Joint Regional Wellbeing Plan for Northern Queensland

A plan to strengthen how the mental health, alcohol and other drug, and suicide prevention needs of northern Queensland are met

2025 – 2028

phn NORTHERN QUEENSLAND
An Australian Government Initiative

Torres and Cape Hospital and Health Service

Cairns and Hinterland Hospital and Health Service

Mackay Hospital and Health Service

Townsville Hospital and Health Service

Acknowledgement of country


As a collective, we acknowledge Aboriginal and Torres Strait Islander people as Australia's First Nations people and the Traditional Custodians of this land. We respect their continued connection to land, sea, country, kin and community. We also pay our respects to Elders past and present as the custodians of knowledge and lore.

This Joint Regional Wellbeing Plan aims to deliver quality culturally responsive service across many Aboriginal, Torres Strait, and Australian South Sea Islander nation groups. We acknowledge the meaningful tapestry of diverse ancestral lands and respect the traditional and current relationships with air, sea and waterways. We acknowledge culture as enduring and ongoing and we pay our collective respects to all.

Acknowledgement of lived experience

Our work goes beyond simply creating a plan – it is about making a positive impact in the lives of the people we are designing it for. In developing this refreshed Joint Regional Wellbeing Plan (JRWP) for Northern Queensland, we have actively sought the voices and perspectives of those with firsthand experience in mental health challenges, suicide, and substance abuse. Northern Queensland Primary Health Network (NQPHN), Torres and Cape Hospital and Health Service, Cairns and Hinterland Hospital and Health Service, Townsville Hospital and Health Service, and Mackay Hospital and Health Service recognise and honour those with direct lived experience – individuals who have faced suicide, mental health challenges, or struggles with alcohol and other drugs, leading to significant life changes and personal transformation. We understand that lived experiences exist on a spectrum and can evolve throughout life.

We deeply value the contributions of people with lived experience. We acknowledge that sharing your story takes immense strength and courage. Every journey is unique, and we respect and appreciate the diversity of experiences people bring to the table. By incorporating these lived experiences into the JRWP, we can ensure the plan is truly effective and meets the real needs of our communities. People in lived experience roles draw on these experiences to provide unique insights that come from personally living through these challenges or supporting someone who has.

Note to readers

This document addresses sensitive topics, including mental health, alcohol and other drug use, and suicide. We understand that these subjects can be deeply affecting for some individuals. Please proceed with caution if you believe this information may be activating.

We extend our deepest respect to those who have lost loved ones or been personally impacted by mental health, alcohol and other drug use, and suicide. We acknowledge the profound pain and grief associated with these experiences. Our commitment remains steadfast to use this work to drive meaningful improvements.

Disclaimer

While the Australian Government Department of Health, Disability and Ageing has contributed to the funding of this material, the information in this document does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed, by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

Limitation: Throughout this document narrative descriptions have been derived from community consultation perspectives and lived experience voices. Please note that these have not been quantified through data sources.

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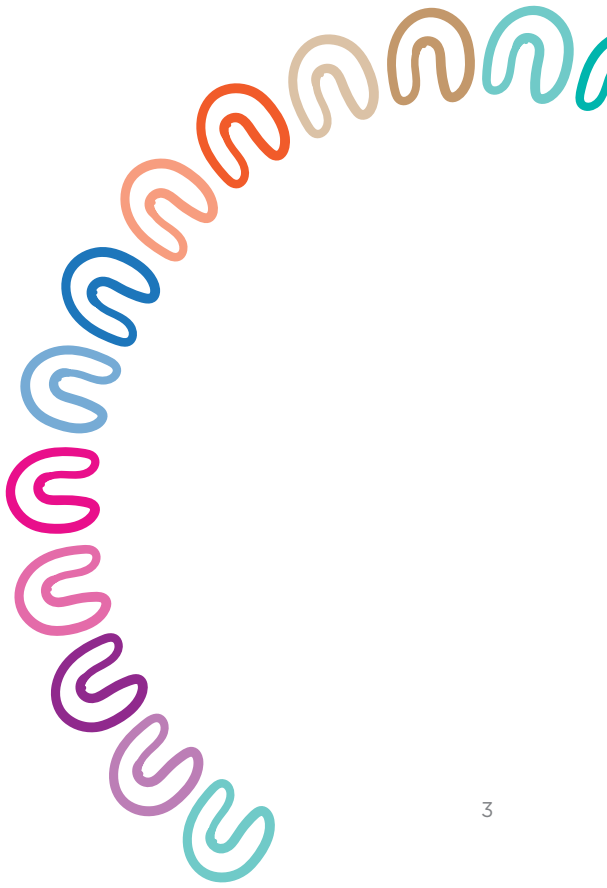

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Foreword

Through collaborative regional planning, this updated Joint Regional Wellbeing Plan (JRWP) presents a strategic opportunity to strengthen mental health, alcohol and other drug (AOD), and suicide prevention services across northern Queensland.

Understanding the diverse health needs and challenges of communities within the Torres and Cape, Cairns and Hinterland, Townsville, and Mackay Hospital and Health Services (HHSs) is essential to improving service delivery and achieving better health outcomes.

This plan reflects a shared commitment across sectors and regions.

It further offers an integrated, evidence-informed approach to improving the wellbeing of northern Queenslanders, including the health workforce and service providers.

It also reaffirms our collective vision - a healthy future for all who call northern Queensland home.

The JRWP has been developed by a dedicated steering committee led by Northern Queensland Primary Health Network (NQPHN), Torres and Cape HHS, Cairns and Hinterland HHS, Townsville HHS, and Mackay HHS.

Extensive input has been gathered from across the region including State Government departments, non-government organisations, First Nations peoples, individuals with lived experience, the peer workforce, and private sector stakeholders.

Contributions came from communities within and across the four HHS regions.

We are proud to present this updated JRWP – not only as a foundation for coordinated strategic planning, but also as a catalyst for innovation, collaboration, and shared responsibility.

Together, we can all build stronger, more connected, and healthier communities as we move closer to our vision of a healthy future for all.

We extend our sincere thanks to those who generously contributed their time, expertise, and lived experience to this vital work.

We invite all readers - including service providers, health professionals and organisations, and community members - to explore the plan, focus on what matters most, consider the opportunities available, and help drive meaningful change across our region.

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The JRWP is a partnership group addressing mental health, alcohol and other drug, and suicide prevention services and needs in the region.

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Cairns and Hinterland Hospital and Health Service

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Townsville Hospital and Health Service

Executive summary

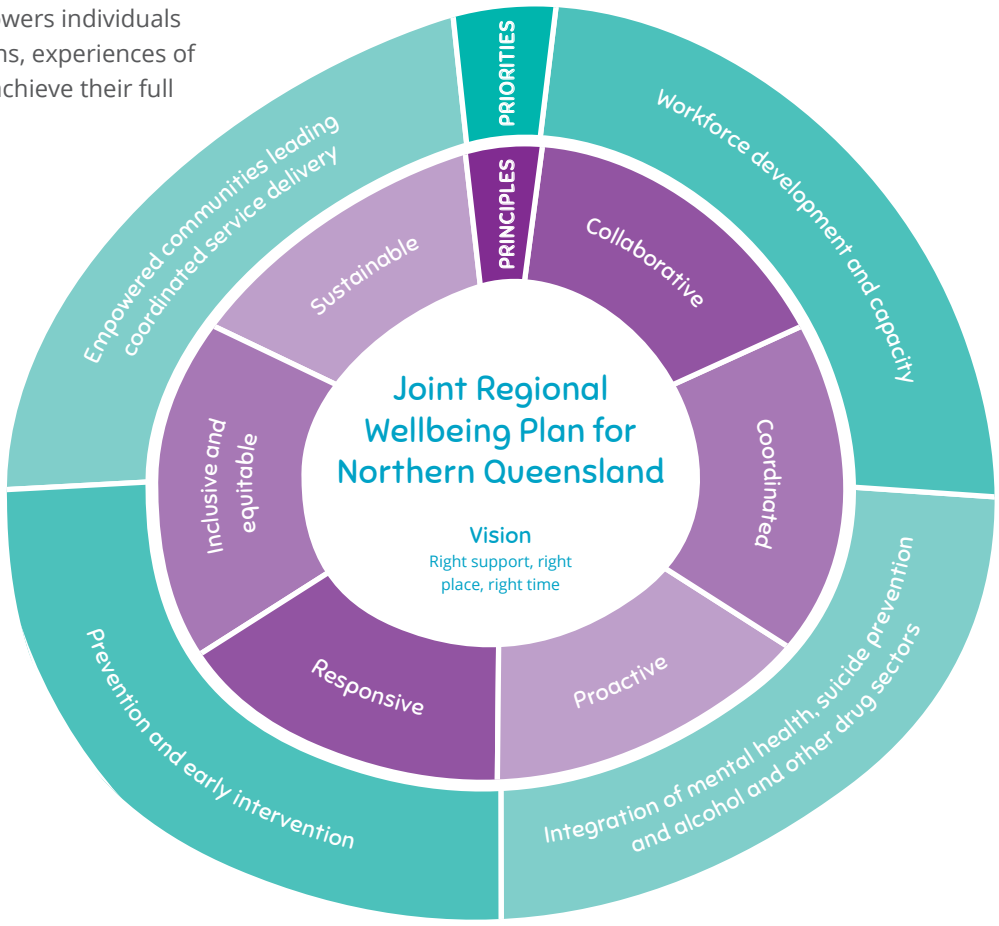
The Joint Regional Wellbeing Plan (JRWP) for Northern Queensland is designed to drive and inform evidence-based service development that addresses identified gaps and delivers on regional priorities in relation to mental health, alcohol and other drug (AOD) treatment, and suicide prevention needs.

The plan was developed through an extensive process of consultation throughout each region with stakeholders, people with lived experience, First Nations communities, hospital and health service staff, and health, government and non-government organisations, and peak bodies. The consultations were balanced and supported with robust data collection and analysis that identified areas of need and provided a benchmark against which progress on the plan's priorities will be measured.

Our vision is of a compassionate, connected, and accessible system of care that empowers individuals impacted by mental health conditions, experiences of suicide, and AOD use to thrive and achieve their full potential in all aspects of their lives.

We aim to support people to access the services they need, in accessible locations, when they are needed: 'Right support, right place, right time'.

In the plan, our vision is enacted through a suite of principles, priorities, and actions that will be implemented across the region and may be adopted by the services and organisations that work in our region. This refreshed plan defines key principles and priorities for the entire northern Queensland region. The plan is strengthened by the addition of sections dedicated to each of the region's four Hospital and Health Services (HHSs) – Torres and Cape, Cairns and Hinterland, Townsville, and Mackay – that address each region's specific needs around mental health, AOD treatment, and suicide prevention with targeted local solutions.



Principles:
- Our ideals for services and ways of working
- Underpin all our priorities and actions

Priorities:
- The focus areas of our region
- Implemented through cross sectoral and region-specific actions

Purpose

The Northern Queensland Joint Regional Wellbeing Plan (the plan) provides an insight into the mental health, alcohol and other drug use, and suicide prevention needs of the northern Queensland community. The plan guides the work of the steering committee to ensure that no matter where people live in our region, they can get the support they need – whether for mental health, alcohol and other drug use, or suicide prevention.

This plan brings together the voices of those with lived and living experience, frontline workers, service providers, and community leaders. It's honest about the challenges we face over the next three years, and bold about what we can achieve together.

At the heart of it is a commitment to do things differently, guided by three core pillars:

- Integration
- Access
- Workforce

Backed by a strong partnership between Northern Queensland Primary Health Network (NQPHN) and the Torres and Cape, Cairns and Hinterland, Townsville, and Mackay HHSs, the plan builds on the groundwork laid by the Foundational Joint Regional Wellbeing Plan. The Joint Regional Wellbeing Plan steering committee (referred to as the Steering Committee) is made up of representation from NQPHN, Torres and Cape HHS, Cairns and Hinterland HHS, Townsville HHS, Mackay HHS, Better Health NQ, National Aboriginal and Torres Strait Islander Health Alliance, Queensland Alliance for Mental Health, Queensland Health – Mental Health Alcohol and Other Drugs Branch, Queensland Network of Alcohol and other Drug Agencies, and Queensland Mental Health Commission.

This is more than a strategy. It's a call to action focused on four key areas: growing a skilled and sustainable workforce, joining up services, acting early to prevent crisis, and empowering communities to lead the way. The actions identified in this plan act as an initial step to progress the key priority areas. Over the next three years, annual review and resetting of actions will ensure momentum is maintained. This document lays out where we're starting from, where we're heading, and how we'll know we're making a difference.

Development of the plan

Foundational plan

In 2021, Northern Queensland Primary Health Network (NQPHN), along with Torres and Cape Hospital and Health Service (HHS), Cairns and Hinterland HHS, Townsville HHS, and Mackay HHS released the Joint Regional Wellbeing Plan (JRWP) for Northern Queensland.

The 2021 plan was a foundational-level document that explored how to 'improve the outcomes and experiences of those being supported by the system and their carers by enhancing coordination between the organisations that fund, plan, and deliver mental health, alcohol and other drug (AOD) services, and suicide prevention'.

The priorities of the foundational plan were:

- workforce, including peer workers
- Aboriginal and Torres Strait Islander partnership in healing
- service access and coordination
- alcohol and other drug (AOD) harm reduction
- physical health of people living with mental illness
- suicide prevention.

The implementation of actions from the foundational plan, including the refresh of the plan, was overseen by the Steering Committee. The key outcome of the plan was to build an effective partnership between our organisations. This partnership was at the heart of the development of the 2025 plan.

Significant developments since the foundational JRWP, including new initiatives and key policy changes, have fostered closer partnerships between NQPHN and the four HHSs. The establishment of Universal Aftercare to Townsville and Mackay is a demonstration of the strong partnership in action.

These new initiatives have seen NQPHN and HHS partners undertake all aspects of design and consultation in partnership, which has seen the implementation of the model delivered by both non-government organisation providers and the HHS strongly aligned to meet community needs. This approach was facilitated by the early engagement and strong relationships which exist in the steering committee.

These strengthened relationships, further cultivated through a range of bilaterally funded projects, have led to improved community engagement and input into service design, and a greater connection with the communities across our regions.

The refreshed plan is designed to be targeted, achievable, and sensitive to local needs across our diverse region. It outlines realistic, high-impact initial actions to be taken against a background of complex challenges and coordinated holistic solutions.

Policy context

This plan aligns with national, state, and regional policy frameworks, which guide and support work at the regional and local level. In recent years, governments at all levels have focused on improving mental health, AOD, and suicide prevention services and support. This has seen a number of national and state system reviews and commissions of inquiry being published. Additionally there are a number of key strategies and plans that operate across different levels of government and governance.

Please note, other policies, frameworks, and documents at the local, state, and national level that are not specific to mental health, AOD, or suicide prevention are and will continue to be important reference points to the sector given the intersection that exists with a range of social determinants on wellbeing in our community

Key national documents include:

Mental health

- National Mental Health and Suicide Prevention Agreement, 2022
- Bilateral Schedule on Mental Health and Suicide Prevention: Queensland, 2022
- Fifth National Mental Health and Suicide Prevention Plan, 2017
- Measuring What Matters Framework, 2023
- National Framework for Recovery-Oriented Mental Health Services, 2013
- Gayaa Dhuwi (Proud Spirit) Declaration, 2015; Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan, 2024
- National Agreement on Closing the Gap, 2020
- National Mental Health Workforce Strategy 2022–2032
- National Children's Mental Health and Wellbeing Strategy, 2023
- National Disaster Mental Health and Wellbeing Framework, 2023
- National Digital Mental Health Framework, 2021

Suicide prevention

- National Suicide Prevention Strategy 2025–2035
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025–2035
- Vision 2030: Blueprint for Mental Health and Suicide Prevention

Alcohol and other drugs

- National Suicide Prevention Strategy 2025–2035
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025–2035
- Vision 2030: Blueprint for Mental Health and Suicide Prevention
- National Drug Strategy 2017-2026
- National Ice Action Strategy 2015
- National Framework for Alcohol and Other Drug Treatment 2019-2029

The JRWP is also aligned with the following Queensland documents:

Mental health

- Shifting Minds: The Queensland Mental Health, Alcohol and Other Drugs, and Suicide Prevention Strategic Plan 2023–2028
- Thriving Lives, Connected Communities: Queensland's Commitment to Mental Health and Wellbeing, 2024
- Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016–2021
- Queensland Framework for the Development of the Lived Experience Workforce, 2019
- Queensland Trauma Strategy 2024–2029
- Digital Information Strategy 2022–2027
- Inquiry into the opportunities to improve mental health outcomes for Queenslanders, 2022
- Queensland Government final response to the Inquiry, 2022

Suicide prevention

- Every Life: The Queensland Suicide Prevention Plan 2019–2029

Alcohol and other drugs

- Achieving Balance: The Queensland Alcohol and Other Drugs Plan 2022–2027
- Better Care Together: A Plan for Queensland's State-funded Mental Health, Alcohol and other Drug Services to 2027
- Queensland Alcohol and Other Drug Treatment Service Delivery Framework, 2022
- Mental Health Alcohol and Other Drugs Workforce Development Framework 2016–2021
- Changing Attitudes, Changing Lives: options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use, 2018
- Don't Judge, and Listen: Experiences of stigma and discrimination related to problematic alcohol and other drug use; 2020 report to the Queensland Mental Health Commission

Development process

Over the past year, the steering committee has worked to develop a refreshed plan that is built on the foundational plan and the strengths of our partnerships.

Project establishment and research

The Steering Committee approved a project plan for the development of the new plan and increased the frequency of meetings to monitor and ensure sufficient focused attention to the completion of the updated plan.

The establishment of the plan was conducted in three key phases.

