Stepped care, NPS and CoS indicated that did not always feel supported.
- 93% (or 62/67) indicated their individuality and values (such as your culture, faith or gender identity, etc.) were always respected
- About 90% (or 56/62) indicated that the service providers always (51/62) or usually (5/62) listened to and followed up on client's feedback or complaints. Few clients (less than 10%) who received Stepped Care and NPS did not feel that there were listened to and their feedback/complaints rarely followed up.
- 85% (or 48/67) indicated the support/care available can always or usually meet their needs; 15% (or 10/67) of the clients were not very satisfied with the service meeting the client needs.
- Notably, only about half the clients (29/57) indicated that they were fully involved in choosing the services offered, while 28% (or 16/57) had a little involvement and 21% (or 12/57) did not get involved at all. Data suggests that NPS client involvement in choosing the services offered were better than Stepped Care and CoS.

In the **PHN community health survey** (20), there were 38 respondents who received MH-telehealth services. Many of them (33 out of 38) were satisfied with the services they received. However, five clients rated the service as "poor" and "fair". Key reasons for the lower rating included lack of confidence in the skills of the professionals, did not feel comfortable discussing mental health issues over the phone and poor internet quality issues. Bundaberg clients highlighted the significant shortage of locally available and appropriate mental health services.

3.5. COVID-19 impact on Mental Health Services

The potential for COVID-19 to impact mental health and wellbeing was recognised early in the pandemic (92). National Mental Health Commission report (86) also indicated that some of the public health measures necessary to contain COVID-19 spread were likely to negatively impact mental health services.

The AIHW report on Mental Health Impact of Covid-19 (18) indicated:

- Increased use of mental health services and an increase in psychological distress during 2020. These changes are associated with the impact of COVID-19. An increased level of distress in April 2020 coincided with the initial lockdown period while the improvement from April to May coincided with the loosening of restrictions.
- Health practitioners delivered more consultations via telehealth.
- Fewer ED presentations: In 2019–20, the number of ED presentations decreased by 1.4% compared to 2018–19 which was likely influenced by COVID-19 restrictions. Prior to COVID-19 (between, 2014–15 and 2018–19) ED presentations increased by 3.2% on average each year.

The 2020 iQSR data(14) also indicated that up until 31 July 2020, 32 of 454 suspected suicides (7%) were due to COVID-19 as reported by police officers.

The PHN community health and stakeholders survey 2020-21: Communities across the PHN area indicated that their appointments with MH specialists had been affected by COVID19 restrictions, and in some places, these were compensated with telehealth appointments (20). However, not all clients felt comfortable receiving mental health services via teleconference or phone consultation. Nevertheless, there were a higher number of telehealth services, including mental health, across the PHN compared to the previous years, mostly due to COVID related restrictions.

4. Triangulation

This section intended to synthesise all quantitative and qualitative evidence provided by various data sources used in the analysis. These include publicly available mental health prevalence and service data for health and service needs as well as additional data analysis (i.e. community health and stakeholders survey, HWQ survey) undertaken to complement the health needs analysis. We have identified and examined the service gap areas to assist the PHN commissioners and planners in deciding which services to prioritise for the next three years, from 2021 to 2024. Some of the broader priorities identified in this report will need further refinement in the PHN annual operational plans for mental health and suicide prevention.

Across the PHN, mental wellbeing is an issue of high importance to individuals, carers, communities, and service providers. Our triangulation and prioritisation exercise were based on the following criteria:

- Scale, urgency, and impact of the issue
- Extent it leads to growing inequities
- Extent it addresses issues faced by priority populations such as young people, Aboriginal and/or Torres Strait Islander population, CALD communities, older people, people living with disability etc.
- Extent it addresses existing service gaps
- Alignment with existing mental health strategies and priorities
- Feasibility of the potential strategies proposed

The following key areas emerged as priority areas:

Social determinants and risk factors: The broader social determinants of health greatly impact mental health and wellbeing. Evidence for the PHN shows higher rates of mental illnesses among socio-economically disadvantaged populations, i.e. people living in remote areas, in areas defined as low SEIFA index. In the PHN, the population living in Wide Bay and Central Queensland regions showed higher levels of socioeconomic disadvantage as measured by annual family median income and the SEIFA indices compared to the population living in the Sunshine Coast region. Therefore, a relative need for mental services is likely to be higher in those locations. Very limited local data were available relating to risk factors leading to poor mental health. Nevertheless, relevant national reports and community and stakeholders' survey respondents informed about the importance of understanding and addressing broader risk factors such as homelessness, social isolation, family background, disability and socioeconomic and other forms of disadvantage through implementing preventive strategies. Although not all mental illnesses are preventable, the likelihood of people developing mental illness can be reduced by implementing the right strategies targeting at-risk people.

Priority populations: Some people were **more at-risk of** experiencing mental health issues compared to others.

- *Data and survey results identify **young people's mental health** as a priority issue across all areas; there were not adequate psychologist and psychiatrist services available especially for those living in rural and remote areas and socio-economically disadvantaged areas.*
- **Older people (65+):** *Issues mentioned were quality of the aged care in general and the need for mental health support specific for older people and affordable aged care services. Main barriers for receiving mental health and other allied health support for older people were lack of public transport or transport support, lack of service information and inadequate number of local mental health staff. Again, these issues were especially common among communities living in rural and remote LGAs.*
- **Aboriginal and Torres Strait Islander people** *are more vulnerable to mental illness and suicide. Higher presence of health determinants such as socioeconomic disadvantage,*

remoteness, low workforce participation and low educational attainment among Aboriginal and Torres Strait Islander people further contributes to the higher prevalence of mental health issues and self-harm among them. Indigenous Health Needs Assessment (HNA) document presents Indigenous specific mental illness.

- Evidence suggested that **LGBTIQ+ people** were at a high risk of suicidal behaviours and had higher rates of suicidality compared to other Australians. The PHN community survey informs that mental health/suicide and chronic conditions are most urgent health concerns for LGBTIQ+ people followed by AoD, smoking, and domestic violence. Common barriers identified by LGBTIQ communities for accessing mental health services were long waiting list, cost of appointment, lack of cultural appropriateness of the MH services, and lack of knowledge how to navigate through the system.
- **Patients with comorbidity** were common among people experiencing mental illnesses. Among the PHN patients experiencing mental illnesses, heart, stroke and vascular disease was the most common comorbid followed by COPD and type 2 diabetes.

Prevalence of **mental health illnesses in the PHN is high and unmet MH service needs** is a concern.

