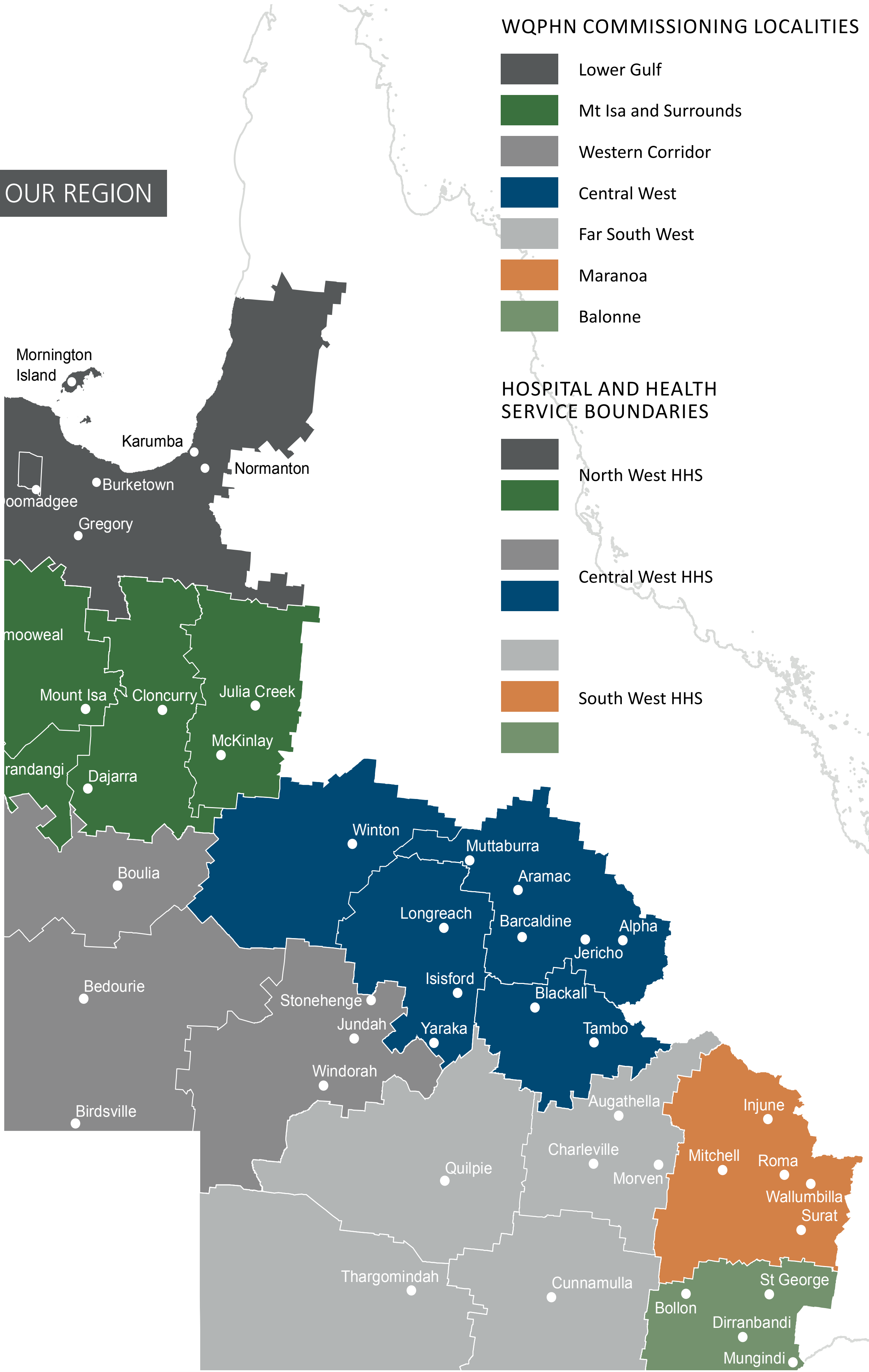
MENTAL HEALTH, SUICIDE PREVENTION, ALCOHOL AND OTHER DRUG SERVICES

REGIONAL PLAN 2017-2020

phn
WESTERN QUEENSLAND

An Australian Government Initiative

OUR REGION



CONTENTS

INTRODUCTION	**3**
1.1 About this Plan	5
1.2 Developing the Plan	5
SETTING THE SCENE	**7**
2.1 Policy context	8
2.2 Western Queensland	10
2.3 Prevalence of mental health and AOD disorders	11
2.4 Treatment targets	12
2.5 Overview of current service delivery models	15
OUR COMMUNITIES	**17**
3. Responding to the Needs of Our Communities	18
3.1 WQPHN strategic direction	18
3.2 Comprehensive primary health care	19
SERVICE DELIVERY	**21**
4. Primary Mental Health and AOD Service Delivery in Western QLD	22
4.1 The nine building blocks	22
4.2 Mental Health	32
4.3 Suicide Prevention	33
4.4 Alcohol and Other Drugs	34
NEXT STEPS	**35**
5. Implementing the Plan	36
5.1 Our Planning Consortium	36
5.2 Activities to progress the building blocks	37
5.3 Other priority activities to improve Mental Health, Suicide Prevention and Alcohol and Other Drug Services	39
5.4 Building capability and capacity	40
5.5 Revising our plans together	40
APPENDIX	**41**
REFERENCES	**43**
OUR PLANNING CONSORTIUM	**45**

INTRODUCTION

Over the course of our life time, every one of us will be touched by mental health or alcohol and other drug (AOD) issues. We know that nearly half of all Australians will experience mental health issues at some point in their lives (Victorian Government, 2016).

"Nearly 1 in 2 Australians will experience mental health issues in their lifetime"

One in five Australians experience some form of mental health or AOD issue every year, and one in four young adults aged between 16 and 24 will be currently experiencing such issues.

These numbers are likely to be much higher for people living in Western Queensland because of our high level of socio-economic disadvantage: people living in the lowest socio-economic areas are 1.4 times more likely to have mental health issues than those living in the highest socio-economic areas (Australian Institute of Health and Welfare, 2016).

In Western Queensland people go to a hospital emergency department (ED) with mental health concerns 1.6 times more often than in Queensland as a whole, and risky alcohol consumption is 1.4 times more common (KBC Australia, 2016). Suicide and self-inflicted injury rates are twice as high in Western Queensland than in Australia as a whole, and are substantially higher for Aboriginal and Torres Strait Islander people than other non-Indigenous Australians.

If the level of need in Western Queensland was the same as that in the rest of Australia, then 13,000 people would experience mental health challenges in any one year, and of these two-thirds would need to access services (University of Queensland, 2016).

Mental health needs are common in our communities. Getting the right help at the right time and in the right place will be essential to improving the mental health and wellbeing of our people. We must all be able to recognise warning signs and know how to support our friends, neighbours and families to prevent problems from developing or worsening. Preventing harm during childhood and building resilience among our children and young people will be hugely protective of their future health and wellbeing.

"In any one year, 1 in 5 Australians experience some form of mental health or AOD issue"

1.1 ABOUT THIS PLAN

This Plan outlines Western Queensland Primary Health Network's (WQPHN's) vision and direction for mental health, suicide prevention, and AOD services in Western Queensland in the future - a direction which is centred on comprehensive primary health care and the Western Queensland Health Care Home. The aim is to build healthy communities, families and individuals and to support their wellbeing by having an integrated Western Queensland health system with primary health care at its core, well supported by the Hospital and Health Services (HHSs) and non-government organisations (NGOs).

Because our region has high levels of mental health and AOD disorders and high co-morbidity, a small population spread across widely dispersed communities and a health workforce that is predominantly generalist in nature, we must take an integrated and holistic approach to service delivery in order to effectively meet the population's needs. For this reason, WQPHN has made the decision to expand the scope of our mental health and suicide prevention plan so that it encompasses AOD services rather than setting these out in a separate planning document. WQPHN will develop a specific Western Queensland AOD sub-plan to augment this report and ensure appropriate specialist AOD skills, experience and the most up-to-date AOD evidence is available to guide implementation planning, monitoring and evaluation.

The intent is that this Plan will support an iterative process with stakeholders and guide WQPHN's commissioning approach over the next three years as well as provide guidance for the clinical redesign and joint efforts of planners and service provider organisations across our catchment.