Phase 1: Desktop research including:

- Review of relevant polices and plans
- Review of progress and system changes since the foundational plan
- Analysis of key regional wellbeing and service data including:
  - Queensland Emergency Department data extracted from the Emergency Department Collection (EDC), via the Planning Portal
  - Mental Health Emergency Department data extracted from the EDC, via the Mental Health and Addiction Portal (MHAP). Data has been presented as rates per 100,000 population, to ensure comparability across regions and to avoid individual counts
  - Queensland Health, The Health of Queenslanders 2023. Report of the Chief Health Officer Queensland, Queensland Government, Brisbane, accessed March 2025
  - Australian Bureau of Statistics, Regional Population By Age and Sex, 2023, accessed February 2025
  - Queensland Government population projections, 2023 edition
  - Australian Bureau of Statistics, 2021, Census of Population and Housing, accessed February 2025
  - Australian Institute of Health and Welfare, 2024, National Drug Strategy Household Survey 2022-23, accessed March 2025
  - Australian Institute of Health and Welfare, 2024, National Mental Health Service Planning Framework (NMHSPF) Planning Support Tool (PST), Version 4.3, accessed February 2025
  - Australian Institute of Health and Welfare,2024, Alcohol and other drug treatment serivces in Australia, 2022-23, accessed March 2025
  - Queensland Health, Mental Health Establishments Collection, accessed via MHAP, February 2025
  - Australian Institute of Health and Welfare, 2024, Mortality Over Regions and Time (MORT) books, accessed March 2025
- Review of consultation data and other data sources, including:
  - survey data and other consultation data through the develop of the Northern Queensland Joint Regional Need Assessment
  - information provided to NQPHN in codesign and consultations conducted over the previous 18 months, including for the redesign of Mental Health stepped care services and establishment of new service initiatives
  - information provided to peak agencies through consultations conducted across the NQPHN footprint over the previous 12 months.

Phase 2: Stakeholder Engagement (see page 14)

Phase 3: Prioritisation and action setting (see page 24)

Limitations

Whilst the Steering Committee undertook a substantial phase of consultation, it is acknowledged that the plan represents only the perspectives shared through consultations and via the other data sources at this specific point in time. The mental health, AOD, and suicide prevention needs of our community are complex, and it is critical for the Steering Committee to continue to be open to new and relevant perspectives to inform the ongoing actions against the priorities developed in this plan.

The process identified limitations to the qualitative data available across the sector, which has impacted the ability to reliably quantify all key themes presented. These gaps will be further explored by the data working group to identify opportunities to better connect data sources to understand the issues and impact of actions.

It is acknowledged that boundaries of HHSs and PHNs do not always align with patient journeys and the natural access points for people in communities. For northern Queensland, this is particularly the case for rural and remote community members. The Steering Committee has engaged with the HHSs and PHNs where our boundaries meet throughout the development of this plan. Shared actions specific to supporting seamless service access for people who travel across boundaries to access their health care needs have not been included in this plan, but this is noted as a key area of future focus for the Steering Committee.

Stakeholder engagement

Starting from our existing PHN and HHS partnerships, the plan was developed with extensive engagement and consultation with stakeholders across the four regions of northern Queensland. Consulted groups and organisations include:

- lived experience representatives
- HHS staff
- peer workforce members
- First Nations
- Aboriginal Community-Controlled Health Organisations (ACCHOs)
- mental health, AOD, and suicide prevention non-government service providers
- federal, state, and local government departments
- private sector representatives
- peak bodies
- regional networks.

Who we met with

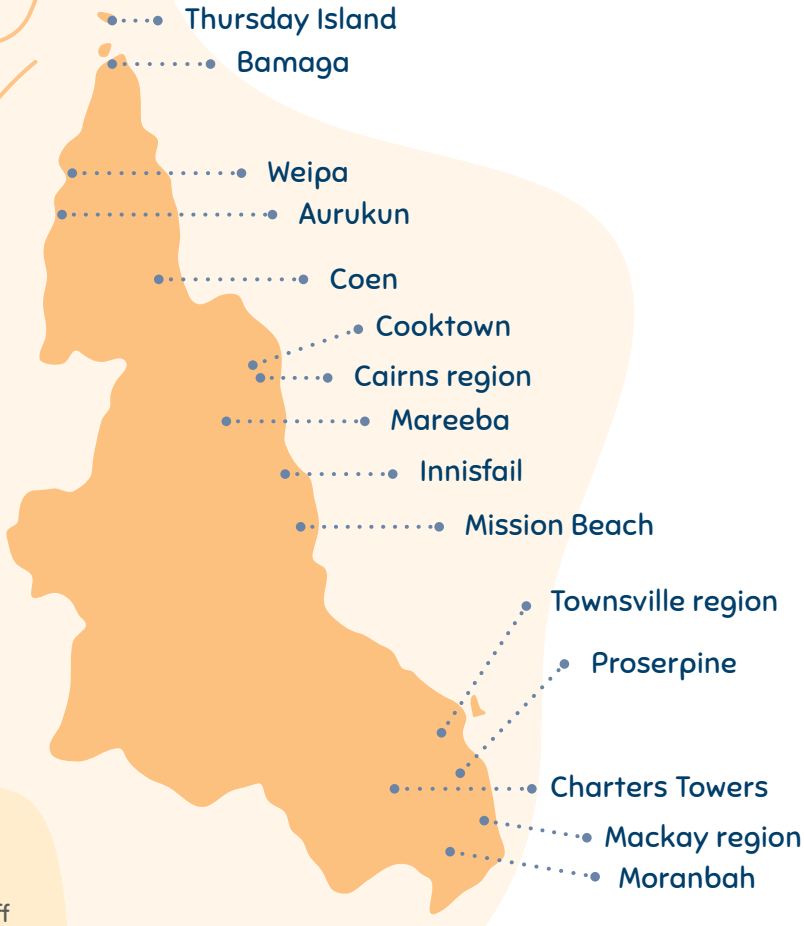
more than 380 people

across 31 face-to-face sessions

27 virtual sessions

12 lived experience engagements

Where



Key groups

- Hospital and Health Service staff
- Non-governmental organisation staff
- Peer workforce
- Private hospital
- Human and social service staff
- Lived experience groups
- Private sector
- First Nations peoples
- Australian South Sea Islanders

What we heard through stakeholder engagement

The steering committee ensured that stakeholder engagement included three key priority stakeholder groups - those with lived experience, First Nations peoples, and Australian South Sea Islander peoples.

Lived experience

- Two lived experience advisory groups were formed through expressions of interest to support the coproduction of the plan. One was made up of people from the Cairns, Townsville, and Mackay regions and the other involved people from across Torres and Cape. In the context of this plan, 'lived experience' is defined as 'firsthand experiences of facing mental health issues, mental illness, the impact of suicide, or AOD complications, alongside the experiences of their support networks (family, friends, kin, and carers)'.

- In codeveloping the plan, the lived experience groups provided invaluable insights that are important considerations in the design of future services that truly meet the needs of users. They also provided feedback on practical programs and features that work for the communities and populations they represent.

- Lived experience voices have played a crucial role in setting the priorities in this plan. Their shared experiences and active role in decision-making and review have helped ensure that the priorities and actions related to this plan are relevant and represent areas in which change will directly impact the outcomes of those who walk behind them.

- The central message from the lived experience groups is that four key elements make all the difference to support: 'We want support that is inclusive, compassionate, coordinated, and responsive.' Here is what that looks like:
  - **Inclusive:** Everyone deserves to feel heard and valued. Support must welcome all, ensuring no one is left behind.
  - **Compassionate:** Every interaction should be grounded in empathy. Compassionate care builds trust and prevents harm.
  - **Coordinated:** Support should be seamless, with teams working together to ensure the right help is provided without confusion or barriers.
  - **Responsive:** Help needs to come when it is needed most. Timely support reduces stress and anxiety, so waiting weeks for care is not an option.
- These four principles have been woven into the foundation of this JRWP and form the basis for our principles and ways of working.

First Nations

- We conducted face-to-face and virtual sessions to connect with First Nations peoples from communities within and across Torres and Cape HHS, Cairns and Hinterland HHS, Townsville HHS, and Mackay HHS.

- Throughout the consultations, we listened to community representatives and heard insights around the enablers and barriers to access for mental health, AOD, and suicide prevention support. We heard the importance of acknowledging different Aboriginal and Torres Strait Island peoples as each having unique cultural considerations that differ from community to community. These considerations shape the way we approach cultural safety and how we understand the role that family and kin for First Nations people plays in the broader context of social and emotional wellbeing.

- The mental health, AOD, and suicide prevention systems in our regions face significant challenges in supporting First Nations peoples. Across northern Queensland, these challenges include complex referral pathways, high staff turnover, workforce shortages, and limited access to essential healthcare providers. Social determinants of health, such as housing insecurity and food scarcity, along with stigma and systemic trust issues, further complicate service delivery. There is also a unique set of barriers in each region.

- Many examples of enablers that help First Nations peoples access support were also highlighted. These resources, which are available in some communities and not others, serve as a beacon of hope for future progress. Key enablers included strong leadership, effective workforce management and a person-centred approach that tailors care to individual needs. Local initiatives work to reduce stigma, while community-led programs, like culturally appropriate suicide prevention efforts, promote resilience and mental health. These strengths demonstrate the region's ability to adapt to challenges and offer valuable support that is customised to the diverse needs of our communities.

- **Three broad themes for improvement emerged from these engagements:**
  - **Integration:** Collaboration between health services, mental health, AOD, and suicide prevention organisations, and community groups is essential to ensure seamless support and reduce gaps in care.
  - **Access:** Increasing access to mental health, AOD, and suicide prevention services, especially in rural and remote areas, is crucial. This includes flexible service delivery, extended hours, and culturally safe services.
  - **Workforce:** Prioritising the employment and development of First Nations peoples in the social and emotional wellbeing (mental health, AOD, and suicide prevention) workforce is essential for culturally appropriate care.
- These themes have been incorporated throughout this plan at both the northern Queensland and subregional levels.

Australian South Sea Islander community

› In Mackay, our consultations with the Australian South Sea Islander (ASSI) community highlighted the need for a community-centred approach that foregrounds cultural safety, trust, inclusion, recognition, and stronger engagement. It also highlighted the needs for workforce diversity and development, and outreach with a purpose.

- **A community–centred approach:** ASSI representatives told us that mental health support services need to shift their current approach and meet people where they are comfortable, rather than asking them to come to unfamiliar, unsafe, and unsuitable spaces. Service providers should travel to these comfortable locations and give a warm and welcoming introduction to the available services. Community members of all ages need to be supported through gradual relationship building, where services begin by establishing trust and offering support in settings that already feel safe. After that, people can be invited and encouraged to attend at other locations.
- **Cultural safety:** It is important that services clearly understand and communicate that ASSI people's cultural values will be respected and reflected in the service offerings. Services must also ensure that community members do not feel stereotyped, disadvantaged, or excluded. This includes understanding that the ASSI population is distinctly different from Aboriginal and Torres Strait Islander peoples. Service providers should not assume that ASSI communities' needs are the same as those of Aboriginal and Torres Strait Islander communities.
- **Trust:** To build trust with the ASSI community, services must not only listen, but also demonstrate that any feedback and input is taken seriously. This can be achieved through supportive and meaningful follow-up and ensuring that community input shapes future service development.
- **Inclusion and engagement:** ASSI community members expressed a strong desire for a system of informal, community-based role models. These individuals would use practical skills to build trust and provide guidance in ways that are not confined to clinical or formal settings. This would help break down barriers and connect young people with support that is more accessible, more supportive, and less intimidating. Community leaders would create pathways to support the ASSI community around mental health, AOD, and suicide prevention matters.
- **Workforce diversity and development:** The current workforce needs to reflect the diversity of the community it serves. To achieve this, ASSI people could be employed in specific roles to ensure better cultural understanding and representation within the workforce. Workforce development should focus on building the capacity of services to understand the needs of the ASSI population through training, mentoring, and recruitment of people from the community. Additional training for existing mental health, AOD, and suicide prevention staff should be explored, locally designed, and locally delivered.
- **Outreach with a purpose:** Services need to be transparent about what they offer and ensure that they communicate in a way that is easily accessible to the ASSI community. They should clearly articulate the levels and types of support that are available and how services will respect the cultural values of the community. Outreach should focus on engaging with the community in a proactive, respectful way that creates a pathway for ongoing engagements with services.

Using the range of consultation data, and considering the review of relevant data available, a thematic analysis was undertaken. Through this, **seven key concepts emerged**, which were then consolidated into **four key challenges** for the region following further thematic review.

Challenge 1:

The mental health, AOD, and suicide prevention workforce is limited and under increasing pressure

A consistent theme in the consultation was the experience of staffing challenges across the region. It was reported that there are insufficient staff across the mental health, AOD, and suicide prevention, including low numbers of staff with lived experience. This reflects a broader picture of staffing difficulties in healthcare in northern Queensland identified in the Joint Regional Needs Assessment. Stakeholders told us that sector staff shortages are exacerbated by retention difficulties and high staff turnover, caused in part by excess workload and burnout. High staff turnover reduces organisational stability and can erode community trust. While collection of consistent data regarding these metrics is difficult, consistent feedback in relation to vacancy rates and recruitment challenges were heard through consultation.

Suggested actions from consultation:

- Understand the sector needs for formal workforce capacity building.
- Partner with universities, further education organisations, and those in the workforce space to build the workforce pipeline.
- Develop cross-sectoral partnerships to capitalise on expertise, identify what each service can contribute, and build collaborative approaches such as student sharing and joint placements.
- Integrate peer and lived experience staff across services through appropriate training, clear role descriptions, and career pathways.
- Educate the broader workforce about the peer and lived experience role and benefits.
- Establish clear career pathways and support systems for all staff, including continuous staff development (clinical and nonclinical) and health and wellbeing support.
- Awareness raising and promotion of Employment Assistance Programs (EAP) across the mental health, AOD, and suicide prevention sector.

Challenge 2:

The mental health, AOD, and suicide prevention sectors are not fully connected

A consistent theme in consultation was an ineffective service system due to disconnection between services. It was noted the sector has a range of services all with important roles to play in meeting the mental health and wellbeing needs of northern Queensland, however the complexity of the service system and referral pathways can be confusing to navigate and duplication and overlap of services can occur.

Suggested actions from consultation:

- Establish and strengthen multidisciplinary teams to collaborate on case planning and service delivery.
- Establish protocols for collaboration and communication across areas, organisations, and the prevention and care continuum.
- Develop and maintain an up-to-date map of service providers and their services to improve visibility and referral pathways.
- Develop a whole-of-life approach, including ways to address service gaps for younger people and improve the transition from youth to adult mental health services.
- Actively engage with projects being progressed through the first 2,000 days framework.
- Develop hospital and non-government partnerships through measures such as service colocation, collaboration, shared care, warm handover, and hot-desking arrangements.
- Focus on AOD harm minimisation.
- Improve collaboration between mental health and AOD services for those seeking support with co-occurring needs.
- Seek to establish regular sector forums.

Challenge 3:

Barriers are preventing people from finding support before a crisis

A consistent theme in consultation was the impact of stigma, along with cultural and communication barriers on people accessing help. This can prevent people from seeking the help they need before they reach a mental health crisis. It was noted that often people do not know how to seek help, community support is seen as lacking, and there is a lack of knowledge about supports available.

Suggested actions from consultation:

- Seek to understand and address the barriers that prevent people from accessing support, such as stigma.
- Implement community wellbeing initiatives, including communication and education initiatives aimed at stigma reduction.
- Increase the early distress support available in the community.

Challenge 4:

Community efforts are not consistently aligned to address the specifics and uniqueness of local needs

Consultations identified that the region has many effective community groups that provide support and supplementary services in mental health and wellbeing.

It was however identified that a lack of coordination and cross fertilisation means that the impact of these individual efforts can be limited, learnings can be lost, and efforts can be repeated.

Suggested actions from consultation:

- Engage with key stakeholders, including local councils and community, state, and federal government departments and other relevant public and private entities.
- Identify and support effective First Nations and other local community efforts.
- Map existing community services to identify gaps and develop codesigned tailored plans for each community.
- Identify and engage with other partners, including State government departments, where there is clear intersection of efforts.
- Establish youth advisory groups and involve them in codesign.
- Implement accountability measures for community services.
- Improve interagency collaboration and streamline funding.
- Develop ways to capture and share learnings for other and future communities.

Determination of plan priorities

The consultation process yielded emerging concepts of what was needed for each subregion and northern Queensland as a whole. These concepts were tested with the community to develop priorities. After considering the consultation results and relevant data, these emerging concepts were considered and ranked by the steering committee using the criteria shown in Table 1. The highest-ranked emerging concepts became priority areas for this plan.

Table 1: Criteria and considerations for selection of priority areas and actions

Criteria	Considerations	Low	Moderate	High
Magnitude	› How many people does this affect? › How widespread is the issue? › Does the issue appear across multiple HHS regions?	0%–9.9% of population affected	10%–24.9% of population affected	More than 25% of population affected
Impact	› How much of an impact does this have? › What is the impact of not taking action? › To what degree has the need worsened over the past 3–5 years? › What is the severity of direct impacts (quality of life, premature disability and/or mortality, operational issues, burden on suppliers)?	Low impact, low cost or problem is already improving	Moderate impacts, moderate cost or problem is stable	High impacts, high cost or problem is worsening
Effectiveness of intervention	› What is our ability to reach the target population and achieve an outcome, given real-world variables?	0–33% of need could be addressed	34–66% of need could be addressed	67–100% of need could be addressed
Scope	› Does the issue fall within the remit of one or more of our partner agencies? › How well can the issue be addressed at a regional level?	Outside the scope of NQPHN and within scope for other providers	Within the scope of NQPHN and several other potential responders	Core business of NQPHN
Equity	› How will disparities in health access and outcomes be impacted if this need is addressed?	No differential occurrence between groups, including between HHS and Queensland average	Moderate differential occurrence between groups, including between HHS and Queensland average	High differential occurrence between groups, including between HHS and Queensland average

The plan

Vision

Our vision is of a compassionate and accessible system of care that empowers individuals impacted by mental health, alcohol and other drug (AOD) use, and experiences of suicide to thrive and achieve their full potential in all aspects of their lives.