Overall, in line with the observed disadvantages across the social determinants of health, the following areas shown higher burden of mental health related morbidity and mortality:

- In the PHN, majority of the SA3s in Central Queensland and Wide Bay regions had higher than the QLD **rate for mental health illnesses (psychological distress and mental/behavioural problems)**; yet the rate of mental health service uptake in these regions were lower than the QLD rate (See Table 28).
- **Eating disorders** is ongoing specific mental health issue; highest rates were observed in Sunshine Coast region
- **Self-harm hospitalisations** among women were high: highest rates observed in Burnett, Nambour, Gladstone, Bundaberg, and Central Highlands SA3 areas.
- The PHN **deaths due to suicide** was 1.4 times higher than national rate per 100,000. LGAS with the highest rates were Central Highlands, Bundaberg, Fraser Coast, Rockhampton, and Gladstone LGAs. There was no record for Woorabinda.
- **Suicide among 15-24 years** in Qld was the highest (ASR 17.1) compared to the other State/Territory rates and the National rate (14.1); the rate increased between 2016 to 2019 (there is no local level i.e PHN and LGA data for suicide among young people)

Furthermore, burden of mental health illnesses is continuing to rise to the point where about one in five Australian adult population requiring mental health interventions with varied intensity (93). This reinforces the importance of implementing holistic, population level approaches that include prevention and early detection and strategies to address mental health determinants.

Table 28: Mental health illness prevalence rates and service rates, by SA3s and remoteness

Remoteness	Area	MH illness prevalence (HEALTH NEEDS)*		MH Service rate (SERVICE NEEDS)*		
		High or very high psychological distress (ASR per 100, 2017-18)	Mental and Behavioural problems (ASR per 100, 2017-18)	Psych MH services per 1000 (2019-20)	Allied MH services per 1000 (2019-20)	GP-MH services per 1000 (2019-20)
	Central Queensland	13.1	24.1	79.5	144.7	123.5
Outer regional	Central Highlands	11.8	20.8	64.1	96.2	139.8
Inner regional	Rockhampton	13.4	25.2	88.3	170.3	128.1
Outer regional	Biloela	10.6	20.8	50.2	92.7	77.1
Inner regional	Gladstone	13.6	24.1	76.5	130.7	117.6
	Wide Bay	14.9	25.2	89.0	197.7	107.1
Inner regional	Bundaberg	13.4	24.9	116.3	171.5	120.6
Inner regional	Burnett	15.2	26.7	64.6	142.2	109.8
Inner regional	Gympie - Cooloola	15.8	25.9	63.8	242.0	163.5
Inner regional	Hervey Bay	14.8	23.7	88.4	226.3	163
Inner regional	Maryborough	16.4	25.4	91.2	220.8	153.1
	Sunshine Coast	12.9	21.2	92.2	346.2	197.7
Major cities	Buderim	12.2	20.2	98.4	334.6	186.7
Major cities	Caloundra	12.6	20.3	99.5	329.6	191.9
Major cities	Maroochy	12.6	23.0	98.7	350.2	210.6
Major cities	Noosa	12.3	20.0	77.1	320.5	156.3
Inner regional	SC Hinterland	13.4	20.4	90.5	383.1	224.9
Major cities	Nambour	14.4	23.3	91.3	382.7	225
Inner regional	Noosa Hinterland	13.3	21.9	66.9	321.4	178.2
	PHN	13.5	23.1	88.5	250.8	161.8
	Queensland	13.0	22.7	116.6	249.7	156.5
	AUSTRALIA	12.9	20.1	98.7	240.2	148.6

*Note that the prevalence rates are from 2017-18 data, whereas service rates shown are 2019-20 data;

*For prevalence rates, the SA3 rates that are higher than the QLD rate are shown in red; for service rates, the SA3 rates that are lower than the QLD service rate are shown in red

A provision of **quality integrated services and care pathways** within current programs and establishing new mental health programs that are integrated into mainstream health care and social services (e.g. disability care, homelessness, social security, migrants etc.) are important. This is more important, especially for those people with co-morbidity and severe and complex MH needs.

Lack of care coordination could contribute to higher co-morbidity and low quality of life for those clients requiring multidisciplinary care across support services. Literature evidence suggests that people with mental illness often experience that their problems are dealt with in isolation with poorly integrated and coordinated care. In the PHN surveys, similar issues such as, i.e. lack of awareness of services, poorly coordinated services and lack of continuity of care were also highlighted as important areas for improvement. Service providers across all areas also expressed a need for appropriate community-level mental health services.

Access to the mental health services was affected by various reasons:

- *Not only physical distance or tangible reasons (i.e remoteness, lack of public transport or high cost) but also intangible factors such as stigma, culturally inappropriate services, and lack of mental health literacy among communities and non-MH professionals etc. served as significant barriers for accessing the service.*
- *COVID-19 served as both a cause for MH issues and a barrier for accessing required care on time. This is evidenced by increased use of mental health services and an increase in psychological distress during 2020, that were associated with COVID-19 impact (i.e social isolation, loss of job, less financial security etc). While there were increase in telehealth appointments, these were not preferred option for everyone suffering from mental illnesses. However, there is a need for increasing an uptake of e-mental health interventions, as these are likely to be an appropriate option for people who have an increased risk of developing mental illness or mild to moderate symptoms of mental illness (94).*

The percentage of **MH-related ED presentations in public hospitals** was higher than the QLD percentage in five SA3s within the PHN. These were Noosa, Noosa Hinterland, Maryborough, Maroochy, and Hervey Bay- all in the Sunshine Coast region, except Maryborough (WB). These suggest that despite the increased uptake of MBS MH services, especially in the SC, there are still unmet needs for MH services provided at the primary care.

There are serious **workforce gaps** in the PHN, particularly in more rural and remote areas. In addition to the shortage of MH professionals, GP and ATSI health workers also had high workforce gap ratings. This impacts not only the ability to provide mental health and psychology services but also the ability for clients to get a GP mental health plan – a key requirement for accessing allied mental health services.

Taking a holistic view, future planning should focus on system enablers (i.e. effective referral process, continuity of care, multidisciplinary team arrangement etc.) and strategies that are required to scale up priority mental health services along with a continuum of care. System enablers are highly context-specific, and the programs promoting system enablers need to be co-designed and consulted with local stakeholders and communities. While an introduction of the Stepped care program is a great step towards moving into the better-integrated continuum of care, the program needs further strengthen the quality and uptake through targeting at-risk populations in the region.

5. Opportunities, Priorities and Options

The opportunities, priorities and options have been suggested based on the needs and priorities identified through triangulation exercise. These were also explored against visions and priority areas of the national and regional mental health programs and plans for consistency and alignment. However, actual implementation of these depends on various factors such as ability to tailor it to local conditions, careful consideration of opportunity cost, and implementation feasibility. It requires close consultation and collaboration with PHN stakeholders.

National and regional strategies all have a common emphasis on integrated approach on addressing mental health issues taking into consideration issues beyond health including social support, education, employment, and other related social factors.