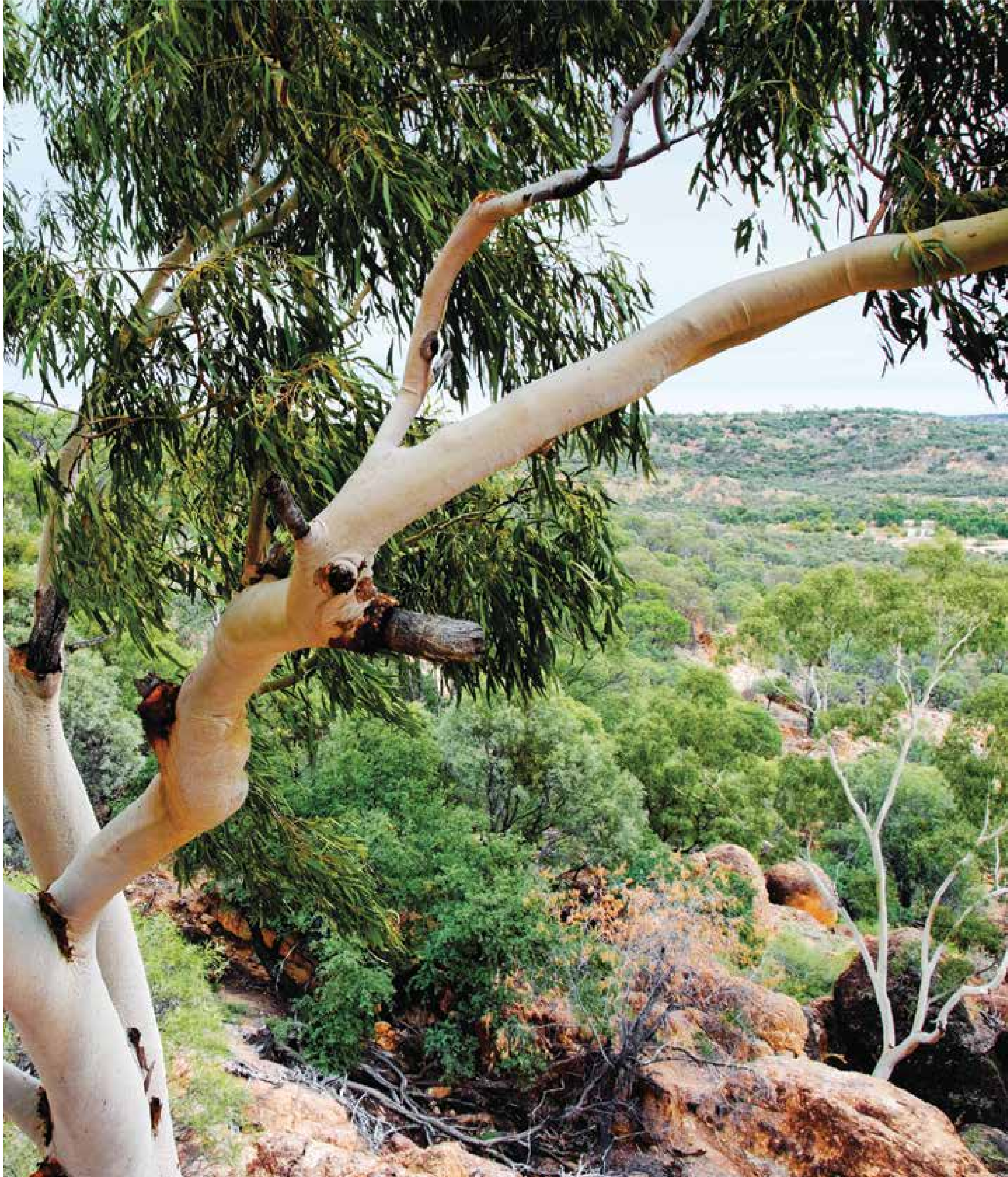
1.2 DEVELOPING THE PLAN

WQPHN works in partnership with the other key health agencies in Western Queensland: the three HHSs – North West, Central West, and South West; Aboriginal and Islander Community Controlled Health Services (AICCHSs) and the NGOs. We have committed to working together to design and implement a future system of health care that builds on the strengths and abilities of local communities and services, improves mental health, prevents suicides and addresses AOD issues in a way that is sustainable given Western
Queensland's characteristics.

In accordance with this commitment to integrated planning and service delivery, this Plan has been developed as a result of a co-design process spanning the past 12 months. Representatives from WQPHN, its partners and other key stakeholders came together in a mental health and AOD consortium (the Consortium) to consider international and national evidence and experience, Commonwealth and Queensland policies and our unique local context in order to develop and agree the future direction and priorities outlined in this Plan. The intention is for the consortium to continue to work together to guide and monitor implementation of the Plan.

WQPHN also received invaluable assistance and expert input from Queensland Aboriginal and Islander Health Council (QAIHC), and would like to recognise the additional expertise and assistance from Queensland Health Mental Health, Alcohol and Other Drugs Branch, Queensland Network of Alcohol and Other Drug Agencies Ltd (QNADA) and Queensland University of Technology (QUT) for their participation in the formal planning consultations.

SETTING THE SCENE



2.1 POLICY CONTEXT

The future service model outlined in this Plan was shaped by the policy context at both the national and state level, including the related Commonwealth guidance for PHNs. In developing this Plan, we have drawn from national and international literature including the:

- Fifth National Mental Health Plan: Draft for consultation (COAG Department of Health, 2016)
- Improving Mental Health and Wellbeing - The Queensland Mental Health, Drug and Alcohol and Suicide Prevention Strategic Plan 2014-2019 (Queensland Mental Health Commission, 2014)
- Connecting Care to Recovery 2016-2021, the services plan for state funded mental health, and alcohol and other drug services in Queensland (Queensland Health, 2016)
- Implementing a Stepped Care Approach to Mental Health Services within Australian Primary Health Networks (University of Queensland, 2016)
- Stepped Care for People with Common Mental Health Disorders Commissioning Guide (National Institute for Health and Care Excellence (NICE), 2011)
- National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (Department of Health and Ageing, 2013)
- National Drug Strategy 2016-2025
- National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019.

The policy context is summarised below.

NATIONAL POLICY DIRECTION

A consultation draft of the fifth National Mental Health Plan was released in late 2016 (Department of Health, 2016). The draft plan spans 2017-2022 and has a strong emphasis on collaborative efforts across government departments to improve the mental health and wellbeing of Australians. It seeks to prioritise activities across the broad spectrum of need and identifies seven target areas:

- Integrated regional planning and service delivery
- Coordinated treatment and supports for people with severe and complex mental illness
- Suicide prevention
- Aboriginal and Torres Strait Islander mental health and suicide prevention
- Physical health of people with mental health issues
- Stigma and discrimination reduction
- Safety and quality in mental health care.

Suicide prevention is a targeted priority area for the next five years. This includes a specific focus on suicide prevention for Aboriginal and Torres Strait Islander people who experience twice the rate of suicide compared with non-Indigenous Australians. The high rates of suicide amongst Aboriginal and Torres Strait Islander people are commonly attributed to a complex set of risk factors which not only includes those shared by the non-Indigenous population, but also a broader set of social, economic and historic determinants that impact on their social and emotional wellbeing and mental health.

In response to this, the Australian Government developed an Aboriginal and Torres Strait Islander Suicide Prevention Strategy in 2013 (Department of Health and Ageing, 2013). The overarching objective of this Strategy is to reduce the causes, prevalence and impacts of suicide on individuals, their families and communities. Six goals underpin this objective:

- Reduce the incidence and impact of suicide and suicidal behaviour in the Aboriginal and Torres Strait Islander population and in specific communities affected by suicide
- Ensure that Aboriginal and Torres Strait Islander communities are supported within available resources to respond to high levels of suicide and/or self-harming behaviour with effective prevention strategies
- Implement effective activities that reduce the presence and impact of risk factors that contribute to suicide outcomes in the short, medium and long term and across the lifespan

- Build the participation of Aboriginal and Torres Strait Islander people in the workforce in fields related to suicide prevention, early intervention and social and emotional wellbeing through the provision of training, skills and professional qualifications at all levels
- Build the evidence base to support effective action and to evaluate the outcomes of suicide prevention activity at local, regional and national levels
- Make high quality resources, information and methods to support suicide prevention for Aboriginal and Torres Strait Islander peoples available across all contexts and circumstances.

In accordance with the national direction outlined in these documents, the Commonwealth has provided guidance to PHNs regarding priority areas for their mental health and suicide prevention plans. These priority areas are listed below and they have been used as the basis for determining the future direction outlined in this Plan:

- Low intensity mental health services for early intervention
- Child and youth mental health services
- Psychological therapies provided by mental health professionals to underserviced groups (e.g. people living in rural and remote communities)
- Primary mental health care services for people with severe mental illness
- Regional approach to suicide prevention
- Aboriginal and Torres Strait Islander mental health services
- Access to specialist AOD Services.

STATE POLICY DIRECTION

In 2014 the Queensland Mental Health Commission published Improving Mental Health and Wellbeing - The Queensland Mental Health, Drug and Alcohol and Suicide Prevention Strategic Plan 2014-2019 (Queensland Mental Health Commission, 2014). In 2016 the Commission released its Proud and Strong Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan 2016-18. This was followed in September 2016 by the Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy (2016 – 2021) and in October 2016 by the Connecting Care to Recovery 2016-2021 (Queensland Health, 2016), a services plan for State-funded mental health, alcohol and other drug services.

Together these plans set the direction for mental health and AOD services in Queensland and provide key themes that resonate strongly within this Plan:

- the need for an integrated mental health and AOD services response;
- the importance of a holistic, life-course approach which builds on the strengths of communities, supports local leadership and better integrates and coordinates services and programs;
- the importance of cultural competency in service delivery;
- support for greater integration, shared health intelligence and partnering to better support prevention and recovery; and,
- integration across primary and specialist care and promotion of partnerships between HHSs and primary care services, particularly those delivered by AICCHSs.

2.2 WESTERN QUEENSLAND

Whilst there are many challenges facing Western Queenslanders and WQPHN, there is also a strong willingness and commitment across the region to work collaboratively to co-design a future model of mental health, suicide prevention and AOD service delivery that is sustainable and can be tailored to local communities.

With adversity comes strength, and across Western Queensland there are resilient individuals and communities who have found ways to work together to enhance wellbeing. Key to successful implementation of this Plan will be active engagement by the WQPHN and its partners with local communities to recognise what is already in place and working; to identify their unique strengths, abilities, resources and leadership, and to build on these when developing ways to implement the future model locally.

Western Queensland's population and geography mean that a well-coordinated, culturally competent and effective system of primary health care is of critical importance for timely access to health services and better health outcomes. Information from WQPHN's Health Needs Assessment about our region's geography, demography, health status, and mental health, AOD use, suicide and self-harm (KBC Australia, 2016) is summarised below.

OUR GEOGRAPHY AND DEMOGRAPHY

- Western Queensland has a small population (72,000 people), dispersed across a very large land area with large distances to travel to access health services and with poor public transport
- WQPHN's geographical area is the most sparsely populated of any PHN in Australia
- WQPHN along with the Northern Territory PHN are the most remote PHNs in Australia
- Western Queensland has a transient population due to its fly-in/fly-out (FIFO), seasonal workers and tourism, with skyrocketing demands for health services during the peak seasons
- Western Queensland has a young population compared with Queensland as a whole, and a lower proportion of young people attending school full time or working.
- The vast majority of Western Queensland is ranked as socio-economically disadvantaged compared to the Australian average, with even higher levels of socio-economic disadvantage within the region's Indigenous population.