We aim to support people with a clear system and processes that provide the services they need, in accessible locations, when they are needed: 'Right support, right place, right time'.

Our vision is enacted through a suite of principles, priorities, and actions that will be implemented across the region and our organisations (Figure 1).

Principles:
- Our ideals for services and ways of working
- Underpin all our priorities and actions

Priorities:
- The focus areas of our region
- Implemented through cross sectoral and region-specific actions

Figure 1: Refreshed JRWP vision, principles and priorities

Principles

The Joint Regional Wellbeing Plan (JRWP) is guided by six interlinked principles that represent our approach to working together in northern Queensland communities. These principles provide a guide for anyone working in our region and delivering mental health, AOD, and suicide prevention services and supports in northern Queensland.

Collaborative

- **Rationale:** Working together across services within and between sectors makes better use of resources and enhances service outcomes.
- **How we work:** Collaboration and codesign is at the heart of all we do. We work to foster strong partnerships at all organisational levels, supported by respect, engagement, and clear communication.

Coordinated

- **Rationale:** Coordinated care reduces duplication and offers people a more efficient and compassionate experience that meets all of their needs.
- **How we work:** We deliver care that reflects each person's unique circumstances and physical, mental, spiritual, and social needs. We streamline referral pathways, work to ensure effective handovers, and partner with other service providers to deliver complete care.

Proactive

- **Rationale:** Prevention-focused early intervention and community-led efforts help reduce long-term reliance on crisis support and build individual and local resilience.
- **How we work:** We focus on preventative measures that empower communities to take charge of their wellbeing. We develop early help for young people and aim to catch people before they reach crisis point.

Responsive

- **Rationale:** Responsive and compassionate care recognises the critical nature of mental health, AOD, and suicide prevention services and ensures that people receive the care they need, when they need it.
- **How we work:** We aim to deliver care when it is needed, reducing delays through improved coordination, community support, and the promotion of service co-location.

Inclusive and equitable

- **Rationale:** Accessibility of services varies across our communities, and our efforts need to continue breaking down the barriers and working towards equity of access across our communities.
- **How we work:** We work to eliminate barriers to care by supporting peer and lived experience staff; providing outreach, mobile services and tailored support, reducing stigma, and ensuring equitable access for priority population groups as they emerge.

Sustainable

- **Rationale:** Sustainable services ensure that the future needs of our communities will be met, driving long-term impact.
- **How we work:** We design and resource programs for long-term operation and impact. We monitor service and resource delivery across our region and implement measures for continual improvement.

Priorities and actions

Through the consultation process, we identified four overarching priority areas for the northern Queensland region. Priorities refer to our main areas of focus, and actions are our key approaches to achieving the stated priorities. The chosen priorities and actions are not a complete list of all of the suggestions we received – rather, they are the ones that were strongly endorsed and judged as most impactful using the prioritisation matrix.

The priorities focus on the changes that can be made within the mental health, AOD, and suicide prevention sectors to address the challenges and improve outcomes for all northern Queenslanders. Addressing these areas through the selected actions is expected to have a widespread positive impact on the sectors, ultimately improving access to timely and appropriate support for individuals. The actions will be implemented across subregions and the entire region within the next three years.

Specific priorities and actions have also been identified for each subregion. These build on the region's existing strengths and focus on the greatest areas of need at the regional level (see regional priorities and actions from page 27).

We recognise that some priority populations and communities have specific needs and are more vulnerable than others. Supporting the needs of current and priority populations, even when specific groups are not identified in actions, will be key to the Steering Committee work, informed by the principle of being inclusive and equitable.

Given the rapidly changing nature of the health context, the Steering Committee will monitor progress and review and update actions against priority areas each year.

Plan priorities

The following high-level priorities describe the first steps towards ensuring that people are provided with timely, accessible and compassionate services.

PRIORITY 1:

Workforce development and capacity

To build workforce capacity, it is important to understand the sector's needs and collaborate with universities, further education providers, and workforce organisations to create a strong talent pipeline. Developing cross-sectoral partnerships is key to sharing expertise, identifying each service's contributions, and implementing joint initiatives such as student sharing and placements.

Integrating peer and lived experience staff across services is vital, supported by relevant training, clear role definitions, and established career pathways. Raising awareness of the value of the peer and lived experience workforce across the sectors workforce is crucial. To support staff retention and development clear career pathways and comprehensive support systems must be in place, including ongoing professional development and wellbeing initiatives for all staff.

PRIORITY 2:

Integration between and within the mental health, AOD, and suicide prevention sectors

Improved integration of mental health, AOD, and suicide prevention services is vital for individuals seeking support and their support networks. Further investment into multidisciplinary teams for case planning will help coordinate care, while clear communication protocols across sectors will improve service efficiency. An up-to-date map of service providers should be maintained to enhance visibility and support referral pathways. A whole-of-life approach can address gaps, especially for youth transitioning to adult mental health services, and strengthen early intervention for families.

Partnerships between hospitals and non-government organisations should be encouraged to increase understanding and capacity across all services, improve AOD harm minimisation approaches, and expand opportunities for co-location. Improved collaboration and coordination will better support people who are experiencing AOD and mental health troubles occurring at the same time. Regular sector forums can facilitate collaboration and ensure services remain responsive to emerging challenges, contributing to a more integrated and effective system, and helping to support warm handovers and shared care arrangements.

PRIORITY 3:

Prevention and early intervention

Preventing and addressing mental health challenges, problematic alcohol and drug use, and suicide early is critical. Increasing access to early distress support in the community will help to ensure that individuals receive help before their troubles escalate, improving long-term outcomes.

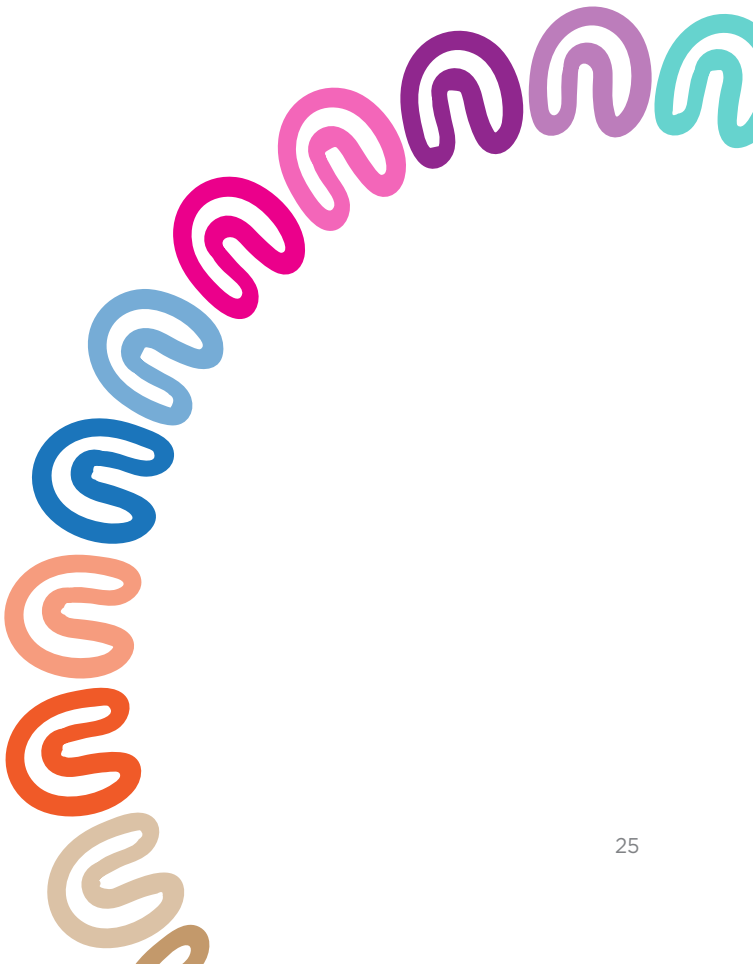
Barriers to support, such as stigma, can prevent individuals from seeking help. These barriers can present differently depending on cultural background and geographical location, and for mental health, substance use, and suicide. Community wellbeing initiatives, including educational campaigns and communication strategies, are essential to reduce stigma and promote mental health, AOD, and suicide awareness. These actions will contribute to a more supportive and proactive system.

PRIORITY 4:

Empowered communities leading coordinated service delivery

Empowering communities to lead coordinated service delivery requires active engagement with key stakeholders, including local councils and service providers and the Hospital and Health Service (HHS) in each community. Efforts need to shift the focus towards identifying and supporting effective First Nations and local community initiatives. Mapping existing community services to identify gaps will create a supportive environment for the development of codesigned, tailored plans for each community.

Engagement with partners in government departments is essential to ensure holistic support. Establishing youth advisory groups and involving them in codesign processes will help services meet the needs of young people. Accountability measures, developed with community input, should be implemented to ensure community services are effective, while improving interagency collaboration and streamlining funding will enhance service delivery. Finally, developing systems to capture and share learnings will support ongoing improvements and benefit future communities.



Mapping strategic priorities by region or regional priority alignment

	Priority 1: Workforce development and capacity	Priority 2: Integration between and within the mental health, AOD, and suicide prevention sectors	Priority 3: Prevention and early intervention	Priority 4: Empowered communities leading coordinated service delivery
Northern Queensland (whole region)	✓	✓		
Torres and Cape region		✓	✓	✓
Cairns and Hinterland region	✓	✓		
Townsville region		✓	✓	
Mackay region		✓		✓

Regional priorities and actions

The following priorities and actions reflect the highest priority areas and initial actions to be undertaken across northern Queensland or at the subregion. The Steering Committee determined these priorities and actions through facilitated workshops and defined these priorities and actions. Their decisions were based on a prioritisation matrix, incorporating both available data and community feedback gathered during consultations. A commitment to these priorities and actions is part of the JRWP.

The subregional priorities and actions are targeted and achievable first steps, presented in order of priority. They are designed to guide our focus, not to limit it. It is acknowledged that through national and state funding initiatives, policy changes, and other local actions, work that supports the priorities and needs will occur in parallel with focused action on the following priorities by the steering committee. An annual review of the progress against actions will provide the opportunity to scan and identify other activity that may link with this work and lead to important resetting of actions.

Northern Queensland

Workforce development and sector integration underpin progress on all our priorities, and thus will be the focus of our initial actions across the region.

PRIORITY:

Workforce development and capacity

Key initial actions:

- Work in partnership with the sector to understand workforce needs and develop shared approaches to building workforce capacity, including shared student placements and collaborative approaches.
- Partner with universities, further education organisations, and other active and interested stakeholders to build the workforce pipeline.

PRIORITY:

Integration of the mental health, AOD, and suicide prevention sectors

Key initial actions:

- Develop hospital and non-government partnerships through service co-location and collaboration.
- Work with the sector to determine approaches to improve system integration, (e.g. sector forums) and implement agreed actions.

Torres and Cape

The Torres and Cape region aims to strengthen connections across the area, with efforts focused on establishing and evolving this action over time.

PRIORITY:

Empowered communities leading coordinated service delivery

Key initial action:

- Support First Nations communities, including key stakeholders, in their decision-making processes to redesign mental health, AOD, and suicide prevention services, ensuring their input is recorded.

PRIORITY:

Prevention and early intervention

Key initial actions:

- Identify health promotion initiatives that have been demonstrated to be effective and impactful and support continued and amplified implementation.
- Establish stronger partnerships between HHS and other stakeholders working in communities to support health promotion resources and initiatives being delivered across the region
- Establishing an approach to easily share culturally appropriate existing health promotion resources and initiatives for awareness raising and learning purposes.

PRIORITY:

Integration of the mental health, AOD, and suicide prevention sectors

Key initial actions:

- Explore and develop after-hours access for mental health, AOD, and suicide prevention support.
- Strengthen and develop localised interagency collaborations with those who already work in the communities across the Torres and Cape regions. This will create an opportunity to further connect and strengthen communities with effective prevention and early intervention efforts.

Cairns and Hinterland

The Cairns and Hinterland region aims to target pressing resource needs, particularly in rural and remote areas, through workforce development and integration.

PRIORITY:

Integration of the mental health, AOD, and suicide prevention sectors

Key initial actions:

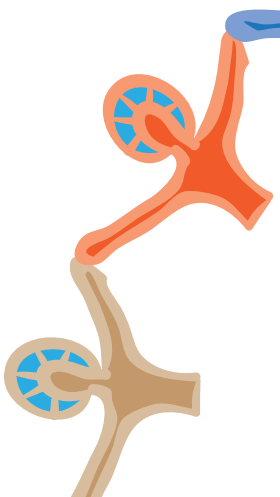
- Strengthen existing partnerships with primary health providers, non-government, and other government agencies to ensure there is a cohesive and coordinated understanding of service provision available to the community, limitations, and opportunities for future streamlined and collaborative consumer care.
- Develop much-needed after-hours access for mental health, AOD, and suicide prevention support.

PRIORITY:

Workforce development and capacity

Key initial actions:

- Develop a coordinated approach to understand the Cairns and Hinterland sector priorities and take a unified development approach towards training offerings in the region to build workforce skills and capability across clinical and nonclinical peer and lived experience workforce roles and with consideration of the needs of priority populations in our region.
- Work across and between sectors to build capacity through existing training options.
- Build skills in the AOD workforce, including the clinical and nonclinical peer and lived experience workforce, in recognition of the growing role of lived experience staff across the AOD sector.



Townsville

Through collaboration across the entire mental health, AOD, and suicide prevention sector, the Townsville region aims to develop integrated approaches to prevention and early intervention.

PRIORITY:

Integration of the mental health, AOD, and suicide prevention sectors

Key initial actions:

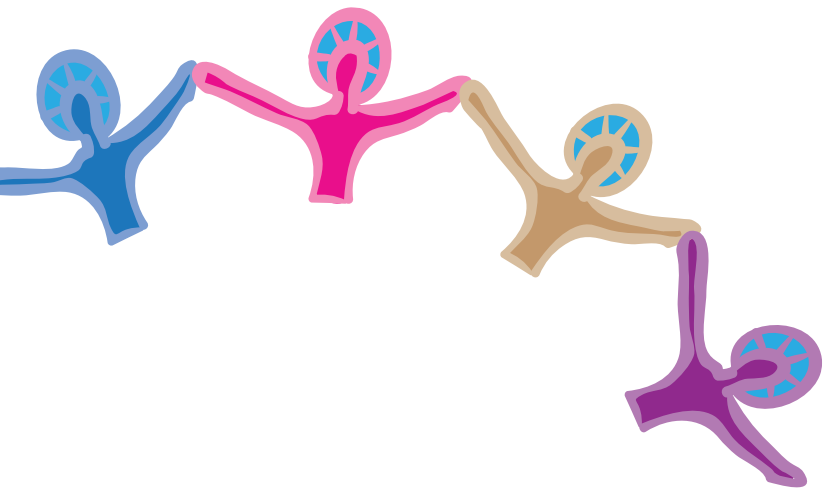
- Map the existing service system and concurrently chart a person's journey through that system when seeking or providing support. Integrate this service mapping with a comprehensive inventory of current training options available across the region.
- Partner to build shared professional development opportunities between the HHS, primary health, ACCHO, and non-government organisation workforce.

PRIORITY:

Prevention and early intervention

Key initial actions:

- Develop an education and harm reduction campaign focused on the AOD sector in partnership with AOD workforce, primary health, general practitioners, and other key stakeholders.
- Connect with existing youth advisory groups or establish a specific youth advisory group to provide guidance on prevention and early intervention efforts for the Townsville region.



Mackay

The Mackay region's key focus areas are suicide prevention and meeting needs of those living in rural communities. The identified priorities and actions aim to promote collaboration to address these critical issues for the region.

PRIORITY:

Integration of the mental health, AOD, and suicide prevention sector

Key initial action:

- Establish and strengthen multidisciplinary teams, including HHS, non-government, ACCHOs, and other key providers.

PRIORITY:

Empowered communities leading coordinated service delivery

Key initial actions:

- Identify community and grassroots initiatives that exist within the Mackay region and establish or build on relationships with these groups to support better utilisation of existing services.
- Identify support and training development opportunities for groups, work with groups to understand the landscape of other supports available, and identify the barriers that hold people back from engaging (e.g. men aged 40-60).
- Work with the sector to determine approaches to improve service integration and collaboration, (e.g. sector forums) and implement agreed actions, including grassroots initiatives.

Implementation

Implementing this plan across the vast and diverse region of northern Queensland requires a considered and flexible governance approach. The structure takes into account the complexity of the region and the important role of those with lived experience, as well as the essential contributions of various agencies and service providers. These range from specialists in mental health, AOD, and suicide prevention services to those addressing broader health and social issues.

Rather than creating new systems, the governance model seeks to strengthen and enhance the existing networks and partnerships already established in each region. It aims to build on the relationships formed during the development of this plan, ensuring continuity and collaboration throughout the implementation phase.

Although the activities and actions identified in the JRWP do not attract specific funding in isolation, strategic oversight and implementation of the plan is a requirement of the four partners under the Bilateral Agreement. Governance of the implementation will be enacted through the Steering Committee and subregional leadership. The existing Steering Committee and subregional leaders responsible for the plan's development will continue to ensure that the actions set for northern Queensland and its subregions are monitored and progressed.

To support the implementation of the subregional actions, each subregion will determine appropriate mechanisms to support and oversee implementation. Lived experience representation throughout implementation will leverage existing lived experience Advisory Group networks to build connections with the regions and connection to action outcomes.

The Better Health North Queensland Alliance will continue to provide executive oversight of the implementation of the plan.

This established body is committed to working effectively together to improve health outcomes and equity of access in northern Queensland, and has identified mental health, AOD, and suicide prevention as a key priority area. Better Health North Queensland fosters a collaborative approach to integration, workforce, access, and health service design.

This approach to implementation and governance will be reviewed annually and changes to the structure will respond to emerging needs to ensure the implementation of actions is supported.