Key strategic documents examined include the following:

1. **Council of Australian Governments (COAG)-The Roadmap for National Mental Health Reform 2012–22.** The Roadmap sets out the Vision as follows *“A society that values and promotes the importance of good mental health and wellbeing, maximises opportunities to prevent and reduce the impact of mental health issues and mental illness and supports people with mental health issues and mental illness, their families and carers to live full and rewarding lives”* (95).
2. **Productivity Commission-Inquiry Report on Mental Health (2020).** The report outlines priority mental health reforms (96). These are:
 - *Prevention and early help for people*
 - *Improve people’s experiences with mental healthcare*
 - *Improve people’s experiences with services beyond the health system*
 - *Equip workplaces to be mentally healthy*
 - *Instil incentives and accountability for improved outcomes*
3. **National Mental Health Commission- The Fifth National Mental Health and Suicide Prevention Plan (24).** The plan identifies eight priority mental health areas. These include:
 - *achieving integrated regional planning and service delivery*
 - *effective suicide prevention*
 - *coordinating treatment and supports for people with severe and complex mental illness*
 - *improving Aboriginal and Torres Strait Islander mental health and suicide prevention*
 - *improving the physical health of people living with mental illness and reducing early mortality*
 - *reducing stigma and discrimination*
 - *making safety and quality central to mental health service delivery*
 - *ensuring that the enablers of effective system performance and system improvement are in place.*
4. **Joint Regional Plan 2020-2025 on Mental health, suicide prevention and alcohol and other drugs:** The plan sets out an important initiative towards the provision of mental health, suicide, alcohol and other drugs services for the communities in the region. It combines the resources and knowledge of CQWBSC-PHN, three regional Hospital and Health Services (Wide Bay HHS, Central Queensland HHS and Sunshine Coast HHS), nongovernment organisations, private health providers and consumer representatives (97). It has three main focus areas for action. These are:
 - *Service development: Building an integrated, consumer-centred stepped care service system*
 - *Workforce development: Building the workforce skills, capacity and infrastructure to meet the region’s needs*
 - *Process development: Embedding collaborative governance and planning.*

5. **Central Queensland Wide Bay Sunshine Coast PHN-Strategic Plan 2021-25 (Sunshine Coast Health Network).** One of the key priorities in the plan is to improve mental health and wellbeing and the PHN is implementing Mental Health, Suicide Prevention and Alcohol and Other Drugs Joint Regional Plan to enhance innovative, integrated and co-designed models of care (98).
6. **The PHN Primary Mental Health Care Activity Work Plan (AWP 2020/21-2022/23).** The plan key priority areas include:
 - *Implementation of National Suicide Prevention Trial (NSPT)*
 - *Child and youth mental health services*
 - *Low intensity mental health services*
 - *Psychological therapies for rural and remote, under-serviced and /or hard –to-reach groups: this includes Mental Health Inreach to RACFs and Sunshine Coast Eating Disorders Trial site*
 - *Mental health services for people with severe and complex mental illness*
 - *Regional approach to suicide prevention: PHN has partnered with Queensland Health, HHS and Beyond Blue to implement The Way Back Support Service (TWBSS) across the region*
 - *Aboriginal and Torres Strait Islander mental health services: Aim of this activity is to provide tailored and culturally appropriate treatment for Aboriginal and Torres Strait Islander people*
 - *Stepped care approach: The PHN partners with Regional Mental Health and Alcohol and Other Drug Council and local service integration networks to facilitate a regional and local level stepped care approach*
 - *Regional mental health and suicide prevention plan: The PHN will commission services to address the mental health and wellbeing needs of the three target groups who have been disproportionately impacted by the Covid-19 pandemic – Older persons, Aboriginal and Torres Strait Islander and CALD people*

Our priorities and approaches for providing mental health services closely align with these national and regional mental health focus areas and strategies. We have identified the following priority areas based on the HNA findings, consultation with relevant strategies/plans and key stakeholders.

Priority area 1: Mental health services for young people

Priority area 2: Improve access to mental health services

Priority area 3: Addressing mental health risks and promote social and emotional wellbeing

Priority area 4: Mental health services for Aboriginal and Torres Strait Islander people

Priority area 5: Suicide prevention services

Priority area 6: Co-Design, Collaboration and Integration of Services

Priority area 7: Workforce Development

Opportunities, priorities, and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Priority area 1: Mental health services for young people			
Key issues and needs: Ensuring access to appropriate mental health service for children and young people. Priority Area: Mental Health Priority sub-category: Other: Young people	<p>Ensure access and continuity of existing Headspace and Stepped Care services for children and young people in the region and explore opportunities to enhance the geographic reach of existing services.</p> <p>Consider the specific mental health related needs of young people across the health care spectrum, including for specific sub-populations and setting, in the implementation of the Joint Regional Plan (2020-25) on Mental Health, Suicide Prevention and Alcohol and Other Drugs</p> <p>Foster enhanced integration between mental health services, other primary health care services, support services and setting where young people frequent – e.g. drug and alcohol, social and vocational support services, school based services.</p>	<p>Improved access to and utilisation of services and programs which are appropriate for and appealing to children and young people to address their mental health needs.</p> <p>Increased mental wellbeing among children and young people across the region</p> <p>Reduced rate of mental health related hospitalisation among young people with mental health issues</p> <p>Improved integration and connections between services to facilitate better continuity of care and support for children and young people specific to their needs</p>	<p>PHN</p> <p>Regional MHAOD Strategic Collaborative (Members: QH, PHN, HHS)</p>
Priority area 2: Improve access to mental health services			
Key issues and needs: Inequity in accessing mental health services by specific population groups Priority Area: Mental Health Priority sub-category: Vulnerable population	<p>Improve implementation and continuity of the PHN commissioned mental health programs (i.e Stepped care, headspace) with a focus on underserved areas (i.e rural and remote) and populations identified through the needs assessment processes</p> <p>Support GPs, other primary health care providers and support services to understand referral pathways for PHN-commissioned (Stepped Care and Headspace) and other available MH services in the region</p> <p>Investigate the use of alternative services for improving mental health services to hard-to reach-priority populations to provide less threatening and stigmatised environments of care</p>	<p>Increased access of underserved areas/vulnerable populations to appropriate and effective mental health services</p> <p>Increased awareness among GPs, other primary health care providers and support services in the region about the range and availability of service options for people needing appropriate mental health (i.e Stepped care, headspace etc) services.</p>	<p>PHN to lead planning in conjunction with HHSs, service providers, consumers and carers and commission services in accordance with regional and organisational plans.</p> <p>Regional MHAOD Strategic Collaborative (Members: QH, PHN, HHS)</p>

Opportunities, priorities, and options			
Priority	Possible Options	Expected Outcome	Potential Lead
		<p>Decreased rate of hospitalisations for mental and behavioural disorder among high-risk groups</p> <p>Reduction in mental illness prevalence among high-priority populations</p> <p>Improved mental health service equity across PHN populations</p>	Service providers, consumers and carers
Priority area 3: Addressing mental health risks and promote social and emotional wellbeing			
<p>Key issues and needs: Higher prevalence of mental health risk factors especially among populations with socio-economic disadvantage and high-risk behaviours</p> <p>A need for promoting early detection and prevention and promoting mental wellness and resilience in communities</p> <p>Priority Area: Mental Health</p> <p>Priority sub-category: Social Determinants</p>	<p>Cross collaboration approaches to address broader social determinants such as financial insecurity, homelessness.</p> <p>Facilitate co-design and implementation of early detection and prevention strategies</p> <p>Improve community understanding of positive mental health and actions to maintain it</p> <p>Implement strategies to increase social and emotional support. These could include:</p> <ul style="list-style-type: none"> - strategies to empower families, carers and patients to promote good mental health - building capacity of communities, schools, health and other services to support good mental health and wellbeing - supporting people to access natural supports, such as family and friends, community groups, and self-help groups, and provide services that assist people in accessing and maintaining these supports <p>Address mental health and suicide risk and protective factors specific to high-priority populations, including family and domestic violence victims</p>	<p>Reduction in risk factors and increase in protective factors among high-priority populations</p> <p>Increase in resilience and mental wellbeing among high-priority populations</p> <p>Reduction in mental illness prevalence among high-priority populations</p> <p>Improvement in providing mental health service among high-priority populations</p>	<p>PHN</p> <p>Regional MHAOD Strategic Collaborative (Members: QH, PHN, HHS)</p> <p>Service providers, consumers and carers</p> <p>Other sectors – education, social services, housing etc.</p>