ABORIGINAL AND TORRES STRAIT ISLANDER POPULATION

- 19.4% of the Western Queensland population is Aboriginal and Torres Strait Islander, compared with 3.0% for Australia as whole and 4.2% for Queensland
- While several PHNs have larger total Indigenous populations, Western Queensland is second only to the Northern Territory in terms of the Indigenous population as a proportion of the total population
- Within Western Queensland more than half the Indigenous population is under the age of 24 years, compared to around one-third for the total population of Queensland, while 4% of the Indigenous population in Western Queensland is aged 65 years and over compared to 11% in the total population
- In Western Queensland, 30% of all children aged under 15 years are Indigenous, and 40% in the North West
- The life expectancy of Indigenous Queenslanders (61.2 years) decreases as remoteness increases (57.8 years in remote communities).

2.3 PREVALENCE OF MENTAL HEALTH AND AOD DISORDERS

Data on the prevalence of mental health and substance use disorders in Western Queensland is poor, however evidence and experience suggests that there is likely to be a higher prevalence of mental health and AOD issues because of:

- The high incidence of chronic diseases, and the co-morbidities that flow from these
- The high proportion of young children at risk, and the higher rates of mental health and substance use issues later in life that result from early childhood neglect and abuse.

What we do know about the prevalence of mental health and substance use disorders in Western Queensland (KBC Australia, 2016) is:

- Suicide and self-inflicted injury rates are twice as high in Western Queensland than in Australia as a whole, with suicide the leading cause of death in men aged 15-34 years, and substantially higher suicide rates for Aboriginal and Torres Strait Islanders than other Western Queenslanders
- The rate of presentations to hospital EDs for mental health concerns is 60% higher than for Queensland overall, while the hospitalisation rate for mental health concerns is 35% lower than for Queensland as a whole
- Compared with the Queensland average, the rate of risky life-time alcohol consumption for adults is 40% higher in Western Queensland and the mortality rate linked to excess alcohol consumption is 49% higher
- The large geographical area and very small population create particular challenges for delivering effective, good quality services to a highly dispersed and mobile population.

2.4 TREATMENT TARGETS

The draft National Mental Health Service Planning Framework (NMHSPF) is a tool developed by the University of Queensland to assist planning, coordination and resourcing of mental health services to meet the needs of the population. This work is based on a stepped care model that tailors the intensity of intervention to the level of need. Drawing on the NMHSPF, the stepped care approach to estimate the number of people in Western Queensland with mental illness in any year within defined levels of severity, and then set treatment targets to help plan for intervention services. This data is shown in Figures 1 and 2. The population numbers used have been drawn from estimates by the Queensland Government Statistician's Office, Queensland Treasury for 2015.

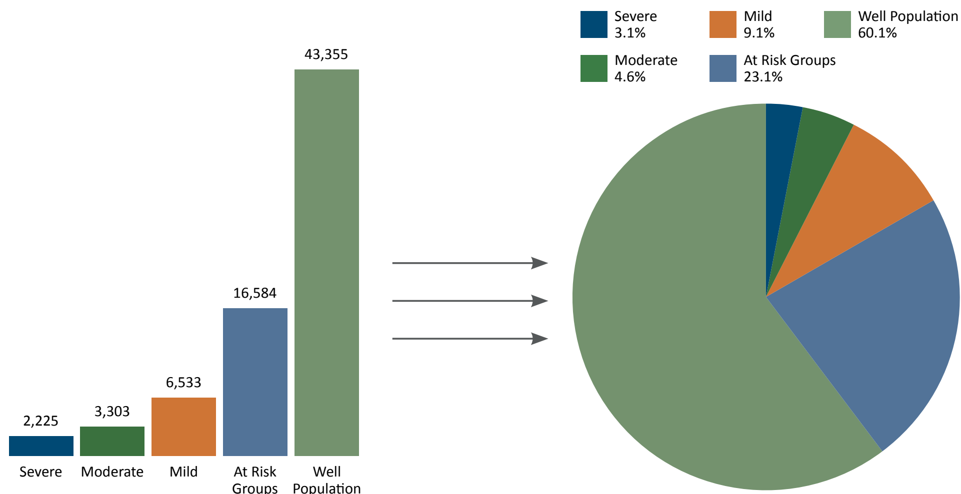
The treatment population estimates are based on national averages, and have not been adjusted to allow for the unique characteristics of the Western Queensland population. Given the demography of our region (99% remote or very remote, large pockets with low socio-economic status, and a higher than average proportion of Aboriginal and Torres Strait Islanders) we have assumed that this data shows the minimum number of people in each category and age group, and that the actual need is likely to be higher.

WQPHN understands that work on the NMHSPF is ongoing and that the basis for estimated treatment targets will be updated as further advice becomes available. The estimates presented here are based on the evidence and advice available at the time of writing.

The burden of mental health and AOD disorders is such that WQPHN and its partners are not prepared to await final data to act. Accordingly, these estimates will be used as interim targets to guide and focus consideration of priority and investment through the next phase of implementation planning. Updates will be incorporated as they become available.

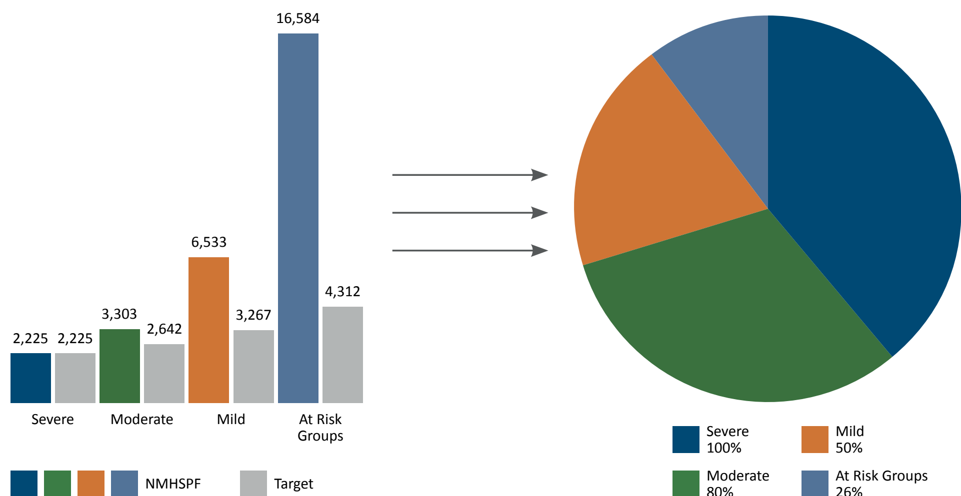
The development of validated, high quality health intelligence to provide better insights into the incidence of mental illness within the defined localities of the WQPHN, and be supported by data sharing arrangements with commissioned providers, Queensland Health, general practice networks (including AICCHSs) and digital referral and treatment modalities.

Figure 1: Estimated prevalence of mental health and AOD disorders in the Western Queensland population



The pie chart on the right of Figure 1 shows the percentage of the population categorised by level of mental health need (severe, moderate, mild, at risk and well), while the bar graph at the left shows the number of Western Queenslanders in each group (assuming Western Queensland had the Australian national average prevalence of the various levels of need).

Figure 2: Estimated treatment targets for mental health and AOD disorders in the Western Queensland population by severity levels.



The pie chart on the right of Figure 2 shows the estimated treatment targets as percentage of people at each level of need.

The bar graph on the left of Figure 2 shows the estimated treatment targets (in orange) in numbers relative to the estimated number of people at each level of need.

Based on this approach, treatment targets have been calculated for the three HHS districts, as set out in Table 1.

Table 1: Treatment targets for North West, Central West and South West

SEVERITY LEVEL	TOTAL TREATMENT POPULATION	NW TREATMENT POPULATION	CW TREATMENT POPULATION	SW TREATMENT POPULATION
Severe	2,225	1,011	385	829
Moderate	2,642	1,200	458	984
Mild	3,266	1,484	566	1,216
At risk group	4,312	1,959	747	1,606
Total treatment population	**12,409**	**5,639**	**2,149**	**4,621**
Total population number including treatment population	71,787	32,621	12,433	26,733

The draft NMHSPF sets treatment targets for each level of severity of need that are consistent across age groups with the exception of targets for people at risk, which decrease as people age (72.5% for people aged 0 - 17, 19.7% for people aged 18 – 64, and 9.4% for people aged 65 and over). In light of its relatively youthful population, Western Queensland has higher treatment targets for young people than the Australian average, and adjusting for population age structure results in total treatment targets that are higher than the national average. Treatment targets adjusted for age are summarised in Table 2, and are based on Australian Bureau of Statistics estimates of the Western Queensland age structure for 2014.

Table 2: Treatment targets by age group

SEVERITY LEVEL	TOTAL TREATMENT POPULATION	0 - 14	15 - 64	65 +
Severe	2,225	487	1,511	227
Moderate	2,642	578	1,794	270
Mild	3,267	715	2,218	334
At risk group	5,008	2,630	2,219	159
Total treatment population	**13,141**	**4,410**	**7,742**	**989**
Total estimated population	71,787	15,707	48,752	7,328

2.5 OVERVIEW OF CURRENT SERVICE DELIVERY MODELS

PRIMARY HEALTH CARE

The current provision of primary health care services is not meeting Western Queensland's needs. The traditional model of privately owned general practice is absent in many communities. The contribution that general practice can make to mental health and AOD service delivery is limited by current capacity and capability, with many people currently experiencing difficulty accessing general practice services. This has meant that the three HHSs in Western Queensland have become significant providers of primary and community health services, and difficulty in longer term recruitment has led to their reliance on locums and FIFO practitioners.

AICCHSs are also significant primary health care providers and deliver health services (including general practice) in many communities, but other communities don't have access to these Indigenous services.