How we measure progress

The priorities for this plan were identified through stakeholder consultation and analysis of evidence. This evidence base will also be used as a benchmark to allow us to measure our progress against the plan.

We will develop a set of reliable indicators that reflect community outcomes and service demand, utilisation, and unmet need, and produce a baseline report to document these at the commencement of the plan.

We will then conduct ongoing monitoring, evaluation, and analysis to inform and continue to improve the effectiveness of our actions. We will work to improve our data systems, including ways to collect data and quantify data consistently and share data across organisations in a timely manner.

Our region

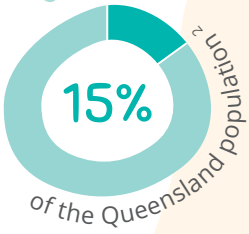
This section provides information about the context of our region, including data on the population and mental health, AOD, and suicide prevention needs of the region and its subregions. We provide a broad overview for northern Queensland (Figure 2), followed by sections dedicated to each subregion that include a demographic snapshot, data on existing services and service needs, and a summary of the results of our community consultations.

Figure 2:

Overview: Northern Queensland regional snapshot

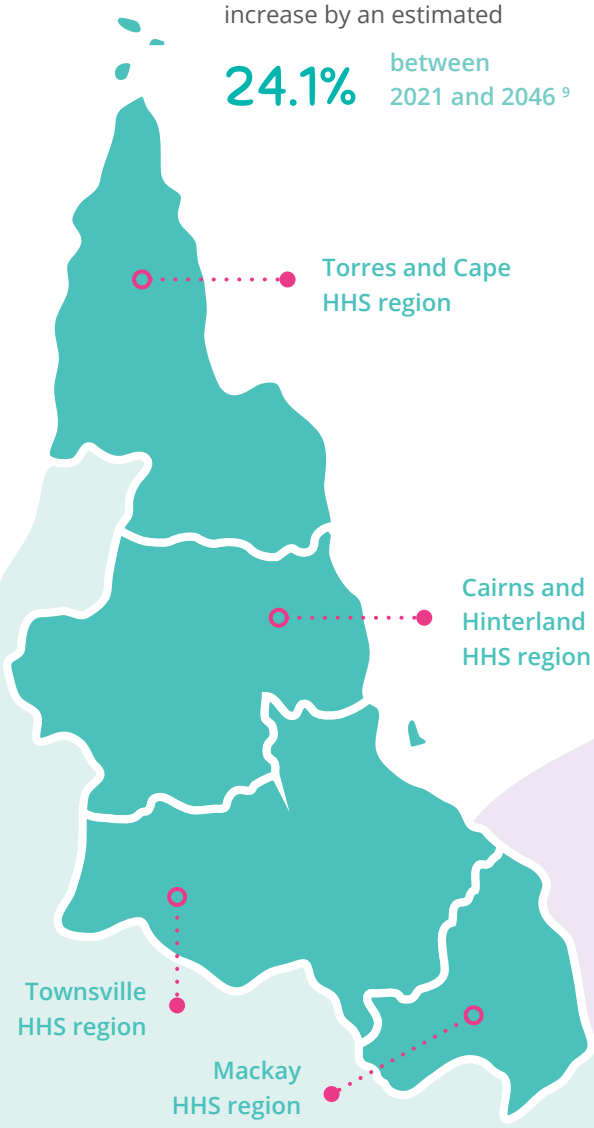
732,270

Northern Queensland population [2]



The region's population will increase by an estimated

24.1% between 2021 and 2046 [9]



The northern Queensland population is ageing across all regions except Torres and Cape

15.1% are aged 65+ [1]

22.7% are aged under 18 [1]

11.9% speak a language other than English at home [1]

11.4% are First Nations (2.5 times the Queensland average) [10]

700 / 100,000

Northern Queensland homelessness rate [1]

430 / 100,000

Queensland homelessness rate [1]

5,017 (estimated) people are experiencing homelessness [1]

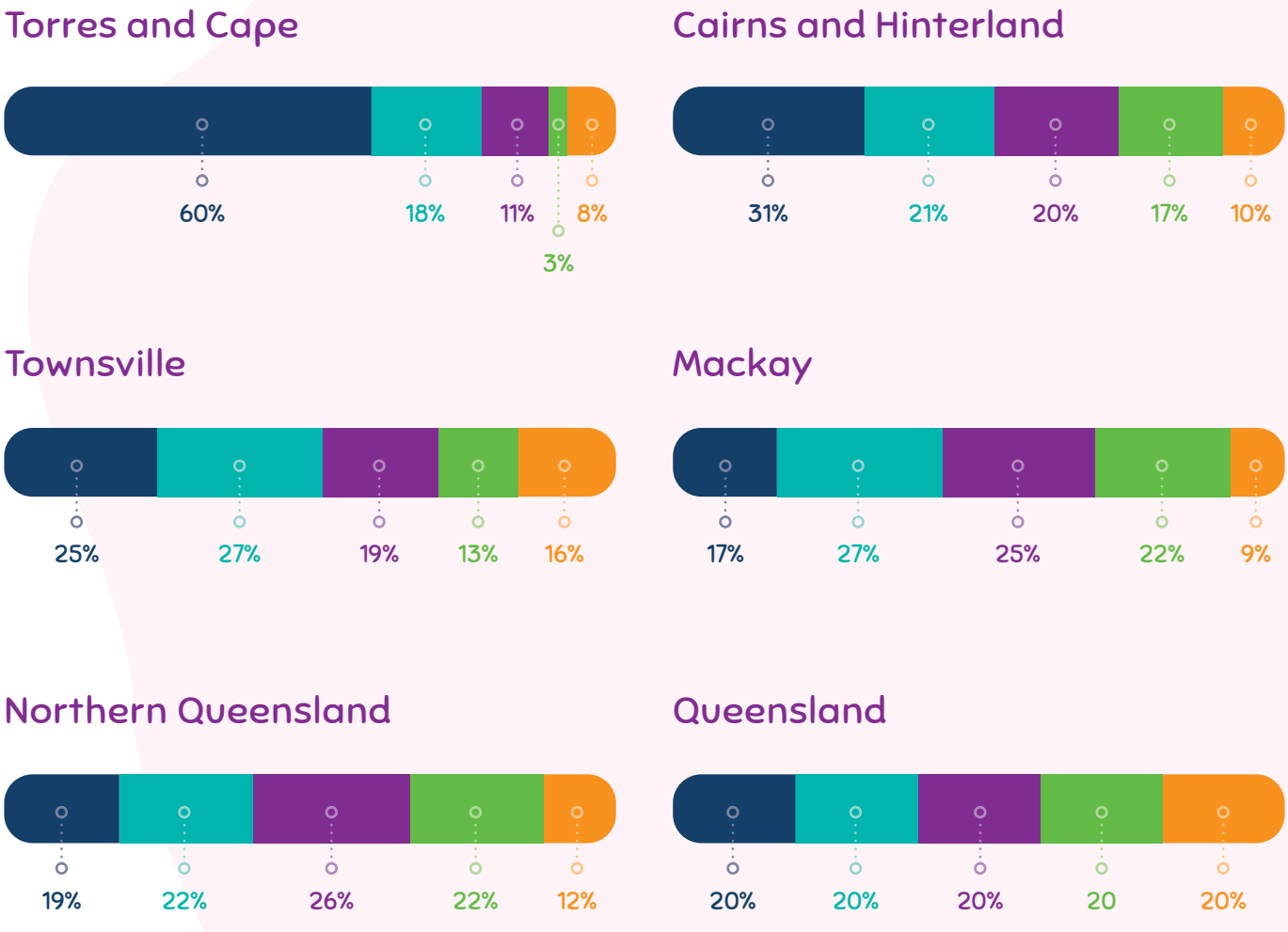
22.7% of all people experiencing homelessness in Queensland [1]

According to the Index of Relative Socioeconomic Disadvantage (IRSD), northern Queensland is more socioeconomically disadvantaged than the Queensland population as a whole (Figure 3).

The least disadvantaged region is Townsville.

The most disadvantaged region is Torres and Cape, with 60% of its population in the lowest IRSD quintile. [1]

Figure 3: IRSD by quintile in Northern Queensland regions compared with Queensland as a whole, 2021 [1]



Mental health

System context

The mental health service system is complex, with various access points and services catering to different levels of need. This complexity stems from the high prevalence of varying mental health issues, psychosocial stressors, and the involvement of both public and private stakeholders. Over the past decade, increasing demand has made the system harder to navigate. Queensland Health, through the HHSs, is the largest provider of public mental health care. These services primarily support individuals with acute or severe conditions and are often the first point of contact for those in distress, particularly for those without an established GP. They offer inpatient and community care, including short-term acute care and long-term management.

Primary mental health services, commissioned by Northern Queensland Primary Health Network (NQPHN) on behalf the Australian Government Department of Health, Disability and Ageing and Queensland Health, provide services along a stepped care continuum. These services, which are often tailored to local needs, aim to support vulnerable communities. These services also include specific programs including headspace, Medicare Mental Health Centres, and the Commonwealth Psychosocial Support services.

GPs are a key provider of mental health to the community, often having trusting long term relationship with their patients. GPs play a key role in mental health care, both by providing direct support to patients in relation to their wellbeing, including the provision of specific treatment as part of holistic health care. Additionally some GPs undertake additional training and provide focused psychological strategies under Medicare. In addition, GPs facilitate access to psychological therapies through Mental Health Care Plans which offer Medicare-subsidised sessions - free mental health services funded through NQPHN and other agencies and referral to other specialist services utilising Health Pathways.

Private psychological therapy services are available throughout the region, either in person or via telehealth for those who can afford to pay. For those with private health cover, this may be covered with a gap to be paid. Referrals from GPs are not required for these services.

Psychological therapy can also be accessed free of charge through the Department of Veterans Affairs (DVA) for current and ex-serving members, as well as through employee assistance programs.

Psychiatry services are available privately through GP referral, but the gap fee can make them unaffordable for many. Telehealth psychiatry offers a more affordable option, though access can still be limited by workforce availability.

In Cairns, Townsville, and Mackay, private mental health beds are available for those who need inpatient care but do not meet the criteria for state mental health services. These private mental health services, via private hospitals, often include day programs and are subsidised for eligible individuals through DVA or private health insurance.

The National Disability Insurance Scheme funds mental health supports for those with approved packages, including psychological therapy and psychosocial support.

A range of not-for-profit organisations offer mental health services for those with mild to moderate issues or distress from life challenges such as relationship or financial problems or for specific cohorts or issues.

These services are provided by a range of organisations, both small locally-based organisations through to national organisations. Across the system a range of ways to access services exist, from in person, telehealth, and virtual/ digital supports. These organisations are funded through a mix of grants, fundraising, and government support.

Mental health data

Population indicators

8.1%

of the population has a mental health condition (Queensland average: 9.6%) [14]

30.0%

of the population had five or more mentally unhealthy days in the last month (Queensland average: 33.0%)[14]

Health system indicators

Mental health-related emergency department (MHED) presentations

increased by 51%

between 2016 and 2024 (Figure 4) [12]

The overall volume of people admitted has increased, but the

% of presentations admitted has decreased [12]

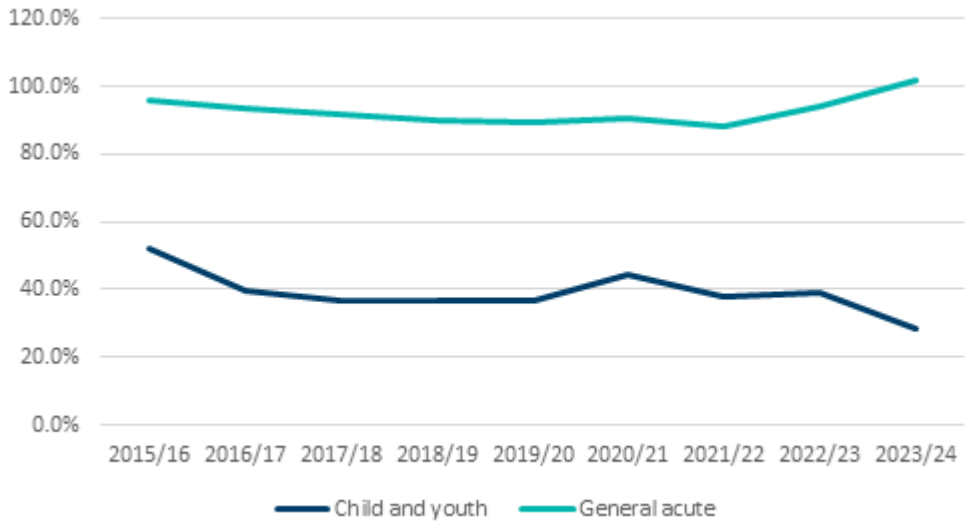
Figure 4: MHED presentations per 100,000 population, 2015–16 to 2023–24 [12]

Near 100%

acute bed occupancy is for general acute.

Capacity for child and youth occupants is declining (Figure 5) [13]

Figure 5: Acute occupancy by service type, northern Queensland [13]



The demand for mental health services is

projected to increase

(Figure 6) [7]

Figure 6: National Mental Health Service Planning Framework projected demand for mental health services in Northern Queensland, 2024–25 and 2029–30 [7]

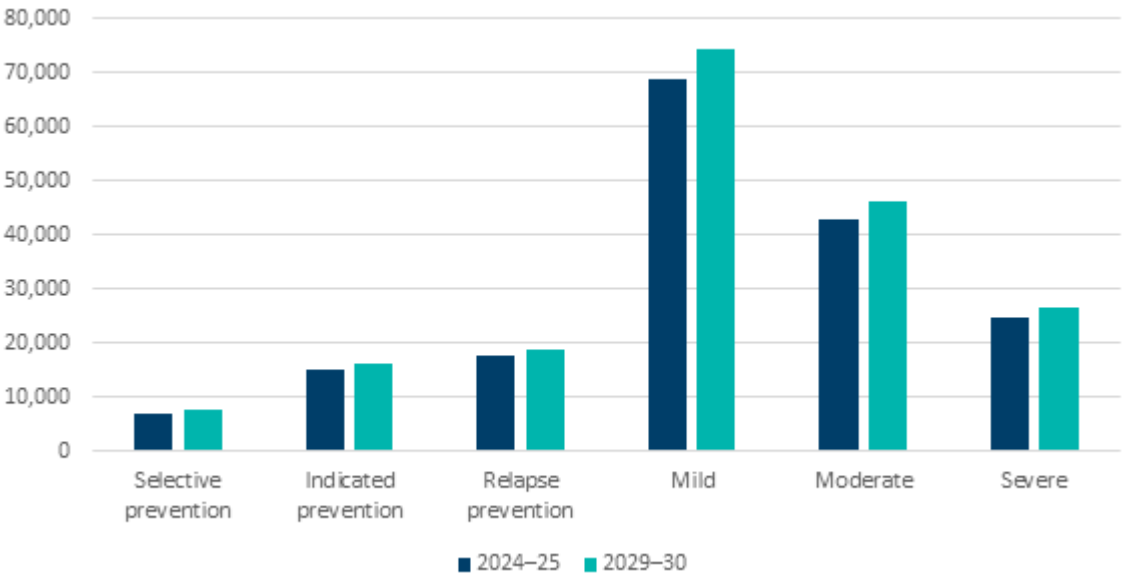


Figure 6 notes:

- **Selective prevention:** Children of parents with mental illness in need of contact with mental health services due to their elevated risk of mental health problems.
- **Indicated prevention:** People experiencing symptoms of mental illness or indicators of distress that do not meet the threshold for a formal mental illness diagnosis, but who may require intervention to prevent progression to a formal diagnosis and to manage distress.
- **Relapse prevention:** People who have a lifetime history of mental illness but do not currently have a 12-month diagnosis of mental illness. These people may require ongoing treatment and support to remain well.
- **Mild:** People with a diagnosed mental illness that has a low impact on their day-to day-lives (it does not strongly affect their ability to attend school or work and maintain healthy relationships).
- **Moderate:** People with a diagnosed mental illness that has a moderate impact on their day-to-day lives. They may experience problems with psychosocial functioning that impede their ability to attend school or work, carry out household responsibilities, or maintain healthy relationships.
- **Severe:** People with a diagnosed mental illness that has a high impact on their day-to-day lives. They have severe, persistent mental illness, or episodic mental illness and many experience significant social and environmental stressors.

The volume of community points of service for mental health care has decreased across the region and the existing workforce is stretched thin. There is a shortfall in peer workers across the continuum of care, but it is hard to measure this outside of the HHS.

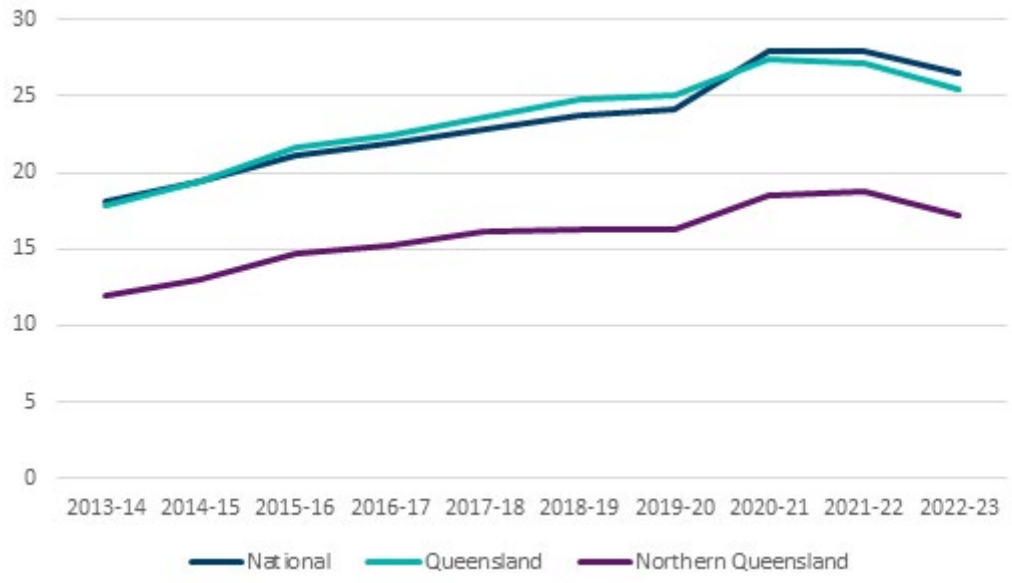
Our preliminary analyses have found significant gaps between current workforce capacity and the projected demand for psychiatrists, nurses, occupational therapists, psychologists, and social workers.