Opportunities, priorities, and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	Implement strategies to address stigma and discrimination associated with mental health		
Priority area 4: Mental health services for Aboriginal and Torres Strait Islander people			
<p>Key issues and needs:</p> <ul style="list-style-type: none"> - Provision of culturally appropriate mental health services for Aboriginal and Torres Strait Islander people - Completeness and accuracy of data to indicate cultural appropriateness of the mental health services - Capacity to provide traditional healing practices and addressing intergenerational trauma <p>Priority Area: Mental Health</p> <p>Priority sub-categories: Aboriginal and Torres Strait Islander health</p>	<p>Work with Aboriginal and Torres Strait Islander organisations and communities to identify and address specific mental health needs and service gaps for Aboriginal and Torres Strait Islander people.</p> <p>Commission 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.</p> <p>Work with headspace to continue to provide and increase the availability services to Aboriginal and Torres Strait Islander young people.</p> <p>Continue to invest in capacity building in providing trauma informed care, traditional healing practices 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.</p> <p>Develop and implement community-driven approaches in building capacity and resilience among high-risk groups including Indigenous Aboriginal and Torres Strait Islander people.</p> <p>Standardize and implement MH service cultural appropriateness data collection and reporting for the PHN commissioned programs in mental health including Stepped Care program</p>	<p>Improved access to and uptake of services which address the mental health needs of Aboriginal and Torres Strait Islander people in culturally appropriate ways.</p> <p>Effective engagement with Aboriginal and/or Torres Strait Islander mental health stakeholders to identify appropriate and effective service delivery options and settings.</p> <p>Enhanced mental health outcomes for Aboriginal and Torres Strait Islander people.</p> <p>Improved integration and connections between services to facilitate better continuity of care for Aboriginal and Torres Strait Islander people.</p> <p>Improved accuracy of reporting of cultural appropriateness of the MH services</p>	<p>PHN to lead planning in conjunction with ACCHSs, Aboriginal and/or Torres Strait Islander organisations, HHSs, other local service providers, consumers and carers and commission services in accordance with plans.</p> <p>Regional MHAOD Strategic Collaborative (Members: QH, PHN, HHS)</p> <p>PHN- data team</p>

Opportunities, priorities, and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	Initiate or maintain (if already exists) the process of collecting patient and provider experience data specific to Aboriginal and Torres Strait Islander people mental health programs/services		
Priority area 5: Suicide prevention services			
<p>Key issues and needs: A need for a more systematic and integrated approach to suicide prevention, particularly after a suicide attempt</p> <p>Priority Area: Mental Health</p> <p>Priority sub-category: Other: Suicide prevention services.</p>	<p>Commission community-based suicide prevention activities using a whole-of-community approaches to suicide prevention</p> <p>Develop coordinated support for people over three months after a suicide attempt through implementation of assertive outreach and aftercare services.</p> <p>Continue to advance the suicide prevention service system which currently exists in the PHN catchment and develop/implement an integrated suicide prevention plan in partnership with service providers and consumers.</p> <p>Develop referral pathways and systems between HHSs and community-based services to facilitate appropriate follow-up care for individuals following a suicide attempt.</p> <p>Build the capacity of primary health care services and the broader community to support people at risk of suicide.</p>	<p>Implementation of a region-wide plan for suicide prevention to guide commissioning activities, development of effective referral pathways, and coordination and integration of services.</p> <p>Commissioned services are delivered to the identified priority target groups.</p> <p>Improved access to timely and appropriate suicide prevention services across the region.</p> <p>Fewer suicidality-related ED presentations</p> <p>Improved knowledge and confidence among service providers that clients will receive continuity of care as they transition between services.</p> <p>Reduced rates of suicide in the region.</p>	<p>PHN will lead commissioning of suicide prevention services</p> <p>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 Joint Regional Plan (2020-25) on Mental Health, Suicide Prevention and Alcohol and Other Drugs</p>
Priority area 6: Co-Design, Collaboration and Integration of Services			
<p>Key issues and needs: Need for a region-wide, integrated stepped care approach to mental health services</p>	<p>Foster enhanced integration between mental health services and other primary health care services and support services to ensure all mental, physical and social needs are met, particularly for</p>	<p>Improved integration and connections between services to facilitate better continuity of care.</p>	<p>PHN</p>

Opportunities, priorities, and options

Priority	Possible Options	Expected Outcome	Potential Lead
Priority Area: Mental Health Priority sub-categories: System Integration	<p>people with severe and complex needs – e.g. drug and alcohol, social and vocational support services, school based services.</p> <p>Ensure the PHNs work together to map providers across the service system, develop stronger referral pathways and build community knowledge of the range of available services and how to access them.</p>		<p>Regional MHAOD Strategic Collaborative (Members: QH, PHN, HHS)</p> <p>Service providers, consumers and carers</p>
Key issues and needs: Lack of integration between the mental health sector, AOD sector and other relevant health and support services Priority Area: Mental Health Priority sub-categories: Care coordination	<p>Work closely with relevant service providers to improve the delivery of integrated care to people with dual diagnosis.</p> <p>To coordinate treatment and supports for people with severe and complex mental illness</p> <p>Increase the mental health literacy of the public, GPs and other primary health care providers, and support services to know when MH support is required, locate, navigate and participate in MH and care choices, and feel empowered to use MH system</p> <p>Ensure adequate response to support mental health impacts of COVID-19 in line with National Mental Health and Wellbeing Pandemic Response Plan (99):</p> <ul style="list-style-type: none"> - Identify and harness opportunities for digital mental health to improve access to the MH services - Monitor the impact of COVID-19 on MH and suicide, including related risk factors across the region and develop appropriate responses to address concerns <p>Increase GP engagement in MH, with focus on rural and remote areas</p> <p>Partner with providers, advocacy bodies, peak and professional bodies to increase participation in the implementation of the joint regional mental health and suicide prevention plan</p>	<p>Improved integration between services to facilitate better continuity of care for people with complex issues/dual diagnosis and risky behaviours</p> <p>Improved recording of MH services by GPs</p> <p>Higher number of clients with GP MH plans in the PHN</p> <p>Client access to required mental health services are less impacted by COVID-19 pandemic</p> <p>Increased rates of GP MH plans especially in rural and remote areas</p>	<p>PHN</p> <p>Regional MHAOD Strategic Collaborative (Members: QH, PHN, HHS)</p> <p>Service providers, consumers and carers</p>