MENTAL HEALTH AND AOD SERVICES

WQPHN commissions a small number of community based mental health services, including allied health providers, to deliver low intensity and psychological treatment services, mental health nursing support in general practice, youth mental health support (headspace), and alcohol and drug treatment services. There is some variation in the levels funded for each local area (Table 3).

Table 3: Mental health and AOD full-time equivalent (FTE) staff funded by WQPHN relative to population

	*MH & AOD FTES FUNDED BY PHN	POPULATION
Central West	6.3	12,433
North West	15.5	32,621
South West	7.5	26,733
Western Queensland	**29.3**	**71,787**

*Excludes any positions recruited under the Nukal Murra Social and Emotional Wellbeing (SEWB) service.

The three HHSs in the region (North West, Central West and South West) all deliver community-based mental health and AOD services within their local districts, although there is significant variation in the amount of service delivered relative to each HHS's population (Table 4).

Table 4: HHS mental health and AOD full-time equivalent (FTE) staff relative to population

	FTES EMPLOYED BY HHS	POPULATION
Central West	12	12,433
North West	60	32,621
South West	20.8	26,733
Western Queensland	**92.8**	**71,787**

Community-based mental health, suicide prevention and AOD services for the people of Western Queensland are also provided by general practice teams, AICCHSs, NGOs, private providers, digital healthcare providers, and HHSs from outside the region (via telehealth or FIFO services). There is currently no data available to show the quantum or spread of these services.

There are no inpatient mental health services in Western Queensland. Local hospitals are used for brief stays for people experiencing a mental health crisis, however in general people who require hospitalisation for a mental health concern are transferred out of area to mental health inpatient units in other parts of the State.

There are very limited AOD residential services available within the region. In the North West there are two NGO-delivered AOD residential services. These services are unable to meet the needs of people with complex co-morbidities and do not provide detoxification services. There are no other specialist NGO AOD services in other parts of the region. Hence as with mental health, most people who require AOD inpatient or residential services are transferred elsewhere in Queensland.

OUR COMMUNITIES

3. RESPONDING TO THE NEEDS OF OUR COMMUNITIES

In responding to the mental health and AOD needs in our communities, we will recognise what is currently working and draw on this strength to develop integrated local systems of care that build community capacity and enable people to get the right type of support when they need it, as close to home as is safe. Key to this is the wider WQPHN strategic vision which has comprehensive primary health care and the Western Queensland Health Care Home ideology at its core.

3.1 WQPHN'S STRATEGIC DIRECTION

The future direction for mental health, suicide prevention and AOD services set out in this Plan reflects WQPHN's overarching strategic vision, the key features of which are illustrated in Figure 3.

This vision and the key features are described in Our People, Our Partnerships, Our Health, WQPHN's Strategic Plan 2016-2020 (Western Queensland PHN, 2016). The WQPHN's strategy responds to the relatively high health needs of Western Queensland, the remoteness and sparse population of our communities, the poor public transport system, and the limited telecommunications. It also responds to the challenges of recruiting and retaining an appropriate health workforce – which for Western Queensland is centred on primary health care.

Figure 3: WQPHN's strategic framework

VISION
A comprehensive and integrated primary health care system that delivers better health outcomes for the people of remote Western Queensland

GOALS			
Improve the health of our population, and reduce inequalities	Enhance patients' and families' access and experience of care	Strengthen the capacity and capability of primary health care	Foster efficient and effective primary health care

STRATEGIES				
Work with partners to organisationally and financially integrate the WQ health system	Co- design and support a clinically integrated model of primary health care	Improve access to culturally competent primary health care for Aboriginal and Torres Strait Islanders	Implement strategies to prevent and better manage chronic and complex conditions	Implement strategies to improve maternal and child health and wellbeing

VALUES						
Collaboration	Fairness	Innovation	Integrity	Respect	Responsiveness	Participation

ENABLERS							
Corporate Governance	Clinical Governance & Leadership	Community Engagement	Commissioning Capability	Provider Development	Workforce Development	Use of Technologies	Health Intelligence

WQPHN is charged by the Commonwealth Government with improving the efficiency and effectiveness of primary care services for patients, particularly those at risk of poor health outcomes. It does this through planning and funding primary health care services, and building effective partnerships with key agencies to foster an integrated system of care. We are well positioned in this regard, given the WQPHN was established as an entity by the region's three HHSs (North West, Central West and South West) operated by Queensland Health.

One of WQPHN's five strategies relates to prevention and better management of chronic and complex conditions – including through mental health and AOD services. Fundamental to this will be the new model of comprehensive primary health care, which will provide the contemporary foundation on which efforts to improve mental health and AOD services will be built. Western Queensland's population and geographic characteristics mean that specialist services cannot operate in isolation from primary health care, but must work together through multidisciplinary teams. Key elements of the new Western Queensland model of care are described in Section 3.2 below.

3.2 COMPREHENSIVE PRIMARY HEALTH CARE

The transformation of primary care is one of WQPHN's key strategies to improve health care in Western Queensland.

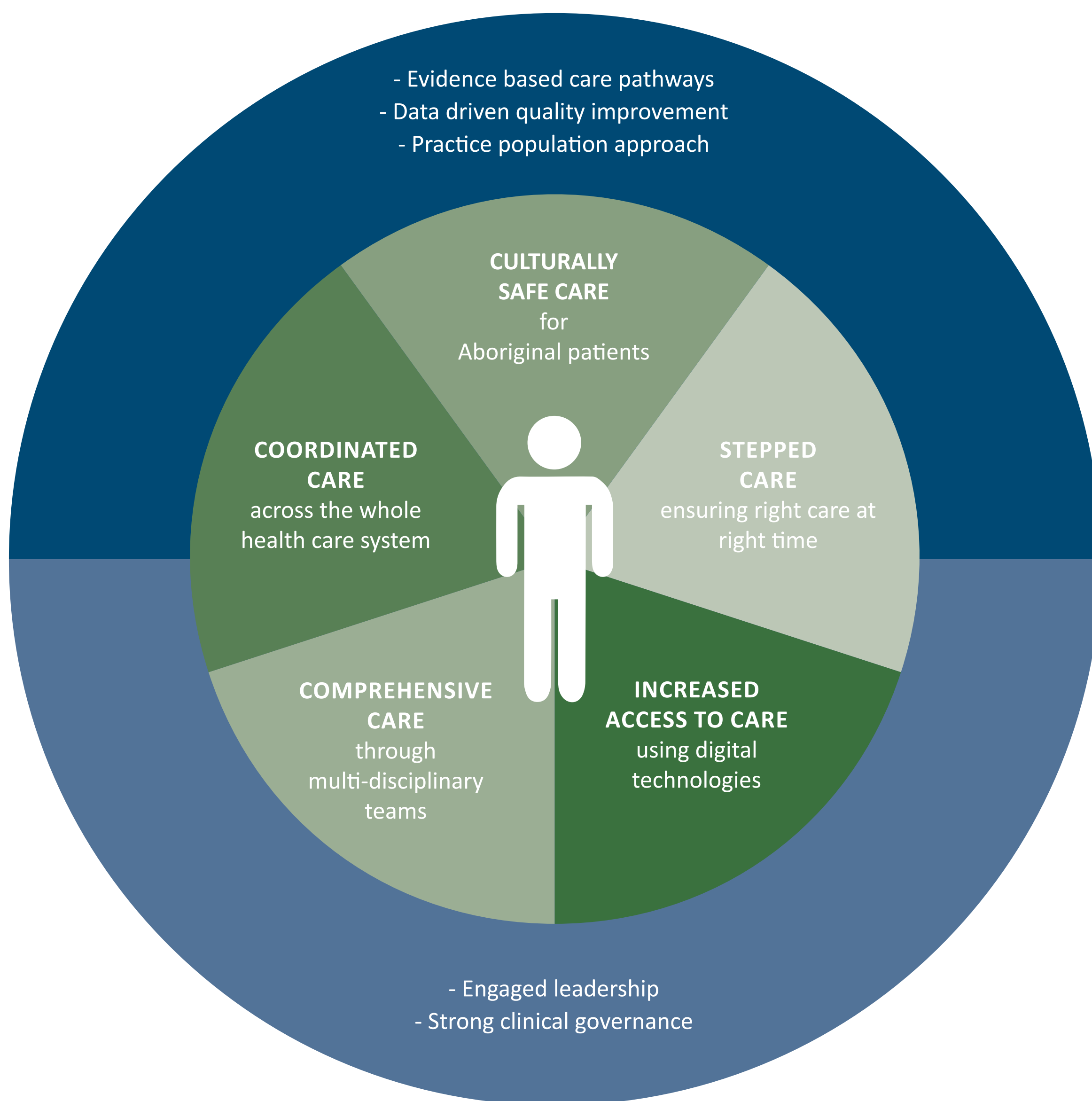
WQPHN is proposing a model of primary care innovation with the objective of ensuring the centrality of the patient in the provision of care; a general practitioner (GP-led multidisciplinary team model of care), better access to an appropriate level of help in your local community, continuity of support, improved self-care and improved population-based health and wellbeing outcomes.

At the heart of this transformation is the adoption of Western Queensland Health Care Home that enables greater customisation of support around the patient and ensures an integrated response to physical and mental health needs.

The key elements of the Western Queensland Health Care Home (Figure 4) are:

- Patient focused care where patients, families and carers are informed and are active partners in their own care
- Effective coordination of care across health care settings, good follow-up in the community following hospitalisations and appropriate long term support
- Improving the coordination of physical health care for people with a mental illness
- A practice-based population health approach
- GPs as champions of the model
- Comprehensive multidisciplinary team-based care
- Culturally safe clinical practice
- Coordination of care across the care delivery system, including appropriate digital interventions
- Support for shared care planning and delivery
- Accessibility for patients using multiple digital tools, including telephone, email and videoconferencing
- Matching the level of patient need with the right intensity of treatment
- Being culturally inclusive in how services are designed and delivered
- Actively seeking out the underserved people with higher needs
- Evidence-based care and data-driven quality improvement.