Medicare Benefits Scheme allied mental health services have

increased by 44%

(Figure 7); data indicates the population is still underserviced. [4]

Figure 7: Medicare Benefits Scheme allied mental health services provided in northern Queensland, Queensland and Australia overall per 100 population, 2013–14 to 2022–23 [4]



Suicide prevention

System context

Suicide in the broad context is influenced by a complex interplay of factors beyond mental illness. While certain mental health conditions can increase suicide risk, recent data indicate that a significant number of individuals who die by suicide, have thoughts of suicide, or attempt suicide, do not have a known mental health condition.

In 2023, Queensland reported 782 suspected suicide deaths, yielding a standardised suicide mortality rate of 14.1 per 100,000 persons[5]. Notably, males accounted for approximately 76 per cent of these deaths[5]. Additionally, 97.8 per cent of individuals who died by suicide during this period experienced at least one recent adverse life event, such as relationship issues, employment challenges, or financial stress.

This highlights that socioeconomic and environmental factors can significantly influence an individual's vulnerability to suicidal thoughts and behaviours. These factors According to Suicide Prevention Australia (2023), socio-economic and environmental factors include:

- bullying and harassment
- chronic pain and health conditions
- contact with the justice system
- damage to cultural continuity/connection
- discrimination and stigma
- domestic, family, and sexual violence
- educational disruption
- employment distress
- environmental degradation
- family and other relationship dysfunction
- financial distress
- food insecurity
- harms of alcohol and other drugs
- harms of gambling
- housing insecurity and homelessness
- impacts of adverse childhood experiences
- impacts of environmental disasters
- impacts of the changing climate
- impacts of traumatic events
- intergenerational/transgenerational trauma
- isolation
- loneliness.

In response to these multifaceted factors, a range of suicide prevention programs and initiatives exist across the region, such as efforts from Queensland Health, Cultura Care Connect, and suicide prevention community networks for Torres and Cape, Cairns, Townsville, Mackay, and Whitsundays regions.

In northern Queensland, services are delivered across a continuum of psychosocial support to respond to those experiencing suicidal distress. This includes tertiary mental health services, universal aftercare services, and StandBy postvention support. Central to these initiatives is recognition of the contributing factors listed above and the LifeSpan framework, an evidence-based approach developed by the Black Dog Institute[8].

LifeSpan offers a comprehensive systems approach to suicide prevention, integrating nine strategies that involve multiple sectors and communities. By addressing both individual and systemic factors, LifeSpan provides a holistic, community-led model for preventing suicide and supporting at-risk individuals.

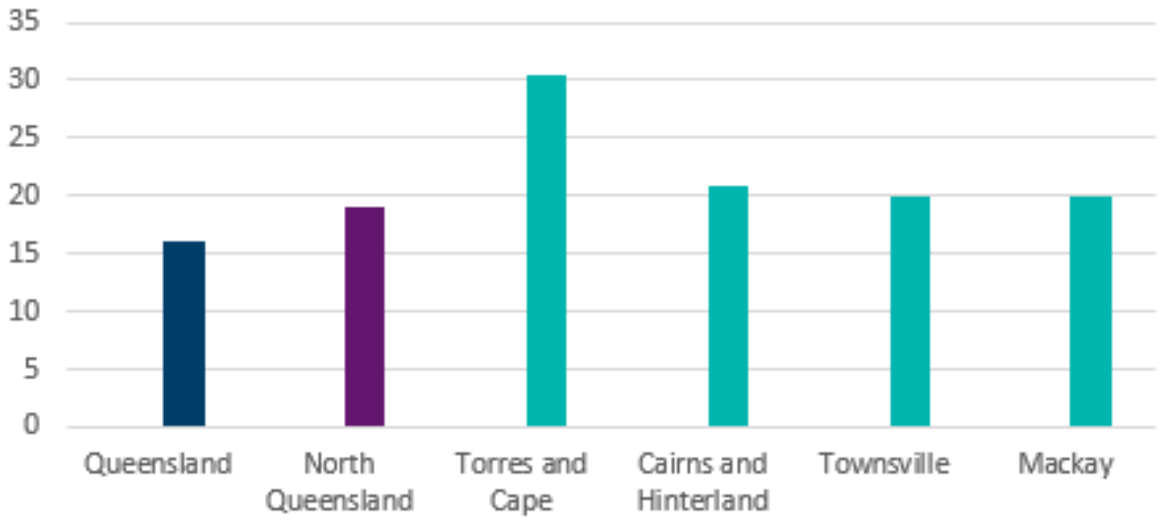
In the Cairns and Hinterland region, Distress Brief Support (a new in approach for suicide prevention in Australia) is looking at an upstream approach focused on identifying and connecting with local supports people are already engaging with. It will provide people in distress with up to three weeks of individualised support focused on their specific need.

Suicide data

The number of suspected suicide-related deaths in
all regions of northern Queensland
in 2019–21 **was higher than the rate for Queensland** overall (Figure 8) [5]

Suspected suicides per 100,000 were
lowest in Mackay and highest in Torres and Cape [5]

Figure 8: Suspected suicide-related deaths by region, 2018–2020 (rate per 100,000) [5]



Alcohol and other drugs

System context

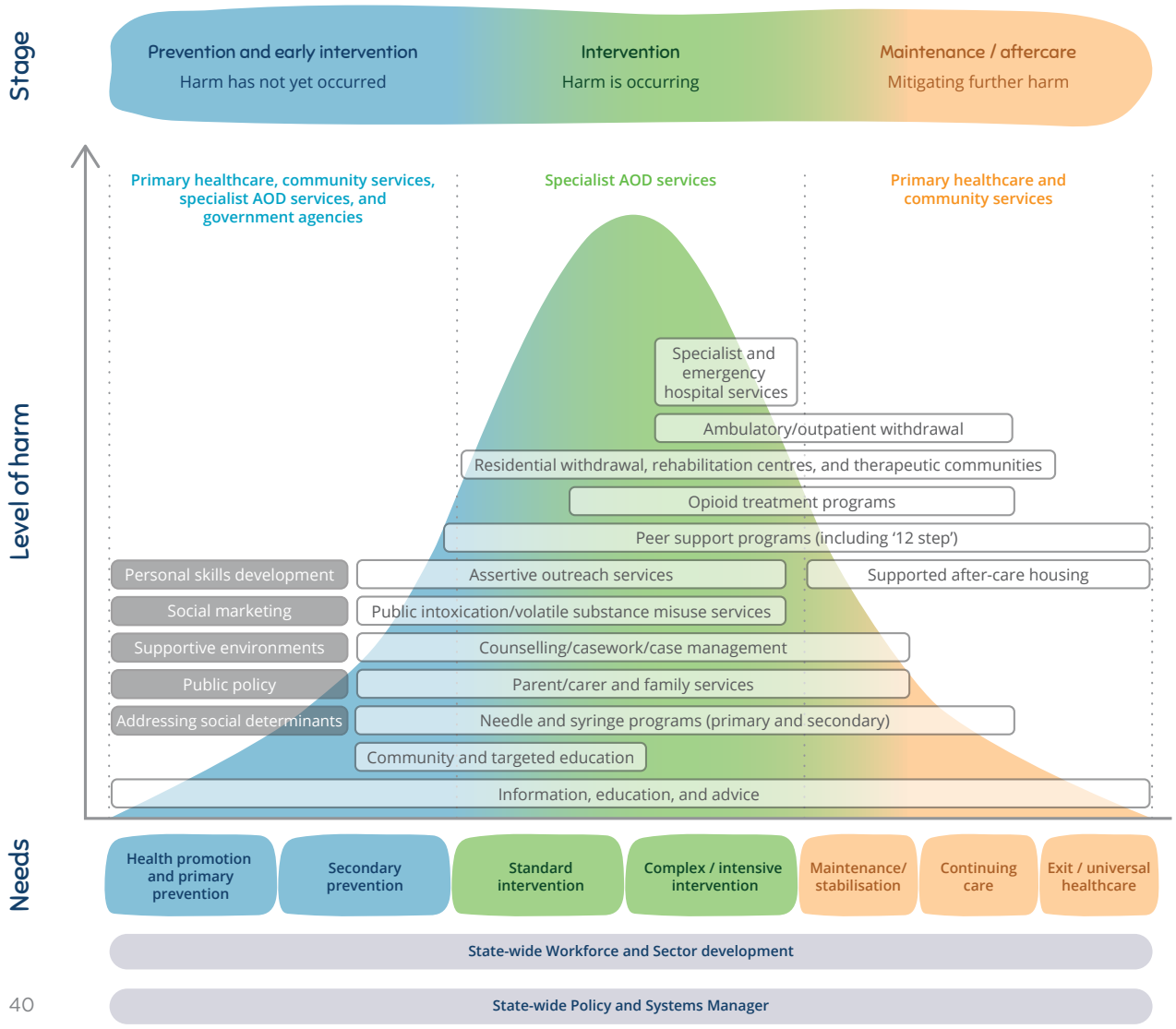
The Queensland AOD Service Delivery Framework provides the foundation for the approach to AOD support, guiding the range of responses to AOD-related issues. This framework reflects the situation at the time the plan was developed, and it is important to acknowledge that service availability can differ from one community to another and will evolve over time.

In northern Queensland, formal AOD services are delivered by a range of nongovernment organisations and HHS providers. It is important to note that primary health providers, general practitioners, and a range of nongovernment organisations and HHS providers working across mental health and suicide prevention will also provide important AOD intervention and support to individuals.

Queensland's approach to AOD support focuses on harm reduction, aiming to minimise the negative effects of substance use. Recognising that AOD use is a part of society and exists along a spectrum, this approach takes into account the wide range of harms that can result. By addressing these harms through tailored strategies, the goal is to reduce the health, social, and economic impacts on individuals and communities. This focus has proven effective in improving outcomes and reducing the broader consequences of substance use.

AOD treatment is far from one-size-fits-all. It comes in many forms, is delivered across different settings, and varies in intensity. Together, these services make up a comprehensive and diverse treatment system. This system spans everything from primary health care and early intervention to acute care, community-based support, and longer-term rehabilitation services (Figure 9).

Figure 9: Spectrum of AOD responses



AOD data

Population indicators

24.6%

of the population has recently used an illicit drug (Queensland average: 18.4%) [6]

42.0%

of the population drink in ways that increase the risk of alcohol-related disease or injury (Queensland average: 36.0%) [5]

14.0%

of the population are daily smokers (Queensland average: 10.5%) [14]

Smoking rates have

decreased significantly

over the last five years

Health system indicators

Demand for AOD treatment is

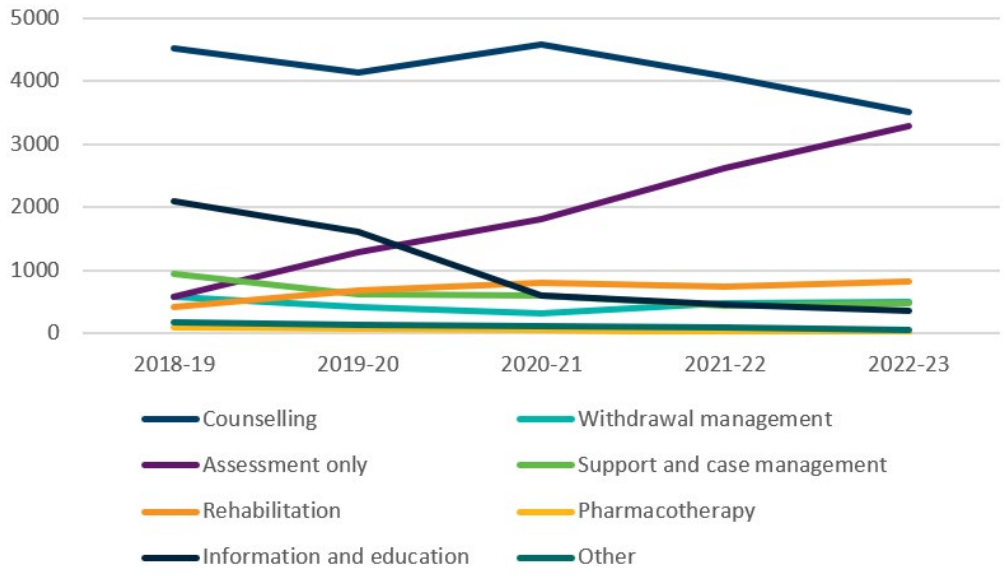
projected to increase

Total AOD treatment episodes have

remained stable,

though there have been relative changes in treatment type over time (Figure 10) [3]

Figure 10: Closed AOD treatment episodes by treatment type across northern Queensland [3]



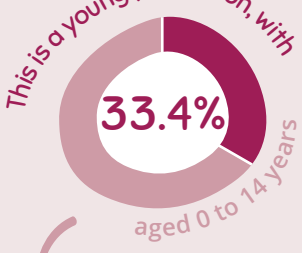
First Nations communities

Demographics

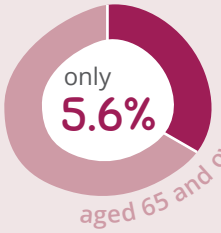
At the time of the 2021 Census, there were

75,467 people

in northern Queensland who **identified as Aboriginal and/or Torres Strait Islander** [10]



(compared to **17.6%** of non-Indigenous population)

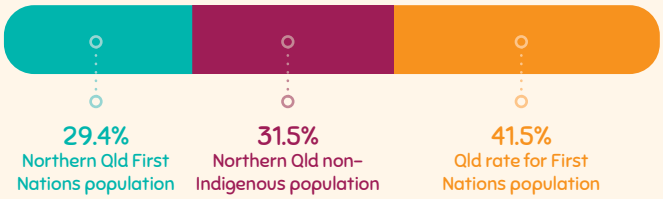


(compared to **17.8%** of non-Indigenous population) [10]

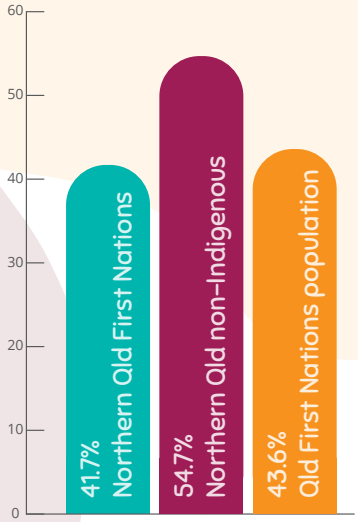
The Census yielded the following population health insights around First Nations communities in northern Queensland:

Rates of mental ill health

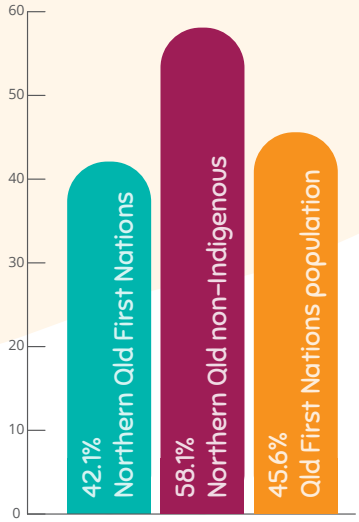
Rates of mental ill health are similar to northern Queensland non-Indigenous people but lower than the overall Queensland rates for First Nations peoples, though this may be due to under-reporting [10]



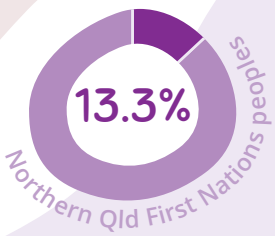
Completion of year 12 [10]

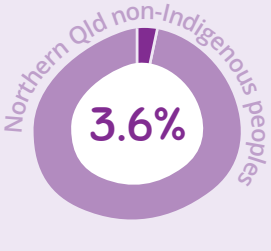


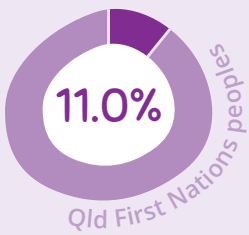
Post-school qualifications [10]



Unemployment rate for people aged 25 to 64 years [10]







Household incomes are also lower.

Housing is an issue among First Nations communities in northern Queensland.