Opportunities, priorities, and options

Priority	Possible Options	Expected Outcome	Potential Lead
	Develop and implement a practice support campaign and support general practice on implementation of stepped care model and recording of MH services		
<p>Key issues and needs: Need for increased consumer voice in planning and service design</p> <p>Priority Area: Mental Health</p> <p>Priority sub-categories: Aboriginal and Torres Strait Islander health</p>	Develop effective MH networks and/ or collaborative committees with strong representation of lived experience consumers and carers, Aboriginal and Torres Strait Islander peoples, and other diverse population groups, to ensure greater inclusion of the consumer voice in the design and planning of all MH, AOD, and SP services.	<p>Established process of network and/ or collaboratives in each sub-regional area to inform service planning</p> <p>Consumer voice component is articulated as key process in PHN commissioning cycle planning documents</p> <p>Structured engagement strategy to ensure consumer voice is not only represented but is representative of diverse population groups.</p>	<p>PHN to lead the development and ongoing management of networks and/ or collaborative</p> <p>Regional MHAOD Strategic Collaborative (Members: QH, PHN, HHS)</p> <p>Service providers, consumers and carers</p>
<p>Key issues and needs: Need for a comprehensive monitoring and evaluation framework for MH, SP, AOD, social and emotional wellbeing (SEWB) and psychosocial services</p> <p>Priority Area: Mental Health</p> <p>Priority sub-category: System Integration</p>	<p>Develop and implement a robust evaluation framework that promotes the use of evidence to inform decision-making for MH by providers, stakeholders and the PHN</p> <p>Strengthen data management systems to improve monitoring and evaluation of MH and related services as stipulated in the Joint Regional Plan (2020-25) on Mental Health, Suicide Prevention and Alcohol and Other Drugs</p> <p>Initiate or maintain (if already exists) the process of collecting patient and provider experience data specific to mental health programs/services</p>	<p>Lessons of what works/does not work and has impact on services is understood and integrated into future planning and decision-making</p> <p>PHN program improvements</p>	PHN will lead in conjunction with service providers and other stakeholders in the region

Opportunities, priorities, and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Priority area 7: Workforce Development			
Key issues and needs: Availability and quality of the local MH workforce Priority Area: Mental Health Priority sub-categories: Workforce	<p>As part of the Joint Regional Plan (2020-25) implementation, work with public/private providers to regularly map the region's service needs and support regional planning for service development</p> <p>Implement regional workforce development framework aligned with the Queensland Health's MHAOD Workforce Development Framework</p>	<p>Improved MH service mapping in the region to effectively guide regional MH service planning</p> <p>Regional workforce development strategy developed in consultation with the MHAOD Strategic Collaborative, service providers and Clinical and Community Advisory Councils.</p>	<p>PHN Regional MHAOD Strategic Collaborative (Members: QH, PHN, HHS) Service providers, consumers and carers</p>
Key issues and needs: Need for building the skills and knowledge of the mental health workforce Priority Area: Mental Health Priority sub-categories: Practice support	<p>Contribute to the cultural competency and capacity to provide trauma-informed care of mental health service providers, including those in primary health care.</p> <p>Develop strategies that support Aboriginal and Torres Strait Islander peoples to take-up careers in mental health.</p> <p>Build GP capacity and support to help expand the skills and resources for GPs to identify and care for patients who are suicidal or who may be at risk of suicide</p> <p>Provide volunteer peers support training</p> <p>Train front line primary healthcare workers and families and carers in suicide prevention intervention skills</p>	<p>Increased cultural competency of mental health workforce, including primary care providers.</p> <p>Increased Aboriginal and Torres Strait Islander mental health workforce in the region.</p> <p>Improved capacity and skills of GP, family, carers and peer support</p>	<p>PHN, relevant GPs, HHS, local training institutions, such as Universities.</p>
Key issues and needs: Shortage of mental health specialists (psychologists, psychiatrists, youth MH specialist) especially in rural and remote areas Priority Area: Mental Health Priority sub-categories: Workforce	<p>As part of the Joint Regional Plan (2020-25) implementation, work with universities and TAFEs to explore opportunities for increased workforce training and regional work placements for students</p>	<p>Improved number of MH specialists deployed especially in high-demand areas</p>	<p>PNH and Local training institutions, such as Universities and the PHN.</p>

6. Annex: Tables and Charts

Table A: Population characteristics, by LGAs, PHN, QLD

Geography	Population living in outer regional, remote or very remote, 2016		SEIFA (% living in most disadvantaged quintile, 2016)	Indigenous, 2016		Homeless Persons (2016)		Unemployment, Dec 2020		Low-income family (<\$33.8k/yr), 2016	
	N	%		N	%	N	rate per 10,000	N	%	N	%
Central Queensland Area	55,698	25.2	26.2	12,681	5.7	932	41.0	7698	6.2	5,631	10
Banana (S)	14,319	100	17.2	579	4.0	53	34.2	292	3.5	319	8.8
Central Highlands (R) (Qld)	27,999	100	14	1,210	4.3	136	42.2	705	4.2	420	6.4
Gladstone (R)	8,516	13.8	21.5	2,503	4.1	215	34.2	2,572	7.4	1,673	10.4
Livingstone (S)	1,959	5.4	16.5	1,607	4.4	93	25.6	972	4.8	963	10.1
Rockhampton (R)	1,943	2.4	39.1	5,874	7.4	372	46.8	3,113	7.1	2,176	10.7
Woorabinda (S)	962	100	100	908	94.4	63	652.2	44	7.5	80	38.8
Wide Bay Area	15,002	7.3	54.8	8,617	4.2	933	44.5	10412	11.8	7,843	14.1
Bundaberg (R)	4,047	4.4	49.5	3,708	4.0	408	43.3	4,619	11.0	3,420	13.6
Fraser Coast (R)	477	0.4	59.4	4,231	4.2	456	43.6	5,427	13.1	4,018	14.5
North Burnett (R)	10,478	100	57.1	678	6.5	69	63.4	366	7.0	405	15.6
Sunshine Coast Area	2,107	0.5	13.3	8,269	2.1	1,184	29.2	15419	7.2	10,937	10.1
Gympie (R)	2,107	4.3	46.1	1,771	3.6	289	58.0	2,407	10.9	1,945	14.6
Noosa (S)	0	0	5.8	782	1.5	110	19.4	1,832	6.7	1,531	10.4
Sunshine Coast (R)	0	0	9.1	5,716	1.9	785	26.2	11,180	6.8	7,461	9.3
Central Queensland, Wide Bay, Sunshine Coast PHN	72,807	8.9	27.1	29,567	3.6	3,049	36.2	33,529	7.8	24,411	11.1
Queensland	791,680	16.8	20.0	148,943	4.0	21,715	45.6	192,978	7.1	115,233	9.4

Source: Queensland Government Statistician's Office, Queensland Treasury 2018. Queensland Regional Profiles.