Figure 4: A WQ approach to support a person-centred health care home



SERVICE DELIVERY

4. PRIMARY MENTAL HEALTH AND AOD SERVICE DELIVERY IN WESTERN QUEENSLAND

4.1 THE NINE BUILDING BLOCKS

Within the overall Western Queensland Health Care Home approach, WQPHN and its partners have the opportunity to build a new model of primary mental health and AOD service delivery in Western Queensland based on the development of the nine building blocks (Figure 5). The aims and principles of the future service model are included in the Appendix to this Plan.

Figure 5: The building blocks of the new model of primary mental health and AOD service delivery in Western Queensland

BUILDING BLOCK 1: STEPPED CARE

Key to the future model of care will be the implementation of a region-wide, integrated, stepped care system of mental health and AOD service provision with the Western Queensland Health Care Home at the centre. Stepped care provides an evidence-based hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one-directional steps, but instead offering a spectrum of service interventions.

Using this approach, people with mental health or AOD concerns are matched to the intervention level that best suits their current need. They can enter the system at any level based upon their need at the time they are assessed. Regular monitoring and assessment, at a level and frequency tailored to an individual's circumstance, will be needed to ensure that the services can be varied over time as needs change.

There is no requirement to start at the lowest, least intensive level of intervention in order to progress to the next step.

It is anticipated that this system will help facilitate improved access to treatment, ensure a range of services is available to meet the needs of individuals and population groups, and make the best use of available workforce and technology. The stepped care model covers the full spectrum of interventions from self-help, digital and low intensity interventions, to primary and specialist clinical treatment and disability support.

The stepped care approach will provide a basis for joint planning and joint delivery of consistent mental health and AOD care, with greater emphasis on patient outcome measures.

Figure 6 below has been adapted from an illustration of the stepped care model for mental health developed by the National Institute for Clinical Excellence (NICE) in England (NICE, 2011). It shows the NMHSPF levels of need and population prevalence as a percentage and the NICE stepped care levels on the right.

Figure 6: NMHSPF stepped care model for mental health

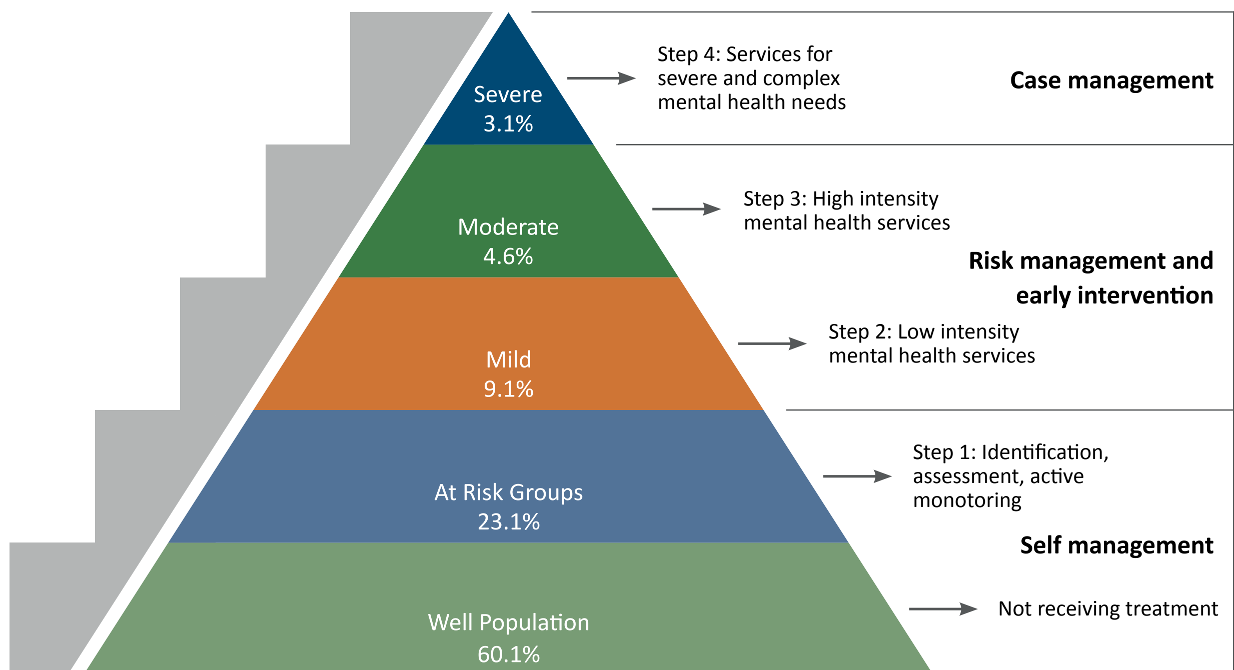


Table 5 maps the NMHSPF severity levels used in Section 2 of this Plan, and shows the treatment targets for the Western Queensland population to give an indication of the number of people likely to require services at each level over the course of a year. It also provides examples of the interventions for each level of severity and the providers delivering them in Western Queensland.

Table 5: WQ Mental health stepped care framework

NMHSPF LEVELS OF SEVERITY	TREATMENT TARGETS FOR WQ	EXAMPLES OF INTERVENTION
Severe	2,225 people	Specialist outpatient and inpatient care, including • medication and/or • Intensive psychological therapies and/or • psychosocial supports *Delivered by psychiatrists and other mental health or AOD professionals working for local and out of district HHSs and by NGOs.*
Moderate	2,642 people	Shared care set out in a shared care plan and including • medication and/or • intensive psychological therapies • consultation/liaison/advice provided by the multidisciplinary locality team to general practice • adjunct digital supports. *Delivered by extended general practice and the multidisciplinary locality team. Support and periodic review may also be provided from HHS Mental Health teams.*
Mild	3,267 people	General practice mental health treatment, set out in a treatment plan, including • brief psychological therapies • e-referral to triage and coordination where more support is required • health coaches • adjunct or stand-alone digital supports. *Delivered by extended general practice and by new non-regulated workforce roles with (appropriate skills, training and qualifications).*
At risk groups	4,312 people	General practice surveillance of registered population and linkage with low intensity resources, e.g. • provision of information and resources • follow up to support self-care • stand-alone digital resources and other new modes of access to supports for self-care e.g. apps, telephone/email. *Delivered by extended general practice and by new non-regulated workforce roles with (appropriate skills, training and qualifications).*

Table 6 provides an example of a patient journey through a stepped care journey where responses are tailored to need and varied over time.

Table 6: Example of a patient stepped care journey[1]

PATIENT JOURNEY THROUGH STEPPED CARE

Patient attends GP seeking assistance after separation from wife
GP identifies grief and loss issues, with K10 Score 20, no suicidal ideation. Refers to low intensity service.
Low intensity service works with patient for 4 sessions and identities perpetuating issues of excessive alcohol use and suicidal ideation triggered by siblings moving out with ex-partner, K10 scores 32, indicating high distress. Refers back to GP.
GP reviews patient and confirms diagnosis of reactive depression, completes a mental treatment plan (MHTP). Outcome: GP engages the services of PHN commissioned care coordinator to assist in managing complex needs. Case conference organised (for depression longer than 6/12).
Case conference attended by patient, GP, low intensity worker and care coordinator. Outcome: Safety Plan with Beyond Now (e-mental health app) completed with care coordinator, follow up sessions arranged, referral to PHN commissioned AOD worker with review of MHTP.
Review of MHTP at four weeks: No longer experiencing suicidal ideation through sessions with care coordinator and AOD worker. Outcome: Maintenance sessions with AOD and commence CBT for grief and loss with psychologist (P3). Care coordinator taking on going role in engaging the patient with community groups and facilitating stepped care with GP through case conferencing and review of MHTP.
Review of MHTP at three months: Care coordinator gathered information from AOD worker and psychologist which revealed K10 score of 15. Discharged from psychologist. Ongoing work with AOD worker and care coordinator both face to face and utilising e-mental health applications. Ongoing reviews of MHTP with GP and care coordinator.

[1]K10 is the Kessler Psychological Distress Scale. This is a 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4 week period.

BUILDING BLOCK 2: COMMUNITY CONTROLLED STRATEGY

Strategic Context

Improving access to culturally competent primary health care for Aboriginal and Torres Strait Islanders is one of the five strategic priorities for WQPHN.

AICCHSs are an enduring feature of the Western Queensland primary health care landscape, and WQPHN is committed to build a strong, resilient AICCHS sector to secure comprehensive, culturally appropriate local services throughout Western Queensland. WQPHN and AICCHSs of WQ have established the Nukal Murra Alliance which is developing a Joint Commissioning Performance Framework to enable commissioning approaches that support the development of a regional Social and Emotional Wellbeing Service (SEWB) that is clinically integrated with the wider mental health network. WQPHN will provide direct investment in the Western Queensland AICCHS sector and promote co-commissioning to expand and better link their services, general practice and specialist providers in the delivery of culturally competent primary mental health care.

Cultural Context

Aboriginal and Torres Strait Islander concepts of mental health and SEWB have been described as a "multidimensional concept of health that includes mental health, but which also encompasses domains of health and wellbeing such as connection to land or 'country', culture, spirituality, ancestry, family and community" (Dee, Dudgeon, Schultz, Hart & Kelly, 2014).

These domains are also described in terms of specific principles:

- Health as holistic
- The right to self-determination
- The need for cultural understanding
- The impact of history in trauma and loss
- Recognition of human rights
- The impact of racism and stigma
- Recognition of the centrality of kinship
- Recognition of cultural diversity
- Recognition of Aboriginal and Torres Strait Islander strengths.

A range of SEWB services operate across Western Queensland through State and Commonwealth funding to AICCHSs, numerous NGO providers and community initiatives. Often these services are disconnected from each other and operate in isolation from mental health treatment services .