Approximately 1 in every 4

First Nations people in the region is living in an overcrowded dwelling

Compared to:

18.8% (Qld First Nations population)

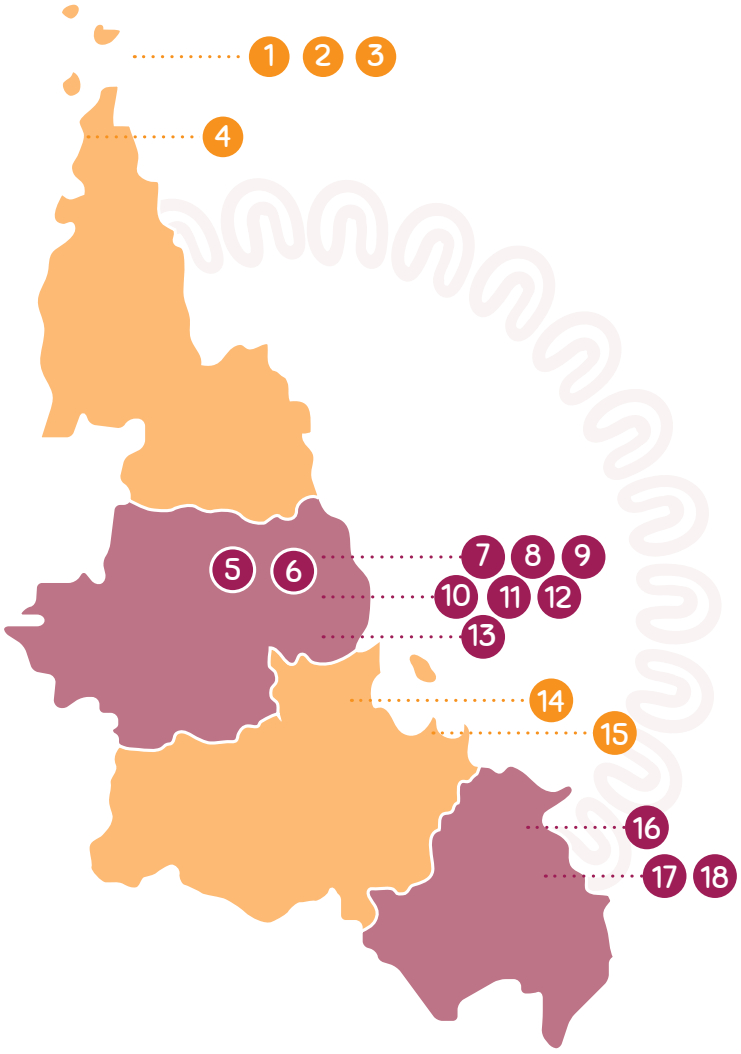
5.0% (Northern Qld non-Indigenous population) [10]

Service Delivery context

Across northern Queensland, Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Medical Services (AMSs), and Aboriginal Community Controlled Organisations (ACCOs) deliver significant culturally governed mental health, AOD, and suicide prevention services to the First Nations communities, funded through a range of Commonwealth and State government departments to deliver a range of programs. In addition, First Nations organisations, and organisations with strong First Nations leadership and governance, exist that deliver specialist or place-based services and supports.

Figure 11 shows the distribution of ACCHOs and AMSs across the Northern Queensland PHN region.

Figure 11: First Nations health organisations (ACCHOs/AMS/ATSICCHO/ACCO/ATSICCO) in the Northern Queensland PHN region



	Organisation	Classification
1	Mura Kosker Sorority Inc	ICCO
2	Torres Health Indigenous Corporation	ATSICCHO
3	Wakai Waian Healing	Specialist Aboriginal & Torres Strait Islander Psychology and Counselling service
4	NPA Family and Community Services Aboriginal & Torres Strait Islander Corporation	ACCHO
5	Mulungu Aboriginal Corporation Primary Health Care Service	ACCHO
6	Ngoonbi Community Indigenous Corporation	ICCO
7*	Apunipima Cape York Health Council Limited	ACCHO
8	Mookai Rosie Bi Bayan Aboriginal Corporation	ACCHO*
9	Wuchopperen Health Service	ACCHO
10	Gindaja Treatment and Healing Centre	ICCO
11	Gurriny Yealamucka Health Service Aboriginal Corporation	ACCHO
12	Ngak Min Health	General practice
13	Mamu Health Service Limited	ACCHO
14	Palm Island Community Company–Bwolgoman Primary Health Care Services	ACCHO
15	Townsville Aboriginal and Islander Health Services	ACCHO
16	Girudala Community Co-Operative Society Ltd	ACCHO
17	Aboriginal & Torres Strait Islander Community Health Services–Mackay	ACCHO
18	Mudth–Niyleta Aboriginal and Torres Strait Islander Corporation	ACCHO

** The map depicts the head office only.*
** Not currently registered as an ACCHO with NACCHO.*

Social and emotional wellbeing

As part of the consultation process for this plan, stakeholders from various First Nations communities highlighted the importance of referring to the concept of social and emotional wellbeing (SEWB) to start to understand how this worldview influences First Nations peoples.

At its core, SEWB[16] is the foundation for both mental and physical health in Aboriginal and Torres Strait Islander communities. It is a holistic view that considers the relationships that individuals have with their family, kin, community, and beyond. It also recognises how deeply the connection to land, culture, spirituality, and ancestry impacts overall wellbeing.

The SEWB model identifies seven key domains of wellbeing. These domains, which overlap and interconnect, are seen as central to a person's sense of health and connectedness (Figure 12).

However, SEWB is understood and applied in different ways by Aboriginal and Torres Strait Islander people. It is shaped by unique cultural, social, and individual experiences, and this can vary from one community to another.

It is important to remember that SEWB issues are distinct from mental illness. While there might be similarities, the challenges people face in terms of SEWB can differ in severity, duration, and whether they meet the criteria for a diagnosable condition. Someone may need support in SEWB, mental health, or a combination of both, depending on their individual needs.

In northern Queensland, SEWB services are funded by State and Commonwealth departments and delivered by ACCHOs, AMSs, First Nations organisations, and Queensland Health.

Figure 12: Social and emotional wellbeing from an Aboriginal and Torres Strait Islanders perspective [16]

Australian Defence Force members, veterans, and their families

Demographics

Northern Queensland, particularly Townsville and Cairns, has a high concentration of Defence personnel, including both current service members and veterans (Table 2).

Table 2: Regional Defence force members, 2021[1]

Region	Currently serving in regular or reserve	Has previously served
Cairns and Hinterland	1,247	7,321
Mackay	138	4,035
Torres and Cape	145	574
Townsville	5,567	9,952
Total	7,097	21,883

Wellbeing

The unique circumstances of service can expose veterans to a range of poorer health outcomes after their military service is complete, including poorer mental health. As of 2021, 18.1 per cent of Australia's population who have previously served in regular service in the Australian Defence Force (ADF) reported living with a long-term mental health condition. This is 1.7 times the rate for the population who have never served in the ADF (10.7 per cent). In northern Queensland, it is estimated that 21.8 per cent of the population who have previously served in the ADF are living with a long-term mental health condition, which is higher than the national rate among veterans (Table 3).

Table 3: Percentage of the population living with a mental health condition by veteran status, 2021[1]

Region	Previously served in ADF	Has never served in ADF	Rate ratio
Northern Queensland	21.8%	10.7%	2.04
National	18.1%	10.4%	1.69

Veterans face a significantly higher risk of suicide compared to those still serving. National suicide monitoring of ex-service personnel by the Australian Institute of Health and Welfare indicates that ex-service personnel have an increased risk of suicide compared to the general population[15]. Increased risk is not consistent across all subpopulations of ex-service personnel, with younger age groups and personnel who separate from the ADF involuntarily due to either medical reasons or retention not in service interest experiencing an elevated risk of suicide (Table 3)[15]. While specific analysis is not available for the veteran population in northern Queensland, the large volume of ex-service personnel living within the region is likely to reflect national figures.

The transition from active service is a critical period, with gaps in support potentially contributing to poor mental health and an increased suicide risk. Additionally, the lack of comprehensive data on ex-serving veterans makes it difficult to implement targeted suicide prevention strategies. However, recent initiatives, such as updates to the 2021 Census and evaluations of suicide prevention programs, present an opportunity to improve both data collection and support for this group.

Table 4: Rates of suicide per 100,000 population per year, 1 January 2003 to 31 December 2022 [15]

Service status	Male rate of suicide	Female rate of suicide
Voluntary separation	22.0	15.9*
Involuntary medical separation	62.7	36.3*
Involuntary retention not in service interest separation	52.9	0
Other involuntary separation	23.9	18.0*
Contractual/ administrative changes separation	15.5	0

Torres and Cape

Context and data highlights

Torres and Cape is the **most sparsely populated of all NQPHN regions**, accounting for only five per cent of the northern Queensland population, spread over a **geographical footprint of 130,238km²**. The population is projected to grow slowly over the next 10 years. A majority **(51.4 per cent) of the residents are First Nations people**, more than 10 times the state average, and **41.2 per cent speak a language other than English at home**, nearly three times the state average[10]. The population is younger than the other NQPHN region populations.

Despite high levels of socioeconomic disadvantage and very low numbers of allied mental health services, Torres and Cape **residents report having fewer mentally unhealthy days than the Queensland average** (possibly due to under-reporting). However, the **number of suspected suicide-related deaths per 100,000 in 2018-20 was 30.4**, almost double the Queensland average[5].

Although census data for many of the communities in the Torres and Cape region are not entirely accurate due to transient nature of the population, the alcohol and other drug (AOD) indicators in this region are well reported to be above the Queensland average, with **21.0 per cent of the population being daily smokers** and **52.0 per cent drinking in ways that increase the risk of alcohol-related disease or injury**[14].

Aboriginal and Torres Strait Islander people in remote regions like northern Queensland and the Torres Strait face significant challenges in accessing mental health support. Consistent with other regions, these remote locations also suffer from workforce shortages, long wait times, and limited access to care due to isolation and inadequate infrastructure.

It is recognised that **cultural stigma can be a barrier to people seeking help with mental health, AOD, or suicide prevention concerns**. Mainstream services at times lack cultural understanding, leading to distrust. Mental health issues are also sometimes viewed through a cultural lens that does not align with mainstream services. This can lead to reluctance in engaging with formal support systems.

Social issues like overcrowded housing and economic hardship further impact mental health. These combined challenges make it difficult for these communities to access timely, effective support.

Regional snapshot

Population

- The **Torres and Cape population** is **33,463** [2]
- The population is **estimated to grow by 5.4%** from 2021-46 (Queensland: 39.9%)[9]

Demographics

- **50.9%** of the population is **male**, **49.1% female**[2]
- **41.2% speak a language other than English** at home (Queensland: 14.4%) [1]
- **11.0%** are **aged 65 and older** (Queensland: 17.0%) [1]
- **28.0%** are **aged under 18** (Queensland: 22.2%) [1]
- **51.4%** are **First Nations** (Queensland: 4.6%) [1]

First Nations communities

- **32.1%** of First Nations people in Torres and Cape are **aged 0–14 years**; **6%** are **aged 65 and over** [10]
- The **rate of mental ill health** is **9.7%** (Northern Queensland First Nations population: 29.4%; Torres and Cape non-Indigenous population: 24.8%) [10]
- **39.7%** of the First Nations population have **completed Year 12** (Northern Queensland: 41.7%; Torres and Cape non-Indigenous: 57.7%) [10]
- **44.7%** of people have **post-school qualifications** (Northern Queensland: 42.1%; Torres and Cape non-Indigenous: 68.9%) [10]
- The **unemployment rate** for First Nations people **aged 25–64** is **14.9%** (Northern Queensland:13.3%; Torres and Cape non-Indigenous: 2.1%) [10]
- The proportion of First Nations people **living in overcrowded dwellings** is **39.4%** (Northern Queensland: 27.7%; non-Indigenous: 9.4%) [10]

Homelessness

- The **estimated homelessness rate** is **617 per 100,000** (Northern Queensland rate: 700 per 100,000)[1]
- An estimated **2,396 people are experiencing homelessness** (10.7% of all people experiencing homelessness in northern Queensland) [1]

Socioeconomic disadvantage

- **60.0%** of the population **lives in an IRSD Quintile 1 area** (most disadvantaged) [1]
- **3.0%** of the population **lives in Quintile 4 and 8.0% in Quintile 5** (least disadvantaged) [1]

Mental health services

Mental health data

- In 2021, **25.0%** of the Torres and Cape population **reported having had five or more mentally unhealthy days** in the last month (Queensland average: 33.0%) [14]
- Between 2024-5 and 2029-30, National Mental Health Service Planning Framework (NMHSPF) **demand for severe mental illness is projected to grow 10.4%** (10.1% for mild; 10.0% for moderate) [7]
- The **number of MHED presentations** per 100,000 in 2023-24 was **2,619** [12]
- **MHED presentations increased** by **11.2%** between 2018-19 and 2023-24 (admitted cases increased by 23.3%; **non-admitted cases increased** by **8.1%**) [12]
- In 2024, there were **4.6 allied mental health services per 100** population (Queensland rate: 25.4) [4]

What we heard: Mental health

**The following narrative descriptions have been derived from community consultation perspectives and lived experience voices. Please note that this has not been quantified through data sources.*

The consultation process identified key strengths, challenges, and focus areas for improvement in mental health services in the Torres and Cape region. The following summary of the strengths and challenges for the Torres and Cape region relating to mental health should not be seen as a reflection of the entire Torres and Cape regions' health systems. It is based on the specific issues raised during the consultation and further discussed in subsequent consultations. This has not been quantified through data sources.

Strengths

Through consultation we heard the region's particular areas of strength in mental health support are:

- community resilience
- a dedicated workforce at the community centre
- active Hospital and Health Service (HHS) outreach
- a supportive hospital environment
- positive police relationships
- grassroots initiatives that are a response to the community wanting to make a difference.

> "WHEN I FEEL HEARD I AM MORE LIKELY TO HAVE A SECOND INTERACTION, EVEN IF MY PROBLEMS ARE NOT SORTED OUT."
>
> *Lived experience workshop participant*

Challenges and areas for improvement

Consultation highlighted regional challenges for mental health services include:

- variable support options available across Torres and Cape communities, including:
  - community lead initiatives
  - GP availability
  - lack of dedicated mental health spaces
  - postvention support after suicide deaths
- increased pressure placed on local services during peak tourist season times in some communities
- overly complex referral pathways and inconsistent referral processes that make it hard to access specialist care, especially for vulnerable groups
- poor communication and coordination between health services, nongovernment organisations and other providers
- staffing challenges, including excess workload, accommodation shortages that lead to recruitment and retention difficulties, high staff turnover, and burnout
- follow-on effects from high turnover, including induction fatigue (negative impacts on existing staff from continually introducing new staff to the community) and difficulty building long-term connections between service providers and the community
- societal barriers and social determinants of health
- cultural barriers and stigma, especially within First Nations communities, that prevent many from seeking help
- the housing crisis
- food insecurity (particularly during the wet season)
- drug and alcohol accessibility
- gambling, financial stress, and social isolation.

There are also several specific populations that need tailored support, especially older adults, First Nations peoples, disengaged men, and young people.

In consultation, the following were identified as important to addressing the region's mental health needs:

- improved service coordination
- increased workforce capacity
- initiatives to tackle social determinants of health and reduce stigma
- expanded services
- targeted interventions for specific populations.

> "A LIVED EXPERIENCE NAVIGATOR WILL BE ABLE TO CHECK IN AND SEE HOW A PROVIDER WENT, IF IT'S A GOOD FIT ETC."
>
> *Lived experience workshop participant*

Suicide prevention

Suicide data

- There were **30.4 suspected suicide-related deaths per 100,000** in the Torres and Cape region in 2018-20 (Queensland: 16.0) [5]

What we heard: Suicide prevention

Current progress and initiatives

The Torres and Cape region has made strides to improve suicide prevention in recent years. Local services have demonstrated the ability to provide tailored support, and a number of grassroots programs have emerged, playing a crucial role in reducing stigma, and encouraging open discussions about mental health and suicide.

Recent suicide prevention initiatives include:

- development of a culturally appropriate suicide prevention program for First Nations communities by the Coen Regional Aboriginal Corporation, supported by the Queensland Mental Health Commission
- establishment of a community-led and community-funded First Nations healing centre
- launch of a comprehensive suicide response and stigma reduction campaign to promote mental health and wellbeing.

"WHAT MATTERS MOST IS THAT THEY HAVE A WELCOMING ENVIRONMENT THAT FEELS GENUINE AND WARM."

Lived experience workshop participant

Challenges and areas for improvement

A consistent theme heard through consultation was the delayed access to crucial support as a result of the complexity and inefficiency of referral pathways to specialist care in the Torres and Cape region. This was a specific concern for vulnerable populations. The long wait times for GPs in some communities can also delay access to essential medication and ongoing care.

Feedback spoke to the insufficiency of vital postvention services, intensifying grief and trauma for those affected by suicide. Negative experiences with referrals and service coordination was reported to erode trust in the system, leading to reluctance to seek professional help and greater reliance on informal support networks.

Alcohol and other drugs

AOD data

- **21.0%** of the population are **daily smokers** (Queensland average: 10.5%) [14]
- **52.0%** of the population **drink in ways that increase the risk of alcohol-related disease or injury** (Queensland average: 36.0%) [6]

What we heard: AOD services

Strengths

Consultation themes highlighted a number of strengths in the Torres and Cape region's existing AOD services including:

- a person-centred approach that tailors support to individual needs and delivers services in appropriate settings
- strong leadership that facilitates effective workforce management, fostering cohesive teams and improving service quality
- high-level coordination of comprehensive services through the HHS to address mental health, substance abuse, and related concerns, ensuring holistic support and improved wellbeing.

Challenges and areas for improvement

Consultations noted the complex referral pathways for specialist care and long GP wait times in this region pose a challenge for AOD services. These poor referral experiences can lead providers to overextend themselves by going beyond the scope of their role to support someone rather than referring the person again. These negative referral experiences can create systemic trust issues, and rebuilding this trust is a slow process.

High rates of burnout contribute to high turnover, with an average two-year work span reported through consultation across the region. At the leadership level, frequent staffing changes can negatively affect staff morale. High staff turnover also reduces organisational stability and can erode hard-won community trust.

Workforce shortages in this area, coupled with high levels of drug accessibility within the community, make supporting staff placements difficult.

The consultation highlighted the growing need to address rising alcohol and drug problems and trauma among young people.

"FOR ME, GOOD SUPPORT LOOKS LIKE STAFF HAVING THE TIME TO CHAT WITH SOMEONE TO GET AN IDEA OF WHAT IS HAPPENING FOR THAT PERSON BEFORE GIVING RECOMMENDATIONS."

Lived experience workshop participant

Cairns and Hinterland

Context and data highlights

Cairns and Hinterland has the **highest population of all NQPHN regions**, accounting for **36.2 per cent of the northern Queensland population**. First Nations peoples make up 10.6 per cent of the population, almost double the Queensland average. The region **covers a distance of 142,000km²** and includes a range of rural and remote communities.

Mental health indicators and service demand indicate a need for more support in the region. In 2021, the proportion of residents reporting **five or more mentally unhealthy days in the last month was 42.0 per cent**, well above the Queensland average[14]. The **number of MHED presentations per 100,000 in 2023-24 was 3,434**, by far the highest of the NQPHN regions, and the **number of non-admitted cases increased by 39.3 per cent** between 2018-19 and 2023-24[12].