Note: Areas with higher than QLD figures are in red

Table B: Estimated number of persons with mental and behavioural problems by PHN SA3 areas, 2017-18 (number and ASR per 100)

Area	n persons	ASR per 100
Central Queensland	52,696	24.1
<i>Central Highlands</i>	5,796	20.8
<i>Rockhampton</i>	29,155	25.2
<i>Biloela</i>	2,906	20.8
<i>Gladstone</i>	14,839	24.1
Wide Bay	74,286	25.2
<i>Bundaberg</i>	22,267	24.9
<i>Burnett</i>	13,255	26.7
<i>Gympie - Cooloola</i>	13,310	25.9
<i>Hervey Bay</i>	13,893	23.7
<i>Maryborough</i>	11,561	25.4
Sunshine Coast	77,495	21.2
<i>Buderim</i>	11,560	20.2
<i>Caloundra</i>	17,283	20.3
<i>Maroochy</i>	13,738	23.0
<i>Noosa</i>	8,753	20.0
<i>Sunshine Coast Hinterland</i>	10,692	20.4
<i>Nambour</i>	10,323	23.3
<i>Noosa Hinterland</i>	5,146	21.9
PHN	194,891	23.1
Queensland	1,089,817	22.7
AUSTRALIA+	4,842,100	20.1

Source: Public Health Information Development Unit (PHIDU), Social Health Atlas of Australia: Data by SA3s, PHIDU, Table: Estimates_chronic_disease

Note: Areas with higher than QLD figures are in red

Table C: Estimated number of males/females/persons with mental and behavioural problems (modelled estimates) 2017-18 (number and ASR per 100)

Area	n males	ASR males	n females	ASR females	n persons	ASR persons
Central Queensland	24,697	22.0	28,036	26.2	52,696	24.1
<i>Central Highlands</i>	2,728	18.4	3,071	23.4	5,796	20.8
<i>Rockhampton</i>	13,572	23.3	15,604	27.1	29,155	25.2
<i>Biloela</i>	1,367	18.8	1,541	23.1	2,906	20.8
<i>Gladstone</i>	7,030	21.9	7,820	26.5	14,839	24.1
Wide Bay	34,749	23.7	39,589	26.7	74,286	25.2
<i>Bundaberg</i>	10,442	23.6	11,841	26.1	22,267	24.9
<i>Burnett</i>	6,291	25.0	6,973	28.6	13,255	26.7
<i>Gympie - Cooloola</i>	6,242	24.2	7,078	27.8	13,310	25.9
<i>Hervey Bay</i>	6,286	22.2	7,616	25.0	13,893	23.7
<i>Maryborough</i>	5,488	24.0	6,081	27.1	11,561	25.4
Sunshine Coast	33,699	18.9	43,834	23.4	77,495	21.2
<i>Buderim</i>	4,865	17.8	6,699	22.4	11,560	20.2
<i>Caloundra</i>	7,504	18.1	9,788	22.3	17,283	20.3
<i>Maroochy</i>	5,916	20.5	7,829	25.3	13,738	23.0
<i>Noosa</i>	3,732	17.5	5,025	22.3	8,753	20.0
<i>Sunshine Coast Hinterland</i>	4,761	18.3	5,938	22.6	10,692	20.4
<i>Nambour</i>	4,627	21.1	5,700	25.5	10,323	23.3
<i>Noosa Hinterland</i>	2,294	19.6	2,855	24.4	5,146	21.9
PHN	88,643	21.1	106,369	25.0	194,891	23.1
New South Wales	653,291	16.9	813,094	20.9	1,465,620	18.8
Victoria	541,166	17.5	720,306	22.5	1,260,935	20.0
Queensland	489,196	20.5	601,225	24.8	1,089,817	22.7
South Australia	148,164	18.1	194,634	22.9	342,646	20.6
Western Australia	204,343	16.5	258,083	20.9	462,192	18.7
Tasmania	50,347	19.5	61,478	23.8	111,765	21.7
Northern Territory	13,287	14.7	15,811	18.4	29,078	16.6
Australian Capital Territory (Canberra)	35,180	17.7	44,885	22.0	80,028	20.0
AUSTRALIA+	2,135,000	17.8	2,709,500	22.3	4,842,100	20.1

Source: Public Health Information Development Unit (PHIDU), Social Health Atlas of Australia: Data by PHN-SA3s, PHIDU, Sep, 2020; Table: Estimates_chronic_disease (Males and Females);

Note: Areas with higher than QLD figures are in red

7. References

1. ABS (Australian Bureau of Statistics). National Survey of Mental Health and Wellbeing 2007: Summary of results. Canberra: ABS; 2016.
2. Leitch E, Wright E, Fjeldsoe K, Diminic S, Oakley P, Jimenez E, et al. Application of the NMHSPF to support integrated Primary Health Network and Hospital and Health Services planning: Central Queensland, Wide Bay and Sunshine Coast Report. Brisbane, QLD: University of Queensland; 2017.
3. World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. In: WHO, editor. Geneva 2014. .
4. WHO (World Health Organization). Promoting mental health: Concepts, emerging evidence, practice. A report of the World Health Organization. In: Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne, editor.: WHO; 2005.
5. Foresight Mental Capital and Wellbeing Project. Final Project report – Executive summary. In: The Government Office for Science, editor. London 2008.
6. VicHealth. VicHealth Mental Wellbeing Strategy 2015–2019. Victorian Health Promotion Foundation, Melbourne; 2015.
7. AIHW (Australian Institute of Health and Welfare). Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2015. Canberra: AIHW; 2019.
8. Compton M, Shim R. The social determinants of mental health. *Focus*. 2015;13(4):419-25.
9. Brackertz N, Wilkinson A, Davison J. Housing, homelessness and mental health: Towards systems change. Melbourne; 2018.
10. Silva M, Loureiro A, Cardoso G. Social determinants of mental health: A review of the evidence. *The European Journal of Psychiatry*. 2016;30(4):259-92.
11. AIHW (Australian Institute of Health and Welfare). Mental health services—in brief 2019. Canberra: AIHW; 2020.
12. AIHW (Australian Institute of Health and Welfare). Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2015, Supplementary Data Tables: Table S8.5: Age-standardised total burden (DALY) rates, selected diseases, by socioeconomic group. 2019.
13. QGSO (Queensland Government Statistician's Office). Queensland Treasury: Queensland regional profiles: CQWBSCPHN region 2021 [Available from: <http://www.qgso.qld.gov.au>]
14. Leske S, Adam G, Schrader I, Catakovic A, Weir B, Crompton D. Suicide in Queensland: Annual report 2020. Brisbane, QLD: Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University; 2020.
15. Holmes E, O'Connor R, Perry V, Tracey I, Wessely S, Arseneault L, et al. Multidisciplinary research priorities for the COVID-19 pandemic: A call for action for mental health science. *The Lancet Psychiatry*. 2020;7(6):547-60.
16. AIHW (Australian Institute of Health and Welfare). Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Canberra: AIHW; 2016.
17. WHO (World Health Organisation). Mental health and COVID-19 2021 [Available from: <https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/publications-and-technical-guidance/noncommunicable-diseases/mental-health-and-covid-19>].
18. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia: Mental health impact of COVID-19, 2021 2021 [Available from: <https://www.aihw.gov.au/getmedia/0e4bf78e-5ec2-4c00-93b4-52e29203b53f/Mental-health-impact-of-COVID-19.pdf.aspx>]
19. Socio-Economic Indexes for Areas (SEIFA) 2016 [Internet]. Available from: <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2033.0.55.001main+features12016>.
20. Central Queensland Wide Bay Sunshine Coast PHN. PHN Community Health Survey 2021.
21. Central Queensland Wide Bay Sunshine Coast PHN. PHN Stakeholder survey. 2021.
22. National Mental Health Commission. Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Sydney: NHMC; 2014.
23. Productivity Commission. Mental health. Canberra; 2020.
24. National Mental Health Commission. The Fifth National Mental Health and Suicide Prevention Plan 2017 27 July 2021.
25. Public Health Information Development Unit (PHIDU). Social Health Atlas of Australia: Table: Estimates_chronic_disease, PHIDU, Available at: <https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks> 2020.
26. Holden L, Scuffham P, Hilton M, Vecchio N, Whiteford H. Psychological distress is associated with a range of high-priority health conditions affecting working Australians. *Australian New Zealand Journal of Public Health*. 2010;34(3):304-10.
27. ABS (Australian Bureau of Statistics). National Health Survey: First results, 2017-18, Australia Canberra: ABS; 2019 [Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/mental-health/latest-release#psychological-distress>]
28. Treasure J, Claudino A, Zucker N. Eating disorders. *The Lancet* 2010;375:583–9.