Aboriginal and Torres Strait Islander cultures are ancient and contemporary, dynamic, strong, vulnerable and valuable. Embracing culture and identity serves to strengthen inclusion, understanding of health and is part of the strength of AICCHSs as representatives of the Aboriginal and Torres Strait Islander communities.

The four AICCHSs operating in Western Queensland are:

- Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health (CWAATSICH)
- Cunnamulla Aboriginal Corporation for Health (CACH)
- Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services (Goondir), with a specific focus on the Balonne Shire
- Gidgee Healing (Mt Isa Aboriginal Community Controlled Health Services Limited).

[2]A stocktake of services is currently being funded by WQPHN to assist in developing a Western Queensland community services directory.

Commissioning Approach
WQPHN has developed an Alliance Contract (Nukal Murra Alliance) with Western Queensland AICCHSs. The Alliance will bring members together for a common purpose with each member bringing their own expertise and contributions in order to achieve the goals of the Alliance.

The Alliance approach has been chosen as it best reflects the nature of the relationships that exists between the organisations, provides a mechanism to guide co-design and investment and will help maintain the focus for decision making and measuring of progress and outcomes on the purpose of the Alliance.

The Nukal Murra Alliance will enable the establishment of a clinically integrated SEWB capability that is founded on the common understanding that:

- Aboriginal and Torres Strait Islander mental health and well-being and mainstream primary mental health services are both specialist areas of practice and are to be respected as such; and,
- establishing connections across these two specialised areas of practice will enhance the effectiveness of both cultural care and clinical primary mental health care for Aboriginal and Torres Strait Islander people.

Key Features of Alliance:
The key features of the Western Queensland SEWB framework will include:

- Strengthening mental health multidisciplinary teams within and operated by AICCHSs
- Teams providing:
  - culturally competent clinical care, connected to the primary mental health care model outlined in this Plan, integrated with care plans, relevant general practices and specialist services in the region; and,
  - SEWB services, connected through the AICCHS to relevant community organisation and families, with State-wide support provided by QAIHC.
- Team composition will include Aboriginal Health Workers with both SEWB and clinical skills (or working to attain these), and clinical professional staff to provide supervision and guidance
- Catchment-wide plans for workforce training, professional development and local recruitment
- Operate within the single system of clinical governance across Western Queensland primary mental health care (Building Block 7)
- Planning for development and extension of services to, include communities currently beyond the reach of AICCHSs.

BUILDING BLOCK 3: INCREASED ACCESS USING DIGITAL TECHNOLOGY

Technology and information will be fundamental to the successful implementation of the integrated stepped care model outlined in this Plan. The range of e-health initiatives will include:

- Optimise readiness and adoption of digital technologies to enable general practice networks to better identify and enrol their patients with a mental illness within a stepped care model of care (Building Block 1)
- Greater interoperability to enable a shared electronic health record summary, and the use of shared care plans across general practice, HHS, NGO providers and patients
- Development and adoption of Clinical Prioritisation Criteria to support clinical pathways linked to stepped care.
- Better coordinated and prioritised e-referral between general practice and service provider networks
- Technology enabled discharge planning as part of stepped care
- Digital mental health interventions including self-guided and clinician-guided e-therapies, telemedicine and Apps.

[3]While the Alliance will drive governance, operation, reporting and evaluation of this venture, individual provider service contracts incorporating standard WQPHN terms and conditions will also be in place.

BUILDING BLOCK 4: GENERAL PRACTICE CAPACITY

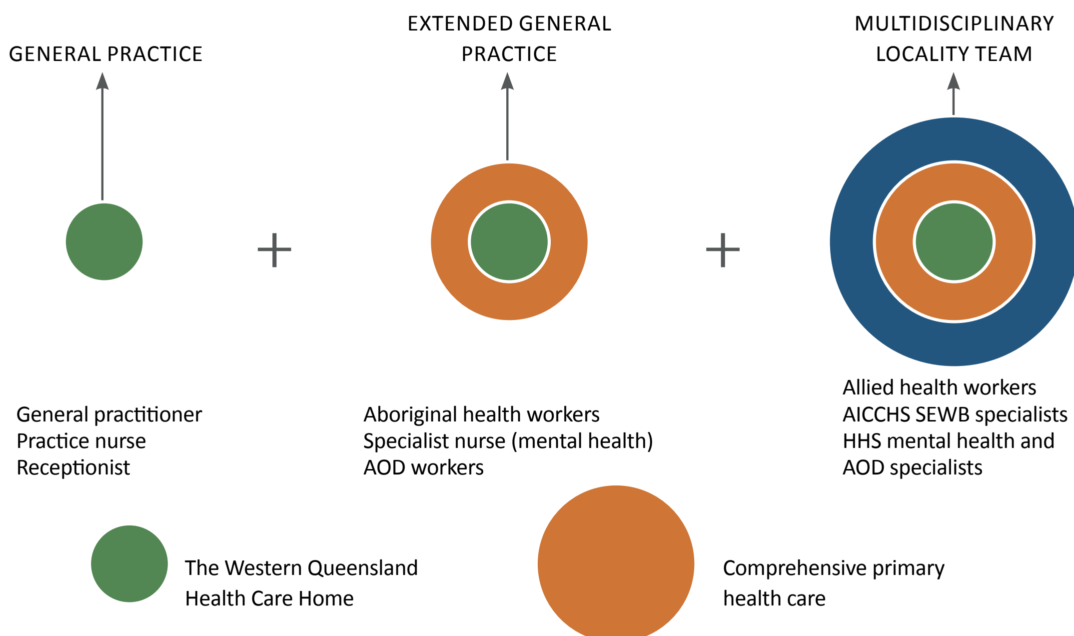
As illustrated in Figure 7, general practice teams, including those in the AICCHSs, will be at the centre of the future model of service delivery, and the Western Queensland Health Care Home will ensure an integrated response to physical and mental health needs, including better management of chronic conditions for people with mental illness.

The general practice team, in collaboration with HHS and NGO provider networks will have a pivotal role in identifying and managing the at-risk population and people with mild to moderate mental illness, matching interventions to patient need across the stepped care model, integrating service delivery and monitoring progress over time. There will be specific mental health and AOD expertise located within the extended general practice team (including mental health nurses and SEWB workers) and access to digital tools to extend workforce capacity and help manage access to services.

Within the comprehensive primary health care approach there will be close links between the Western Queensland Health Care Home and the multidisciplinary locality team. Wherever possible the sense of 'one team' across general practice and the multidisciplinary locality team will be supported by co-location, with the aim of enhancing access, care coordination and efficiency. Ensuring a shared narrative across the team and a clear understanding of roles, responsibilities and clinical pathways will safeguard patient experience, self management and navigation of care regimes.

WQPHN will develop general practice-based commissioning approaches across selected sites to develop a deeper understanding of workforce and system enablers critical in building capacity to better manage and prevent mental illness in remote practice populations.

Figure 7: The Western Queensland model of comprehensive primary health care, as it relates to primary mental health



General practice teams will also be closely linked to the social care sector to support recovery, wellbeing and resilience.

BUILDING BLOCK 5: HHS CLINICAL SUPPORT AND SHARED CARE

Joint planning will be an important component of the new model of service delivery, with the aim of ensuring integrated service responses and continuity of care across the stepped care continuum. To support collaborative planning, WQPHN, AICCHSs, HHSs and CheckUP will jointly develop local stakeholder networks within each of the HHS regions to:

- Plan and coordinate services regionally and within localities
- Optimise access to all available funding, including co-commissioning pooling of funds
- Develop mechanisms to promote greater integration of specialist services
- Support the development of clincial directories that document care pathways locally, regionally and State-wide, with the aim of ensuring seamless transition from primary to specialist services and back (particularly for those people who need to access specialist services out of the region) and ready access to specialist advice for general practice teams
- Support shared data arrangements to support measurement and improve service effectiveness.

BUILDING BLOCK 6: PLACE-BASED COMMISSIONING

By describing the full spectrum of mental health, AOD and suicide prevention services for WQPHN, and gaining shared ownership of the Plan by stakeholders involved in funding and providing services, WQPHN aims to provide a foundation for future co-commissioning of services that ensures both value for money and integrated care.

Through joint planning and co-design, all potential mental health, suicide prevention and AOD funding streams including Commonwealth, State and private health funding, and other relevant social services funding can be identified and aligned to support the stepped care approach.

WQPHN will leverage from the centrality of general practice to develop a co-commissioning framework that recognises the importance of best aligning available resources with outcome measures.

Critical in place-based commissioning is creating a more robust business model to sustain an expanded and well connected community based mental health service within the Western Queensland Health Care Home and regional localities.

BUILDING BLOCK 7: CLINICAL GOVERNANCE

Joined up, system-wide clinical governance arrangements are key components of an integrated model of care that will ensure shared care arrangements across multiple organisations and jurisdictions, including HHS and primary care services.

WQPHN will work with the Consortium (see Section 5), Clinical Council and Consumer Advisory Council to develop and implement a shared clinical framework to support stepped care and ensuring active patient engagement and participation as an equal partner in their health care journey. Clinical prioritisation within defined care pathways, agreed referral framework between primary and secondary care, and the adoption of digital technologies to support treatment and self management regimes will require robust shared clinical governance and agreed quality performance measures.

BUILDING BLOCK 8: JOINT PLANNING AND MONITORING

Essential to the development and refinement of a new model of care is monitoring implementation and continuously measuring performance to support and evidence based approach.

WQPHN commissioned services will provide data in accordance with the National Mental Health and the Alcohol and Other Drug Treatment Services minimum data sets (NMHMDS and AODTSMDS). This combined with other data sets within the WQPHN Qlik Sense Health Intelligence Portal (including practice-population level data, e-referral information, and other data sets) will inform service planning, facilitate ongoing performance monitoring and evaluation, and feedback performance information to service providers.