Cairns and Hinterland has slightly elevated alcohol and other drug (AOD) indicators compared to the Queensland average, with **42.0 per cent of the population drinking in ways that increase the risk of alcohol-related disease or injury** and **13.0 per cent of the population smoking daily** [6]. The region has the **highest homelessness rate** of all NQPHN regions, at 900 per 100,000, and a **homeless population that accounts for 42.7 per cent of all homeless people in northern Queensland** [1].

Aboriginal and Torres Strait Islander people of the Torres and Cape and Cairns and Hinterland HHS regions engage in regular cultural and geographical movement between and across communities. This movement is central to their identity, community connections, and traditional practices. At times this movement is due to other reasons including movement for health care, education, and employment, and can in itself have an individual and community impact. The **mental health, AOD, and suicide prevention supports need to adapt to this mobility, ensuring that services are not only accessible but also responsive** to the unique needs of these communities.

For supports and care to be effective, they must recognise the importance of continuity across regions while embracing cultural safety and responsiveness. Support services need to be designed to follow individuals as they move between communities, remaining consistent, culturally appropriate and tailored to the distinct experiences of Aboriginal and Torres Strait Islander peoples, no matter where they are located.

Regional snapshot

Population

- The **Cairns and Hinterland population** is **265,366** [2]
- The region's **population will grow by an estimated 29.7%** from 2021–2046 (Queensland projected growth: 39.9%) [1]

Demographics

- **50.1%** of the population is **male**, **49.9% female** [2]
- **14.8% speak a language other than English** at home (Queensland: 14.4%) [1]
- **18.0%** are **aged 65 and older** (Queensland: 17.0%) [1]
- **22.0%** are **aged under 18** (Queensland: 22.2%) [1]
- **10.6%** are **First Nations** (Queensland: 4.6%) [1]

First Nations communities

- The **rate of mental ill health** is **28.9%** (Northern Queensland First Nations population: 29.4%; Cairns and Hinterland non-Indigenous population: 30.1%) [1]
- **43.3%** of the First Nations population have **completed Year 12** (Northern Queensland: 41.7%; Cairns and Hinterland non-Indigenous: 56.4%) [10]
- **43.7%** of people **have post-school qualifications** (Northern Queensland: 42.1%; Cairns and Hinterland non-Indigenous: 60.6%) [10]
- The **unemployment rate** for Cairns and Hinterland First Nations people **aged 25–64** is **16.1%** (Northern Queensland:13.3%; Cairns and Hinterland non-Indigenous: 4.1%) [10]
- The proportion of First Nations people **living in overcrowded dwellings** is **30.3%** (Northern Queensland: 27.7%; non-Indigenous: 5.9%) [10]

Homelessness

- The **estimated homelessness rate** is **903 per 100,000** (Northern Queensland rate: 700 per 100,000) [1]
- An estimated **2,370** people are **experiencing homelessness** (47.2% of all people experiencing homelessness in Northern Queensland) [1]

Socioeconomic disadvantage

- **31.0%** of the population **lives in an IRSD Quintile 1 area** (most disadvantaged) [1]
- **17.0%** of the population **lives in Quintile 4** and **10.0%** in **Quintile 5** (least disadvantaged) [1]

Mental health services

Mental health data

- In 2021, **42.0%** of the Cairns and Hinterland population **reported having had five or more mentally unhealthy days** in the last month (Queensland average: 33.0%) [14]
- Between 2024-5 and 2029-30, NMHSPF **demand for severe mental illness is projected to grow 8.4%** (7.9% for mild; 7.9% for moderate) [7]
- The **number of MHED presentations** per 100,000 in 2023–24 was **3,434** [12]
- **MHED presentations increased by 23.1%** between 2018-19 and 2023-24 (admitted cases increased by 5.3%; non-admitted cases increased by 39.3%) [12]
- In 2024, there were **19.8 allied mental health services per 100** population (Queensland rate: 25.4) [4]

What we heard: Mental health

Strengths

Through consultation we heard about a number of areas of strength in mental health support in the Cairns and Hinterland region:

- clear client information and user-friendly intake processes that ensure timely access to care
- streamlined information sharing
- a diverse workforce, including those with lived experience, that fosters trust and understanding
- integrated practices, peer support, and a focus on staff wellbeing.

> "WHEN YOU ARE MET BY A LIVED EXPERIENCE PERSON, YOU MAY NOT NEED TO WORRY ABOUT THE PERSON NOT 'GETTING' YOU."
>
> *Lived experience workshop participant*

Challenges

Through consultation the challenges of for mental health services in Cairns and Hinterland to connect people with the right services at the right time, especially for people who are already facing disadvantage was identified.

Reasons for this identified through consultation include:

- inconsistent funding, leading to instability in service delivery
- inequitable resource allocation, especially in regional areas
- geographic isolation in remote areas that limits access
- service delivery gaps for remote communities and those with complex needs
- systemic barriers, including bureaucratic hurdles and mental health stigma, that impede access and hinder help-seeking behaviours for marginalised groups, particularly First Nations peoples and individuals with disabilities.

> THERE ARE WEEKS TO WAIT TO GET A SPACE IN A PROGRAM. THIS IS A LONG TIME TO TRY AND GET THROUGH WHEN YOU ARE WANTING TO MAKE A CHANGE, AND WHAT DO YOU DO IN THE MEANTIME?
>
> *Lived experience workshop participant*

Focus areas for improvement

Despite these challenges, consultation identified that solutions are within reach. Consultation suggested a multipronged approach to address the region's challenges and create a more effective and equitable mental health system will involve:

- simplified referrals and consistent support, underpinned by a focus on the client's needs
- person-centred care
- workforce development (including peer workers and lived experience)
- improved community engagement (including schools and alternative therapies)
- better integration across health, social services, and justice systems
- strong interagency collaboration, including central referral points and system navigators to guide individuals through the system
- effective efforts to address systemic discrimination and racism through proactive inclusion and greater First Nations representation
- improved funding for grassroots services to improve accessibility and equity, address the specific needs of First Nations peoples and reduce wait times.

> ACCESS TO SUPPORTS THAT ARE SUPPORTIVE IS HARD WHEN CONNECTING WITH MANY [STAFF] WHO ARE NOT CONFIDENT IN WORKING WITH DIFFERENT CULTURES.
>
> *Lived experience workshop participant*

Suicide prevention

Suicide data

- There were **20.9 suspected suicide-related deaths per 100,000** in the region in 2018-20 (Queensland: 16.0) [5]

What we heard: Suicide prevention

Current progress and initiatives

Through consultation it was identified that a range of suicide prevention initiatives are emerging across the Cairns and Hinterland region, including:

- improvements in service delivery integration, including system navigators, to streamline access
- cross-departmental collaboration
- promotion of service colocation.

Challenges and areas for improvement

Consultation suggested a range of challenges including:

- difficulties with funding instability and inconsistent service delivery across the region create gaps in support for people at risk of suicide.
- widespread stigma and judgment around suicide prevent many people from seeking help, especially those who are also experiencing cultural and language barriers
- high school suspension rates may signal an increased suicide risk, reflecting students' isolation and the need to better reach those missed by prevention efforts.

Consultation suggested that a comprehensive approach combining systemic change, community engagement, and individual support will be key to effective prevention in Cairns and Hinterland. Grassroots support is vital. More funding needs to be directed to local organisations, and community connectors must be empowered to serve as safe places for community groups and people to turn towards when life gets 'wobbly'. It is crucial to address systemic racism through proactive strategies and culturally inclusive practices.

IT'S OFTEN HARD TO FIGURE OUT WHAT COMMUNITY RESOURCES EXIST, AND THE ADDED BURDEN OF CONSTANTLY EXPLAINING YOUR SITUATION ONLY TO BE SENT ELSEWHERE IS DEEPLY DISCOURAGING.

Lived experience workshop participant

Alcohol and other drugs

AOD data

- **42.0%** of the population **drink in ways that increase the risk of alcohol-related disease or injury** (Queensland average: 36.0%) [6]

- **13.0%** of the population are **daily smokers** (Queensland average: 10.5%) [14]

What we heard: AOD services

Strengths

Consultation identified regional strengths in the area of AOD support include:

- clear client information and user-friendly intake processes
- diverse workforce
- integrated practices
- peer support for staff.

There are excellent examples provided through consultation of streamlined information sharing that supports a trauma-informed approach to AOD support.

Challenges and areas for improvement

Instability generated by short-term or inconsistent funding was identified through consultation as a key challenge to AOD services. Other challenges reported include:

- a lack of service models tailored for remote communities
- restrictive regulations that hinder staff recruitment (especially those with lived experience)
- inconsistent referrals and limited integration with other sectors that needlessly complicate client journeys.

Key actions identified in consultation will include:

- strengthening partnerships between agencies and community organisations to streamline service delivery
- improving accessibility and equity, particularly for marginalised groups and remote communities
- investing in workforce training, development and support to enhance service quality and improve retention
- continuing to focus on client-centred care, including leveraging lived experience, to empower individuals in recovery
- developing community education initiatives to reduce stigma and raise awareness
- streamlining referrals and information sharing to minimise bureaucratic hurdles.

SELF-STIGMA CAN LEAD TO A RELUCTANCE TO DISCLOSE LIVED EXPERIENCE DUE TO FEAR OF JUDGEMENT OR DISCRIMINATION. WHEN MET BY A LIVED EXPERIENCE PERSON THERE IS AN INSTANT UNDERSTANDING. STIGMA IS REMOVED.

Lived experience workshop participant

Townsville

Context and data highlights

The Townsville region is home to **33.3 per cent of northern Queensland's population**. The **proportion of First Nations people in this region is 9.0 per cent**, double the Queensland average. The **region covers a distance of 148,000km²** and includes a range of rural and remote communities.

Most of this region's mental health indicators, including mental health emergency department (MHED) presentations and number of mentally unhealthy days, are close to the state average. There were **19.9 suspected suicide-related deaths per 100,000** in the region in 2018-20[5].

Alcohol and other drug (AOD) indicators are slightly above the Queensland average, with **13.0 per cent of people smoking daily** and **39.0 per cent of the population drinking in ways that increase their risk of alcohol-related disease or injury** [6, 14].

Townsville faces a range of interconnected challenges across its mental health, AOD, and suicide prevention systems, made more complex by its large rural population and significant Defence community. The fragmentation of the AOD system leads to delays in treatment and inconsistent care, while stigma often prevents individuals from seeking the help they need.

Mental health services are hindered by geographical and financial barriers, workforce shortages, and gaps in care for vulnerable groups, such as young people, First Nations communities, and those in rural areas, where long distances further limit access. Suicide prevention efforts face similar struggles, with a lack of family support, recruitment issues, and complex referral pathways, leaving youth – especially adolescent males – at higher risk.

The **region's strong connection to the Defence force adds another layer of complexity, with many veterans and current service members living in the area**. This creates an overlap with Department of Veteran Affairs (DVA) services, but addressing the unique needs of both civilian and veteran populations requires more integrated and accessible care. Tackling these challenges is essential for improving outcomes and supporting Townsville's diverse, vulnerable communities.

Regional snapshot

Population

- The **Townsville population** is **243,798** [2]
- The region's **population will grow by an estimated 27.8%** from 2021-2046 (Queensland projected growth: 39.9%) [9]

Demographics

- **50.3%** of the population is **male**, **49.7% female** [2]
- **8.8% speak a language other than English** at home (Queensland: 14.4%) [1]
- **16.0%** are **aged 65 and older** (Queensland: 17.0%) [2]
- **23.0%** are **aged under 18** (Queensland: 22.2%) [2]
- **9.0%** are **First Nations** (Queensland: 4.6%) [1]

First Nations communities

- The **rate of mental ill health** is **36.0%** (Northern Queensland First Nations population: 29.4%; Townsville non-Indigenous population: 33.9%) [1]
- **41.9%** of the First Nations population have **completed Year 12** (Northern Queensland: 41.7%; Townsvile non-Indigenous: 56.2%) [10]
- **39.9%** of people **have post-school qualifications** (Northern Queensland: 42.1%; Townsville non-Indigenous: 56.7%) [10]
- The **unemployment rate** for Townsville First Nations people **aged 25–64** is **12.7%** (Northern Queensland:13.3%; Townsville non-Indigenous: 3.6%) [10]
- The proportion of First Nations people **living in overcrowded dwellings** is **23.3%** (Northern Queensland: 27.7%; non-Indigenous: 4.2%) [10]

Homelessness

- The **estimated homelessness rate** is **538 per 100,000** (Northern Queensland rate: 700 per 100,000) [1]
- An estimated **1,317** people are **experiencing homelessness** (26.3% of all people experiencing homelessness in northern Queensland) [1]

Socioeconomic disadvantage

- **25.0%** of the population **lives in an IRSD Quintile 1 area** (most disadvantaged) [1]
- **13.0%** of the population **lives in Quintile 4** and **16.0%** in **Quintile 5** (least disadvantaged) [1]

Mental health services

Mental health data

- In 2021, **35.0%** of the Townsville population **reported having had five or more mentally unhealthy days** in the last month (Queensland average: 33.0%) [14]
- Between 2024-25 and 2029-30, NMHSPF **demand for severe mental illness is projected to grow 7.9%** (7.5% for mild; 7.5% for moderate) [7]
- The **number of MHED presentations** per 100,000 in 2023-24 was **2,818** [12]
- **MHED presentations increased by 5.2%** between 2018-19 and 2023-24 (admitted cases fell by 17.4%; non-admitted cases increased by 16.4%) [12]
- In 2024, there were **19.4 allied mental health services per 100** population (Queensland rate: 25.4) [4]

What we heard: Mental health

Strengths

Consultation identified a number of areas of strength in mental health support in the Townsville region including:

- strong interagency collaboration
- effective coordination between healthcare providers
- a compassionate, evidence-based approach that fosters positive outcomes for the community.

Challenges and areas for improvement

Challenges for the mental health system identified in the consultation include:

- poor coordination that hinders effective service delivery
- geographic disparities that limit access in rural and remote areas
- financial barriers that disproportionately affect low-income families
- complex referral systems that complicate access to care
- workforce shortages and burnout that put increased strain on the system
- systemic discrimination
- service gaps, particularly for young adults
- additional hurdles for First Nations communities, including cultural stigma, language barriers, and a lack of culturally competent services.

> A BIG PROBLEM WITH SEEKING SUPPORT IS TRYING TO FIRST FIGURE OUT WHAT IS AVAILABLE – IT'S HEARTBREAKING WHEN YOU ARE REFERRED TO A PROGRAM THAT NO LONGER EXISTS.
>
> *Lived experience workshop participant*

Key ideas to address the above challenges identified in consultation in a way that acknowledges their complexity will involve:

- improving service accessibility by bringing services to people rather than expecting people to travel to the service
- promoting culturally responsive care
- integrating mental health services with primary care
- empowering peer workers
- increasing support for teachers
- improving coordination by reoffering missed or cancelled appointments to individuals who haven't been able to get one
- focusing on youth initiatives and improving intergenerational support
- integrating homelessness support into primary care.

Suicide prevention

Suicide data

- There were **19.9 suspected suicide-related deaths per 100,000** in the region in 2018-20 (Queensland: 16.0) [5]

- There are **significant disparities in suicide risk among youth**, with male adolescents at a higher risk than females

What we heard: Suicide prevention

Strengths

Consultation spoke to Townsville's strengths in suicide prevention include:

- greater involvement of experienced older adults in local mental health services
- strong community connections that support youth and meet young people where they are
- a strong peer model that connects young people with adults who have shared a similar path (e.g. drug use, sleeping rough or an unsupportive home environment).

Challenges and areas for improvement

Key limitations to suicide prevention efforts in Townsville were identified through the community consultation process. These include:

- a lack of support for families, making it difficult for them to assist loved ones at risk of suicide
- difficulty in recruiting qualified mental health professionals
- regular assessment of suicide prevention training and resources can strengthen support for GPs, primary care providers, and non-government organisations, improving referral pathways and care for people in crisis
- limited local training opportunities for mental health professionals, leading to gaps in care for individuals transitioning out of hospital settings.

> WHEN IN DISTRESS IT CAN BE DIFFICULT TO EXPRESS HOW YOU ARE FEELING. FEELING SAFE ENOUGH TO DO THIS IS IMPORTANT. LIVED EXPERIENCE WORKERS HELP WITH THIS.
>
> *Lived experience workshop participant*

Children and young people who present to Child and Youth Mental Health Services consistently identify suicide ideation, acute crises, and substance abuse as primary reasons for seeking help.

To address these challenges, several solutions have been proposed to improve mental health services in Townsville, including:

- creating a comprehensive service directory to enhance connectivity and accessibility
- locating homelessness services in areas frequented by homeless individuals to improve engagement
- expanding youth mental health and suicide prevention support to include family care within the same framework
- integrating peer workers with experience in youth justice

- expanding training in First Nations mental health first aid
- reducing stigma around mental health
- offering more age-specific services.

Alcohol and other drugs

AOD data

- **39.0%** of the population **drink in ways that increase the risk of alcohol-related disease or injury** (Queensland average: 36.0%) [14]

- **13.0%** of the population are **daily smokers** (Queensland average: 10.5%) [14]

What we heard: AOD services

Strengths

Consultation identified The existing strengths of the AOD system in Townsville are:

- the dedication of its AOD workforce, including doctors, nurses, psychologists, and social workers
- wide use of effective evidence-based interventions, such as cognitive-behavioural therapy and medication-assisted treatment
- a holistic approach to AOD support, with an increasing focus on harm reduction strategies.

Challenges and areas for improvement

Fragmentation was the key challenged identified through consultation for the AOD system in Townsville. This disjointed system is reported to often causes delays in accessing treatment, inconsistent care and a lack of coordination between services. Other challenges identified include:

- stigma and discrimination that discourage many individuals with AOD issues from seeking help
- difficulties in addressing complex needs, such as mental health disorders and homelessness that co-occur with (or cause) AOD issues, leaving vulnerable populations underserved.