29. The Butterfly Foundation. The National Agenda for Eating Disorders 2017 [Available from: <https://nedc.com.au/assets/NEDC-Resources/Butterfly-Foundation-National-Agenda-for-Eating-Disorders-2018.pdf>].
30. AIHW (Australian Institute of Health and Welfare). Australia's health 2018. 3.13 Eating disorders, Chapter 3: Causes of ill health. Canberra: AIHW; 2018.
31. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia, 2019. Community mental health care tables 2018-19 table CMHC.14: Community mental health care service contacts, by principal diagnosis in ICD-10-AM groupings, states and territories, 2018-19. 2020.
32. Queensland Health Statistical Services Branch. Queensland Admitted Patient Data Collection: Eating disorder principal/other diagnosis. Custom data request. 2017 - 2020 calendar years, Statistical Services Branch, Queensland Health. 2021.
33. WHO (World Health Organisation). Suicide: Key facts 2021 [updated 27 July 2021. Available from: <https://www.who.int/news-room/fact-sheets/detail/suicide>].
34. Lifeline Australia. Self-harm 2021 [Available from: <https://www.lifeline.org.au/get-help/information-and-support/self-harm/>].
35. AIHW (Australian Institute of Health and Welfare). Suicide & self-harm monitoring: National Hospital Morbidity Database: Table NMD S11: Age-standardised suicide rate (ICD 10 X60–X84, Y87.0), by year of registration of death, statistical area 3, 2014–2018, 2015–2019. 2020.
36. Department of Health. Chapter 8: Suicidality. The Mental Health of Australians; Available from: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-mhaust2> 2011.
37. World Health Organisation. Suicide Data: Suicide Estimates. 2019; Available from: https://www.who.int/mental_health/prevention/suicide/estimates/en/ 2019.
38. AIHW (Australian Institute of Health and Welfare). MORT (Mortality over regions and time) books: Local government area (LGA), 2015–2019: AIHW; 2021.
39. Causes of death, Australia, 2019 [Internet]. ABS. 2020.
40. AIHW (Australian Institute of Health and Welfare). Suicide and self-harm monitoring. National Mortality Database-Suicide: Table NMD S9: Suicide (ICD 10 X60–X84, Y87.0), by year of registration of death and Primary Health Network, 2010 to 2019; Table NMD S4: Suicide (ICD 10 X60–X84, Y87.0), by year of registration of death, states and territories, 1979 to 2019 2020.
41. AIHW (Australian Institute of Health and Welfare). MORT (Mortality over regions and time) books: Primary Health Network (PHN), 2015–2019. Canberra: AIHW; 2021.
42. AIHW (Australian Institute of Health and Welfare). Suicide and self-harm monitoring, National Mortality Database-Suicide: Table NMD S8: Suicide (ICD 10 X60–X84, Y87.0), by year of registration of death, remoteness area and sex, 2010 to 2019. 2020.
43. AIHW (Australian Institute of Health and Welfare). Suicide and self-harm monitoring, National Mortality Database-Suicide: Table NMD S7: Suicide (ICD 10 X60–X84, Y87.0), by year of registration of death, Indigenous status and sex, Australia, 2001 to 2019. 2020.
44. HealthDirect. Self-harm 2021 [Available from: <https://www.healthdirect.gov.au/self-harm>].
45. AIHW (Australian Institute of Health and Welfare). Suicide and self-harm monitoring, National Mortality Database: Table NHMD S1: Intentional self-harm hospitalisations, by states and territories, age and sex, 2008–09 to 2019-20. 2021.
46. AIHW (Australian Institute of Health and Welfare). Suicide and self-harm monitoring, National Hospital Morbidity Database: Table NHMD S7: Intentional self-harm hospitalisations, by Primary Health Network areas, age and sex, 2019-20; Table NHMD S9: Intentional self-harm hospitalisations, by statistical area 3 (SA3) and sex, 2019-20. 2021.
47. AIHW (Australian Institute of Health and Welfare). Suicide and self-harm monitoring, National Hospital Morbidity Database (NHMD), 2008-09 to 2019-20. Table NHMD S10: Intentional self-harm hospitalisations, by statistical area 3 (SA3) and age, 2019-20. 2021.
48. Biddle N, Ellen L, Korda R, Reddy K. Suicide mortality in Australia: Estimating and projecting monthly variation and trends From 2007 to 2018 and beyond. Canberra: Centre for Social Research and Methods, Australian National University; 2020.
49. AIHW (Australian Institute of Health and Welfare). Mortality over regions and time (MORT) books. State and Territory (STE), 2015-2019. Canberra: AIHW; 2021.
50. AIHW (Australian Institute of Health and Welfare). Mortality over regions and time (MORT) books. 2015-2019. Canberra: AIHW; 2021.
51. AIHW (Australian Institute of Health and Welfare). Australia's youth- in brief 2021.
52. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia: Overnight admitted mental health-related care 2018-19 Table ON 11: Overnight admitted mental health-related population rates of separations and bed days, with and without specialised psychiatric care, by statistical area 3 (SA3) area, 2018–19. 2020.
53. Lawrence D, Johnson S, Hafekost J, Boterhoven de Haan K, Sawyer M, Ainley J, et al. The mental health of children and adolescents: Report on the second Australian child and adolescent survey of mental health and wellbeing. Canberra; 2015.
54. AIHW (Australian Institute of Health and Welfare). Australia's Health 2020: Health of young people 2020 [Available from: <https://www.aihw.gov.au/reports/australias-health/health-of-young-people>].