As part of the co-commissioning framework discussed above, we will work with our partners to agree on a consistent monitoring framework across the mental health and AOD stepped care system including:

- Shared health intelligence from customised reporting (WQPHN Qlik Sense), and using the NMHSPF and other population-based data within defined localities
- Integrated clinical information and shared analysis
- Performance measurement against agreed KPI measures, evaluation and support for improvement activities
- Implementation and analysis of a mental health and AOD minimum data sets and information systems to assist the responsiveness of assessment, treatment and patient reported experiences within the stepped care pathway.
- Development of collaborative arrangements with Queensland Health and an academic partner/s as part of the commissioning and development process.

BUILDING BLOCK 9: CONSUMERS AND CARERS

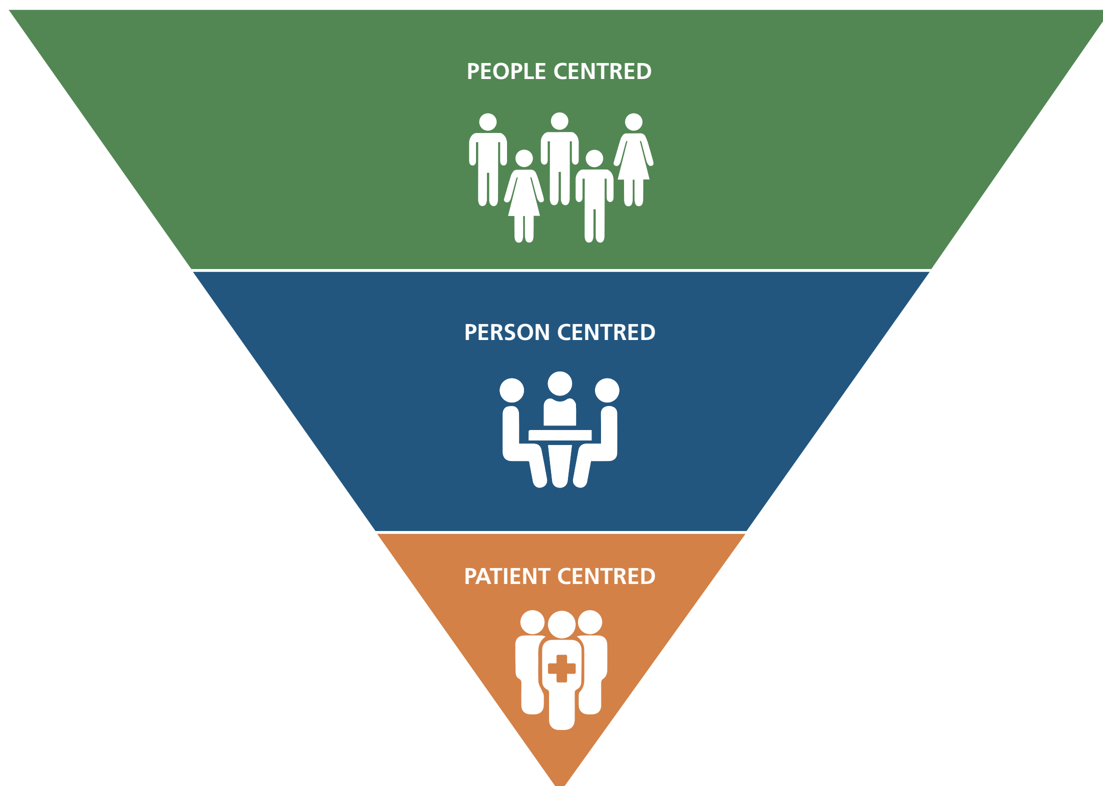
WQPHN recognises consumers and carers play a critical role in the planning, implementation and evaluation of quality health Services. Patient empowerment is fundamental to patient centred care and puts the patient at the heart of health care services so they can participate in decision making and take care of their needs. Figure 8. Patient Centred Model of Care

This Plan has been informed by the Western Queensland Consumer Advisory Council and representatives from Health Consumers Queensland who have generously contributed to the meetings of the Planning consortium. We are seeking to ensure organisational aligment through a joint approach to stepped care, shared and applied health intelliegence, careful resource allocation and joint funding and commissioning to create a more people centred mental health system.

Ensuring we hear from consumers and carers regarding their experience of care is important, particularly for those in crisis or with complex conditions where different providers and professionals are involved in care pathways. Primary care is increasingly delivered by teams across emergency, primary and social care settings rather than individual practitioners. Listening to patient experiences of care and incorporating the knowledge of people with lived experience is central to patient engagement, participation and quality of care.

- The WQPHN and its partners are committed to identifying the different levels of engagement and to ensure that people with lived experience can be active partners in the planning, implementation and evaluation and services. We will work with our HHS and AICCHS partners, Health Consumers Queensland and other mental health advocacy groups to adopt mechanisms to enable people with lived experience to inform peer group planning and service development activities.
- This framework will support new innovative mechanisms for hearing the voices of patients, families and carers at local and regional levels.

Figure 8: Patient Centred Model of Care



PEOPLE CENTRED

Engaging communities in the delivery of health care

Population based policy, analysing, applying and planning with health intelligence, resource allocation and funding innovation

PERSON CENTRED

Modifying the way services and organisations work

Greater emphasis on multidisciplinary team based care, working across jurisdictions, avoiding the communication mismatch through shared patient narratives

PATIENT CENTRED

Strengthening relationships between individual users and health professionals

Co-producers and greater engagement in health protective factors, harm minimisation and shared decision making. Holistic, culturally competent approach with an attitude of respect for individuals and his or her experience and need

4.2 MENTAL HEALTH

The mental health service continuum will encompass a comprehensive range of service responses tailored to the needs of individuals, families and communities. This continuum will include:

- Digital mental health interventions including self-guided and clinician-guided e-therapies
- Low intensity, time limited programs delivered by trained workers (health coaches) who may or may not be registered health practitioners. These interventions may be delivered by telephone, other electronic media, face to face or a combination of all three.
- Primary mental health services delivered via comprehensive primary health care. This includes interventions delivered by GPs, practice nurses and allied health professionals including access to psychological therapies, mental health nursing and SEWB services
- HHS community mental health services integrated as part of multidisciplinary locality teams which will be closely aligned with comprehensive primary health care.
- Specialist advice and support (including telemedicine options) that are well coordinated and closely aligned with comprehensive primary care and community multidisciplinary teams
- Out of region specialist services (public and private), that are well connected to local services and have mechanisms in place to ensure seamless transition between services for those people who require out of region responses.

Mental health services will be closely linked to the social care sector to support recovery, wellbeing and resilience.

4.3 SUICIDE PREVENTION

WQPHN will ensure it develops an evidence-informed, systems-based, region-wide approach to suicide prevention that is aligned with guidance provided by the Black Dog Institute (2016). Suicide prevention activities will sit within all levels of the stepped care model and be a key priority within each of the building blocks referred to in Section 4.1. We understand how stigma, a lack of resources, community knowledge and other social determinants impact help-seeking behaviours and how these factors need to be in scope for effective suicide prevention services.

Key areas of work will include:

- WQPHN will collaborate with HHS and AICCHSs to ensure an alignment of strategy and to adopt an integrated approach to suicide prevention that intersects with the needs of local communities, is culturally informed, promotes early intervention and ensures support for people affected by suicide.
- Development of media guidelines on the reporting of suicide
- Strategies to reduce access to suicide means
- Training for gatekeepers (e.g. teachers and pharmacists) and frontline staff (e.g. police and emergency staff)
- Promoting access to evidence-informed digital options such as Lifeline, the suicide call back service, Beyond Blue's 'beyond now' app, and 'the Way Back' telephone support
- Training for general practice teams regarding suicidal behaviour, risk assessment, and detecting and treating depression and other common mental illnesses
- Ensuring appropriate consideration is given to regional and hard to reach groups. For example, men are known for their reluctance to seek help
- Ensuring systems are in place to provide assertive, coordinated follow-up and support for people who have self-harmed or attempted suicide
- The provision of prompt post-vention support for families and communities.
- Adoption of high quality health information systems and mental health training for primary care staff.

4.4 ALCOHOL AND OTHER DRUGS

As with the mental health service continuum, the AOD service continuum will encompass a comprehensive, well integrated range of service responses tailored to the needs of individuals, families and communities with the Western Queensland Health Care Home at the centre of service delivery.

General practice teams will be supported by local AOD workers, and by addiction specialists via FIFO and tele-medicine options. Treatment modalities will work across early intervention and community education, relapse prevention, counselling, pre and post rehabilitation support and case management and coordination.

This AOD service spectrum will be implemented within the stepped care approach and include:

- Population-based promotion and prevention programs aimed at supply reduction and increasing awareness of AOD related issues
- Digital and telehealth options such as the Alcohol and Other Drug Information Service
- Low intensity, time limited programs delivered by trained workers (health coaches) who may or may not be registered health practitioners. These interventions may be delivered by telephone, other electronic media or face to face
- Primary level services delivered via the extended general practice team. This includes harm reduction and treatment interventions delivered by GPs, practice nurses and other allied health professionals
- HHS AOD services will form part of the multidisciplinary teams that are closely aligned to general practice. This will include the provision of consultation and advice to general practice teams
- Specialist advice and support via FIFO and telemedicine options that are well coordinated and closely aligned with the general practice and multidisciplinary teams. This will include assistance with opiate treatment programs, withdrawal management and psychosocial interventions
- Access to local detoxification programs (community-based and in local hospitals)
- Advocacy for better access to local residential rehabilitation services
- Out-of-region specialist residential and inpatient services (public and private), that are well connected to local services and have mechanisms in place to ensure seamless transition between services.

NEXT STEPS

5. IMPLEMENTING THE PLAN

5.1 THE CONSORTIUM

The stepped care approach that underpins the Plan involves a wide range of organisations that have a role in identifying the level of care people need, linking people to services, or providing services that meet needs. Each of these organisations has its own specific role to play and works closely with others to ensure that the stepped care approach works in practice.