> SUPPORTS EXIST BUT A LOT OF PEOPLE MAY NOT BE AWARE OF THEM.
>
> *Lived experience workshop participant*

To address these challenges, the following solutions have been proposed through consultation:

- improving system integration (e.g. through centralised intake processes)
- better information sharing
- streamlined referral pathways
- stigma reduction efforts such as public awareness campaigns, healthcare provider training, and a focus on person-centred care
- service expansion to address complex needs, such as specialised treatment for co-occurring disorders and support for housing and employment.

> IT'S DIFFICULT WHEN VALUABLE HELP ISN'T CONTINUED. MANY GRASSROOTS ACTIVITIES, WHICH WERE FUNDED BY SMALL COMMUNITY GRANTS AND HAD GREAT RESULTS, STRUGGLE TO SECURE CONTINUED FUNDING.
>
> *Lived experience workshop participant*

Mackay

Context and data highlights

The **Mackay region is home to 25.6 per cent of northern Queensland's population** [2]. The proportion of **First Nations peoples in this region is 6.0 per cent**, close to the Queensland average. Relatively few people **(7.0 per cent) speak a language other than English at home**[1]. The **region covers a distance of 90,363km**[2] and includes a range of rural and remote communities. The region includes a large number of mines and mining communities.

In general, mental health indicators such as mental health emergency department (MHED) presentations and number of mentally unhealthy days are better than the averages for the state. The projected growth in NMHSPF demand over the next five years is the lowest in northern Queensland, at around 7 per cent [7]. The **region is severely underserved by allied mental health**, with only 12.2 services per 100 population, less than half of the Queensland rate. There were **19.8 suspected suicide-related deaths per 100,000** in 2018-20[5].

Mackay's alcohol and other drug (AOD) indicators are elevated compared to state averages, with **17.0 per cent of the population smoking daily** and **45.0 per cent drinking in ways that put them at risk**. Mackay has the lowest homelessness rate in region, at 389 per 100,000 [14].

Mackay is a region with natural beauty and diverse communities, that also faces challenges in supporting the health and wellbeing of its residents. In particular, **access to AOD services is a pressing issue for rural and remote communities**. The large Australian South Sea Islander population experiences limited support sensitive to their cultural needs. Fly-in, fly-out (FIFO) workers and those with complex needs struggle to find consistent care, while geographic isolation and resource constraints exacerbate these difficulties.

Despite these challenges, **Mackay's strength lies in its collaborative approach**. Organisations work together to provide critical services, while the mining industry benefits from tailored AOD support. However, FIFO workers face unique barriers to accessing help.

Mental health services in Mackay are similarly affected by stigma and cultural gaps. Efforts to incorporate culturally relevant care are underway, alongside a focus on peer support and early intervention to build community resilience.

Regional snapshot

Population

- The **Mackay population** is **189,643** [2]
- The region's **population will grow by an estimated 28.8%** from 2021-46 (Queensland projected growth: 39.9%) [9]

Demographics

- **51.5%** of the population is **male**, **48.5% female** [2]
- **7.0% speak a language other than English** at home (Queensland: 14.4%) [1]
- **15.0%** are **aged 65 and older** (Queensland: 17.0%) [2]
- **23.0%** are **aged under 18** (Queensland: 22.2%) [2]
- **6.0%** are **First Nations** (Queensland: 4.6%) [1]

First Nations communities

- The **rate of mental ill health** is **34.9%** (Northern Queensland First Nations population: 29.4%; Mackay non-Indigenous population: 29.8%) [1]
- **44.8%** of the First Nations population have **completed Year 12** (Northern Queensland: 41.7%; Mackay non-Indigenous: 50.4%) [10]
- **43.3%** of people **have post-school qualifications** (Northern Queensland: 42.1%; Mackay non-Indigenous: 56.1%) [10]
- The **unemployment rate** for Mackay First Nations people **aged 25–64** is **6.7%** (Northern Queensland:13.3%; Mackay non-Indigenous: 3.0%) [10]
- The proportion of First Nations people **living in overcrowded dwellings** is **13.0%** (Northern Queensland: 27.7%; non-Indigenous: 5.2%) [10]

Homelessness

- The **estimated homelessness rate** is **389 per 100,000** (Northern Queensland rate: 700 per 100,000) [1]
- An estimated **713** people are **experiencing homelessness** (14.2% of all people experiencing homelessness in Northern Queensland) [1]

Socioeconomic disadvantage

- **17.0%** of the population **lives in an IRSD Quintile 1 area** (most disadvantaged) [1]
- **22.0%** of the population **lives in Quintile 4** and **9.0%** in **Quintile 5** (least disadvantaged) [1]

Mental health services

Mental health data

- In 2021, **26.0%** of the Mackay population **reported having had five or more mentally unhealthy days** in the last month (Queensland average: 33.0%) [14]
- Between 2024-25 and 2029-30, NMHSPF **demand for severe mental illness is projected to grow 7.4%** (7.1% for mild; 7.1% for moderate) [7]
- The **number of MHED presentations** per 100,000 in 2023-24 was **2,407** [12]
- **MHED presentations increased by 12.4%** between 2018-19 and 2023-24 (admitted cases increased by 14.6%; non-admitted cases increased by 9.1%) [12]
- In 2024, there were **12.2 allied mental health services per 100** population (Queensland rate: 25.4) [4]

What we heard: Mental health

Strengths

Areas of strength in mental health support highlighted in consultation in the Mackay area include:

- growing recognition of mental health as a key public health issue
- increased investment
- an emphasis on evidence-based practices and innovative treatments
- increasing numbers of peer support programs and online resources
- the resilience and advocacy of individuals with mental health conditions and their families and caregivers.

Challenges and areas for improvement

Community consultations revealed the following limitations within the Mackay mental health system:

- widespread stigma surrounding mental illness that deters individuals from seeking help and accessing vital support
- a pronounced gap in culturally competent services, particularly for marginalised groups, that exacerbates disparities in mental health outcomes
- a tendency to focus on crisis intervention, rather than preventative care, resulting in delayed intervention and prolonged suffering
- a fragmentation of mental health services that impedes the coordination and continuity of care, hinders recovery efforts, and creates barriers to effective treatment.

> TRUST IN THE OTHER PARTS OF THE SYSTEM IS IMPORTANT. ONCE TRUST HAS BEEN LOST, IT'S VERY HARD TO REGAIN.
>
> *Lived experience workshop participant*

In response to these challenges, various solutions have been proposed to reform the mental health system. These include:

- implementing comprehensive stigma reduction strategies, including public awareness campaigns, and educational initiatives
- expanding access to culturally competent services by training mental health professionals from diverse backgrounds and incorporating culturally relevant approaches into treatment plans
- shifting the focus towards preventative care, with an emphasis on early intervention and mental wellbeing
- improving coordination and integration between mental health services to enhance the overall quality of care and ensure smoother transitions between providers.

> TO BUILD TRUST WITH THE ASSI COMMUNITY, SERVICES MUST NOT ONLY LISTEN... BUT ALSO DEMONSTRATE THAT THEIR FEEDBACK AND INPUTS ARE TAKEN SERIOUSLY. THIS CAN BE ACHIEVED THROUGH SUPPORTIVE AND MEANINGFUL FOLLOW-UP AND ENSURING THAT COMMUNITY INPUT CONTRIBUTES TOWARDS SHAPING FUTURE SERVICE DEVELOPMENT.
>
> *Lived experience workshop participant*

Suicide prevention

Suicide data

- There were **19.8 suspected suicide-related deaths per 100,000** in the region in 2018-20 (Queensland: 16.0) [5]

What we heard: Suicide prevention

Strengths

Consultation identified that Mackay has significant strengths in suicide prevention, including:

- community initiatives, like Safe Talk, that promote mental health awareness and combat stigma
- school-based support systems
- industry-specific programs, especially in high-risk sectors like mining, that address occupational stress and mental health concerns
- personalised peer support, with adequate time allocation, that provides tailored interventions to foster holistic care for people in need.

Challenges and areas for improvement

Suicide prevention efforts in Mackay face a range of challenges identified through consultation, including:

- stigma surrounding mental health issues that discourages individuals from seeking help, especially in the mining industry
- system fragmentation and disjointed care, especially for individuals with multiple diagnoses, who often find it difficult to navigate the complex healthcare system and do not get the care they need
- rising demand for mental health services that leaves the workforce stretched and overburdened
- burnout and high attrition rates among healthcare providers due to the high-stress nature of the mental health profession and the limited support available
- underuse of employee assistance programs and inconsistent uptake of mental health training, which together limit the reach and effectiveness of suicide prevention initiatives.

To overcome these limitations, consultation suggested a multifaceted approach is needed. Investing in individuals with Lived Experience, including those who have encountered early educational disruptions, may offer a viable approach to workforce and support system development.

Providing access to skill development and educational opportunities can enable these individuals to participate more fully in these areas. Other solutions include:

- strengthening service connections through in-service opportunities to promote collaboration and knowledge sharing among service providers and provide pathways for those with lived experience to assume local roles
- shifting from a treatment-focused approach to a prevention-focused approach by prioritising strategies that identify and address risk factors before a crisis occurs.

Alcohol and other drugs

AOD data

- **45.0%** of the population **drink in ways that increase the risk of alcohol-related disease or injury** (Queensland: 36.0%) [14]
- **17.0%** of the population are **daily smokers** (Queensland: 10.5%) [14]

What we heard: AOD services

Strengths

Consultation noted Mackay's areas of strength in AOD services include:

- positive work environments that aid in recruitment and retention and act to counterbalance job-related stress
- strong interagency collaboration
- proactive service providers who go beyond their formal roles to support individuals in need
- accessible, high-quality services for specific populations, such as those in the mining industry.

Challenges and areas for improvement

Through consultation a number of challenges were identified including:

- insufficient resources
- geographic disparities and age-based inequities especially for rural and remote communities with limited access to care
- significant barriers for young people under 18 (e.g. a lack of youth detox services)
- policy constraints, such as Blue Card requirements, that pose barriers to employment
- barriers to staff seeking professional development and skill-building opportunities, including a lack of locally available programs and no budget for travel
- fear, stigma, and a lack of transparency surrounding AOD issues
- fragmented care that often sees individuals with complex needs fall through the cracks
- cultural barriers
- employee assistance programs can be ineffective when counselors lack peer experience in the AOD field
- staffing shortages and poor coordination between AOD, mental health, and other services.

> IT PAINFUL TO SEEK SUPPORT AND SEE SOMEONE WEARING A LANYARD WITH FLAGS ON IT, ONLY TO REALISE THE PERSON DOES NOT UNDERSTAND WHAT THE FLAGS MEAN.
>
> *Lived experience workshop participant*

To overcome these limitations, several solutions have been proposed. These include:

- improving interagency communication to optimise resource allocation and enhance coordination
- strengthening remote community support through collaborations with organisations like Grow Queensland
- developing sustainable care pathways
- prioritising comprehensive physical health assessments
- investing in the lived experiences of individuals, providing educational opportunities, and empowering those with lived experience by creating specific pathways for them
- expanding the local workforce and establishing a relief worker network to support staff wellbeing
- shifting the focus towards prevention strategies to address the root causes of AOD issues.

Where to go if you or anyone you know would like support

24/7 Crisis Services	
13 YARN (for First Nations people)	13 92 76
1800 Respect	1800 737 732
Beyond Blue	1300 22 46 36
Kids Helpline	1800 55 1800
MensLine Australia	1300 78 99 78
MH Call	1300 642 255
Lifeline	13 11 14
Suicide Call Back Service	1300 659 467

Other support and information services	
Alcohol and Drug Information Service	1800 177 833
Butterfly Foundation (eating disorders)	1800 334 673
Counselling online (drug and alcohol)	1800 888 236
Eating Disorders Queensland	(07) 3844 6055
Griefline	1300 845 745
Grow Australia (support through peer groups)	1800 558 268
Headspace	1800 650 890
Head to Health	1800 595 212 www.headtohealth.gov.au
PANDA (perinatal anxiety and depression)	1300 726 306
QLife (LGBTI)	1800 184 527
Queensland Health 13 HEALTH	(13 43 25 84)
Quitline	13 78 48
SANE Australia	1800 18 7263
Veterans Support Service	1800 011 046
Youthbeyondblue	1300 22 46 36

Acronyms and glossary

Term	Definition
Aboriginal Medical Service (AMS) / Aboriginal Controlled Health Organisation (ACCHO)	Primary health care services that deliver holistic, comprehensive and culturally appropriate health service to the Aboriginal and Torres Strait Islander community.
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
ADIS	Alcohol and Drug Information Service
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drug
Carer/support	A person who cares for or otherwise supports a person living with mental illness and/or alcohol and other drug use. A carer has a close relationship with the person they support and may be a family member, friend, neighbour, support worker, or member of a broader community.
Children, youth, and young people/adults	Policy documents, data, services, and this plan will use various terms to refer to children and young people, with various age ranges applied. For the purposes of this plan the following terminology and definitions apply: › children: up to 12 years › youth: 12-18 years › child and youth: up to 18yo
Consumer/client/ individual/person/ community member	A person who accesses, has accessed mental health, suicide prevention and/or alcohol and other drug treatment services and support.
ED	Emergency Department
FTE	Full Time Equivalent
General practitioner (GP)	A doctor based in the community who primarily treats patients with minor or chronic illnesses and refers individuals to secondary and tertiary care.
HCQ	Health Consumers Queensland
Heteronormativity	The assumption that heterosexuality is the normal mode of sexual orientation and other forms of sexual expression and relationships are 'abnormal'. This view impacts the structures of institutions of society, including things like marriage, and produces a set of ideas that favour a specific view on sexual orientation.
Hospital and Health Service (HHS)	Independent statutory bodies, funded by the Queensland Department of Health. There are 16 HHSs in Queensland. Particularly relevant to this plan are the HHSs in Northern Queensland: Torres and Cape, Cairns and Hinterland, Townsville, and Mackay. HHSs provide public health services, including mental health, suicide prevention and alcohol and other drug services, for individuals with severe and complex conditions.
Indicator/measure/KPI	A quantitative measure that is used to assess the extent to which a given objective has been achieved.
JRNA	Joint Regional Needs Assessment
LGA	Local Government Area
LGBTIQA+	Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual

Acronyms and glossary (cont)

Term	Definition
Living and/or lived experience	People who have lived or living experience of suicide, mental health concerns and/or alcohol and other drug use.
Locum practitioner	A physician who works in place of a regular physician when they are absent or when filling a gap in the workforce.
MBS	Medicare Benefits Scheme
Mental health	The World Health Organization defines mental health as a state of wellbeing in which every person realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.
Mental illness	A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders, and schizophrenia.
MH	Mental Health
MHSPAOD	Mental Health Suicide Prevention, Alcohol and Other Drug
National Disability Insurance Scheme (NDIS)	Provides eligible participants with a permanent and significant disability with the reasonable and necessary supports they need. The NDIS also connect people with a disability and their carers, including people who are not NDIS participants and their carers, to supports in their community. The National Disability Insurance Agency (NDIA) is an independent statutory agency that implements the NDIS.
NDIA	National Disability Insurance Agency
NMHSPF	National Mental Health Service Planning Framework
Non-Government Organisation (NGO)	A not-for-profit, non-government organisation. NGOs range from single-focus, locally based organisations to large national and international organisations working across a range of areas including but not limited to mental health.
PBS	Pharmaceutical Benefits Scheme
Peer worker	Workers with lived experience who provide valuable contributions by sharing their experience of illness and recovery. Peer workers are employed across a range of service settings and perform a variety of roles, including providing individual support, delivering education programs, providing support for housing and employment, coaching, and running groups and activities.
Primary care	The first point of contact for people living with mental health conditions or mental illness and their carers. Primary care providers include general practitioners, nurses, allied health professionals, pharmacists, and Aboriginal and Torres Strait Islander health workers.
Primary Health Networks (PHNs)	Independent primary health care organisations largely funded by the Australian Government in many locations around the country. The role of PHNs is to commission health care services, rather than provide the services. Northern Queesnland PHN offices are in Cairns, Townsville, and Mackay.
Psychological therapies	A group of therapies provided by psychologists, counsellors, and psychiatrists. It involves exploring thoughts and feelings in an effort to increase understanding and address negative behaviours. It is used to treat a number of conditions (e.g. depression, anxiety, bipolar disorder).
Primary Mental Health Care Minimum Data Set (PMHC-MDS)	Provides the basis for PHNs and the Department of Health to monitor and report on the quantity and quality of service delivery, and to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Government.
Psychosocial disability	The disability experience of people with impairments and participation restrictions related to mental illness. These impairments and restrictions can include reduced ability to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives.

Acronyms and glossary (cont)

Term	Definition
Psychosocial support	Psychosocial support services offer both one-on-one and group support activities to help people with severe mental illness. These services can support people to improve their skills in dealing with their mental health, help them with daily living tasks, improve their social skills, and to access housing and education.
QAIHC	Queensland Aboriginal and Islander Health Council
QAMH	Queensland Alliance for Mental Health
QLD	Queensland
QMHC	Queensland Mental Health Commission
QNADA	Queensland Network of Alcohol and Other Drug Agencies
RACF	Residential Aged Care Facility
Secondary care	Care provided by medical specialists. Secondary care providers can include psychiatrists and psychologists.
Service provider	A person, business or organisation who delivers services (in this context, these are services primarily in mental health, suicide prevention and/or alcohol and other drug).
Social and Emotional Wellbeing (SEWB)	Refers to the Aboriginal and Torres Strait Islander view of health. This view is holistic and includes mental health and other factors such as the social, spiritual, and cultural wellbeing of people and the broader community.
SP	Suicide Prevention
Stepped care	An evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to an individual's needs. A Stepped care approach promotes person-centred care which targets the needs of the individual.
Tertiary care	Specialised medical care that typically involves complex treatments, often in hospital settings.
WHO	World Health Organisation

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