55. AIHW (Australian Institute of Health and Welfare). Suicide and self-harm monitoring, National Hospital Morbidity Database (NHMD), 2008-09 to 2019-20. Table NHMD S6: Intentional self-harm hospitalisations, by remoteness area and age, 2012-13 to 2019-20. 2021.
56. Australian Institute of Health and Welfare. GEN Factsheet 2018-19: People's care needs in aged care. 2020; Available from: https://www.gen-agedcaredata.gov.au/www_ahwgen/media/Factsheets-for-2019%E2%80%932020-GEN-update/Peoples-care-needs-in-aged-care-factsheet.pdf 2020.
57. Australian Institute of Health and Welfare. National Aged Care Data Clearinghouse, Analysis of Custom data request R1819_3268 Schoubroeck (Aged Care Funding Instrument data), Australian Institute of Health and Welfare, Editor. 2019. . 2019.
58. Australian Human Rights Commission. Face the facts: Lesbian, gay, bisexual, trans and intersex people 2014 [Available from: www.humanrights.gov.au/our-work/education/face-facts-lesbian-gay-bisexual-trans-and-intersex-people].
59. National LGBTI Health Alliance. Snapshot of mental health and suicide prevention statistics for LGBTI people. 2020.
60. Central Queensland Wide Bay Sunshine Coast PHN. PHN Indigenous Community Health Survey. 2021.
61. Lawrence-Wood E, McFarlane A, Lawrence A, Hodson S, Benassi H, Bryant R, et al. Impact of combat report. Canberra: Australian Government Department of Veterans' Affairs, ; 2019. Report No.: 0648160971.
62. AIHW (Australian Institute of Health and Welfare). National suicide monitoring of serving and ex-serving Australian Defence Force personnel, 2002-2018. 2019.
63. Degenhardt L, Hall W, Teesson M, Lynskey M. Alcohol use disorders in Australia: Findings from the National Survey of Mental Health and Well-being. Sydney, NSW: National Drug and Alcohol Research Centre, UNSW; 2000.
64. AIHW (Australian Institute of Health and Welfare). Asthma, associated comorbidities and risk factors: Data table AC.2: Prevalence of other chronic conditions in people aged 45 and over with and without asthma, 2017-18 2020.
65. Morgan V, Waterreus A, Jablensky A, Mackinnon A, McGrath J, Carr V, et al. People living with psychotic illness in 2010: The second Australian national survey of psychosis. Australian and New Zealand Journal of Psychiatry. 2012;46(8):735-52.
66. Gray D, Cartwright K, Stearne A, Saggars S, Wilkes E, Wilson M. Review of the harmful use of alcohol among Aboriginal and Torres Strait Islander people. Australian Indigenous HealthInfoNet Perth; 2018.
67. Public Health Information Development Unit. Social health atlas of Australia: Selected composite indicators 2014-15 (modelled estimates) 2019.
68. COAG (Council of Australian Governments). The Australian Health Performance Framework. . Canberra: COAG; 2017.
69. AIHW (Australian Institute of Health Welfare). Mental health services in Australia: AIHW; 2021 [Available from: <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia>].
70. AIHW (Australian Institute of Health and Welfare). Mental health services—in brief 2019. Canberra: AIHW; 2020.
71. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia: Medicare-subsidised mental health-specific service 2021 [Available from: <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/medicare-subsidised-mental-health-specific-services>].
72. AIHW (Australian Institute of Health and Welfare). Medicare-subsidised mental health-specific services, by PHN area and SA3 area and provider, 2015-16 to 2019-20 2021.
73. Mindspot. Mindspot data: July 2017 to December 2017. Primary Health Network; 2018.
74. AIHW (Australian Institute of Health and Welfare). Australia's hospitals at a glance 2018-19 2020 [Available from: <https://www.aihw.gov.au/reports/hospitals/australias-hospitals-at-a-glance-2018-19/summary>].
75. Queensland Health Statistical Services Branch. Queensland admitted patient data collection: Eating disorders. Custom data request. Queensland; 2018.
76. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia, 2020: Services provided in public hospital emergency departments 2019-20. 2020.
77. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia: State and territory community mental health services 2018-19. 2020.
78. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia: Residential mental health care 2018-19. 2020.
79. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia: Mental health related prescriptions 2019-20 2021.
80. Central Queensland Wide Bay Sunshine Coast PHN. PHN Program Twelve Month Performance Report, 1 July 2019 to 30 June 2020 2020.
81. AIHW (Australian Institute of Health and Welfare). Australia's health snapshots 2020. 2020.
82. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia —Specialist homelessness services data 2019-20. 2021.
83. Australian Institute of Health and Welfare. Specialist homelessness services annual report. Available from: <https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/clients-services-and-outcomes#Clientsserviceusein2019%E2%80%932020> 2020.
84. ABS (Australian Bureau of Statistics). 2049.0 - Census of population and housing: Estimating homelessness, 2016 2018 [

85. Central Queensland Wide Bay and Sunshine Coast Primary Health Network. Data Analysis of Stepped Care for Mental Health services 2019-20. 2021.
86. National Mental Health Commission. National mental health and wellbeing pandemic response plan. 2020.
87. AIHW (Australian Institute of Health and Welfare). Coordination of health care: Experiences of information sharing between providers for patients aged 45 and over 2016: Supplementary data tables. Canberra: AIHW; 2019.
88. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia—Restrictive practices data 2019-20. 2021.
89. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia—Mental health workforce data 2019. 2021.
90. HWQ. Health Workforce Needs Assessment Summary Report: Central Queensland Wide Bay Sunshine Coast PHN. June 2021, Health Workforce Queensland: Queensland. . 2021.
91. AIHW (Australian Institute of Health and Welfare). Mental health services in Australia: Consumer perspectives data 2018-19 2019.
92. WHO (World Health Organization). Substantial investment needed to avert mental health crisis 2020 [Available from: <https://www.who.int/news/item/14-05-2020-substantial-investment-needed-to-avert-mental-health-crisis>].
93. ABS. National Survey of Mental Health and Wellbeing. 2007: Summary of Results. Canberra, ACT.; 2016.
94. The Royal Australian College of General Practitioners. e-Mental health: A guide for GPs. In: RACGP, editor. Melbourne, Victoria2015.
95. Council of Australian Governments. The Roadmap for National Mental Health Reform 2012–2022. 2012.
96. Productivity Commission. Mental Health, Report no. 95. Canberra, Available at: <https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf> 2020.
97. Joint Regional Plan 2020-2025 on Mental health, suicide prevention and alcohol and other drugs [Internet]. 2019 [cited 05 Aug, 2021]. Available from: <https://www.ourphn.org.au/wp-content/uploads/210105-Joint-Regional-Plan-2020-2025-Final.pdf>.
98. Central Queensland Wide Bay Sunshine Coast PHN. Strategic Plan 2021-25 Sunshine Coast Health Network 2020.
99. National Mental Health Commission (NMHC). National mental health and wellbeing pandemic response plan; Available from: <https://www.mentalhealthcommission.gov.au/getmedia/1b7405ce-5d1a-44fc-b1e9-c00204614cb5/National-Mental-Health-and-Wellbeing-Pandemic-Response-Plan> 2020.