There is currently no overarching system-wide clinical governance framework in place to guide practice across the many organisations involved in order to ensure that stepped care supports people to achieve the outcomes they need.

For this reason, one of the first steps in implementing this Plan will be to re-convene a MHSP and AOD planning consortium to develop system-wide, patient-centred clinical framework to support the implementation of the stepped care approach including for example:

- definition of care packages across stepped care spectrum
- development of appropriate outcomes measures
- defining the patient progression within a stepped care framework
- enabling cultural competence
- capturing and sharing data (e-referral, discharge planning, stepped care)
- sharing information
- multidisciplinary team based care and shared care planning
- clinical pathways including referrals
- patient engagement and communication strategies
- workforce development and supervision
- optimal utilisation of the visiting specialist workforce within the Western Queensland Health Care Home and stepped care approaches outlined in this Plan
- utilising telemedicine

The consortium will be strengthened by additional consumer and carer members with lived experience and will play a key role in developing a formative evaluation framework, potentially with an academic partner, that will enable WQPHN and partners to learn from our experience in order to refine our model and commissioning approach. The work of the consortium will continue to be supported by the Clinical Council (and three Clinical Chapters), the Consumer Advisory Council and other Mental Health peer-led forums that were established to assist the implementation of this Plan.

5.2 ACTIVITIES TO PROGRESS THE BUILDING BLOCKS

Successful implementation of the direction outlined in this Plan will require a systematic and coordinated approach to implementing the identified building blocks. There is work underway, the process is highly iterative and planned for early implementation of these, including:

1: STEPPED APPROACH

- Shared health intelligence and planning using the NMHSPF to better understand mental health needs within practice populations and across the catchment
- Ongoing promotion of the stepped care approach with clinicians and administrators as the basis for joint planning and joint delivery of mental health care
- Development of systematic approaches to enable assessment and re-assessment to monitor changing needs and prompt consideration of appropriate adjustments to levels of care when indicated.
- Further definition and transition toward stepped care for existing mental health allied health providers and headspace (Mount Isa), with an emphasis on supporting patients in general practice populations and contributing to greater team based care outcomes across mild and moderate mental illness.

2: COMMUNITY CONTROLLED STRATEGY

- Establishing an Alliance with Western Queensland AICCHSs to improve access to and quality of, mental health and AOD services for Aboriginal and Torres Strait Islanders, including the commissioning of AICCHSs to establish the new SEWB workforce with combined cultural and clinical skills to deliver treatment and build effective connections between cultural and clinical practice areas. (For example, the 'AOD our Way' program from the Queensland Indigenous Substance Misuse Council)

3: INCREASED ACCESS THROUGH DIGITAL TECHNOLOGY

- Linking patient data is a pre-requisite for improving quality across pathways of care.
- Build the capacity and linkage of practice-based mental health information systems to guide patient identification, and enrolment into stepped care support
- Introduction of an electronic referral tool for all primary mental health providers and general practices to use in supporting referral and follow-up coordination across providers
- Commissioning a national specialist mental health provider to tailor digital options to support greater self-management and low intensity services as part of stepped care support in Western Queensland
- Exploration and implementation of new modalities appropriate to Western Queensland, e.g. Apps, telehealth.
- Evaluate the adoption of health pathways for mental illness, particularly for people suffering moderate to severe illness.

4: GENERAL PRACTICE CAPACITY

- Building general practice capacity and capability to identify and manage the at-risk population and mild to moderate mental illness, substance use disorders through the Western Queensland Health Care Home and stepped care models
- Boosting access to mental health nurses through practice-based commissioning initiatives in selected sites
- Building practice capacity and systems for planning care and access to multidisciplinary support within a stepped care framework. This will involve identifying and engaging with patients within a practice population, particularly those with severe mental illness and those with chronic disease.
- Supporting Practice-based data support and systems development including data cleaning, staff training and support, provision of monthly practice supports and KPI development, and adoption of other enablers linked to the Western Queensland Health Care Home.

5: HHS CLINICAL SUPPORT AND SHARED CARE

- Continue to ensure representation and leadership from HHS on the mental health planning consortium.

- Support clear referral pathways between HHS and general practice (including AICCHSs) and ensure the adoption of shared care arrangements, particularly for patients with a severe mental illness
- Ensure shared care approaches and better referral and information exchange between HHS mental health and AOD workers and general practice.
- Shared health intelliegence on priority patients including shared registers linked to stepped care, and joint KPI measures linked to reduced hospital and emergency department presentations.
- Promote better access to specialist networks and harmonise assessment and referral practices to create a more seamless patient journey with formal linkage to general practice
- Developing mechanisms to enable the adoption of more responsive and better integrated suicide prevention and support programs and services within a multidisciplinary team based approach
- Collaborating closely with the South West HHS integrated mental health initiative including joint planning, workforce development and early adoption of patient-centred general practice-based stepped care approaches across hospital mental health and community based provider networks.
- Joint advocacy for mental health residential support within HHS facilities.

6: PLACE-BASED COMMISSIONING

- Augmenting WQPHN purchasing capacity through:
    - joint commissioning strategies
    - shared health intelligence within the WQPHN Qlik Sense at LGA, locality, HHS and catchment wide.
    - promoting greater MBS and private market activity
    - promoting greater multidisciplinary team based approaches
    - pursuing priorities in integrated planning and service delivery across major providers
    - Alliances to promote improvement outcomes.

7: CLINICAL GOVERNANCE

- Working with general practices, HHS mental health teams and AICCHSs to develop a single system for clinical governance across multidisciplinary teams and stepped care.
- Building the clinical and system capacity to actively monitor patients and to competently intervene as a patient's mental illness improves or declines within a stepped care framework will be a critical area of focus within general practice networks and wider multidisciplinary team based care.
- Development of clinical prioritisation for high risk patients and joint configuration and adoption of health pathways for mental health.

8: JOINT PLANNING AND MONITORING

- Support the ongoing work of the regional consortium as part of ongoing design and development activities
- Joint planning with HHSs, AICCHSs and Clinical Council to produce a common understanding and foundation from which to pursue the Western Queensland primary mental health care model
- Incorporating relevant mental health considerations into planning being led by WQPHN to develop a model of care for child and maternal health services, and into planning for chronic conditions
- Improving the collection and quality of information about services provided
- Using data effectively for monitoring and quality improvement.
- Ensuring high quality data reports from WQPHN Qlik Sense to evidence-inform planning, system redesign and investment.
- Through the adoption of consumer informed data, we will also measure what matters to patients.

5.3 OTHER PRIORITY ACTIVITIES TO IMPROVE MENTAL HEALTH, SUICIDE PREVENTION AND ALCOHOL AND OTHER DRUG SERVICES

- Establish procedures with HHSs to ensure appropriate follow-up from primary care or mental health team resources for people who are at risk returning to the community. The aim will be to ensure patient enrolment within a clear recovery pathway within a nominated case manager and general practice team.
- Complete work with the Queensland Mental Health Commission on piloting a collective impact approach to place based suicide prevention, implementing evidence based suicide prevention strategies and an evidence based framework for community capacity building and risk identification in remote communities. A critical element of the project will be to ensure non-clinical community based interventions are integrated with established clinical networks and general practice services.
- Develop through the Consortium, a suicide prevention plan to coordinate and prioritise strategies including stigma reduction, new models of shared care to promote coordination across primary and social care systems in line with available resources.
- Develop an AOD specific sub-plan in collaboration with QNADA and specialist NGOs to increase access to additions medicine specialists and build skills within the generalist primary care workforce.

5.4 BUILDING CAPABILITY AND CAPACITY

Successful implementation of this Plan will rely on the efforts of skilled and motivated staff working alongside service users and their families. To this end, WQPHN and its partners will prioritise workforce development and will actively involve consumers and their families when developing, reviewing and refining their Plans.

WORKFORCE SUPPORT AND DEVELOPMENT

In order to implement the stepped care approach and Western Queensland Health Care Home models outlined in this Plan, WQPHN will work to build capability and capacity within general practice teams through upskilling the existing workforce in better meeting mental health and AOD needs, and the exploration of new workforce roles .

WQPHN will work with the HHSs to align and coordinate workforce development across HHS and primary care services including mental health, first aid training, training in the stepped care approaches, care pathways training and professional development for GP's and practice teams.

In collaboration with partners, develop a structured continuing medical education program and continuing professional development to guide the knowledge and uptake of the stepped care approach, support new roles for health professionals, expanded scope of practice, and allocate health professional roles efficiently within the primary care system.

Furthermore, recruitment and retention policies and practices will be developed to foster a skilled primary mental health workforce. A key part of this initiative will be building capability within local communities to undertake roles such as that of SEWB workers, care coordinators and navigators, advanced nursing skills (including mental health) and health coaches.

CONSUMER INVOLVEMENT

Mechanisms for ensuring participation by consumers and carers in formal and informal planning, implementation, delivery and evaluation of all activities associated with this Plan will be established. This will include:

- Applying principles of co-design when commissioning services – with a focus on recovery-oriented approaches
- Workforce development and planning which is inclusive of trainers and educators with lived experience
- Identifying and addressing the goals of consumers and carers at each point of the commissioning cycle
- Actively seeking to eliminate stigma and discrimination in primary health care settings.
- Providing community education and training for consumers and carers including campaigns to improve health literacy, reduce stigma and promote education and self management

5.5 REVISING OUR PLANS TOGETHER

This Plan is intended to be a living iterative document. It describes our intent regarding our future model of care, our commissioning framework and forms the basis for what will work best for our population. WQPHN will adapt as necessary to Commonwealth and State policies, emerging health needs and unforeseen factors in the operating environment.

The Plan reflects the foundation of strong partnerships between key stakeholders in Western Queensland with a shared purpose of achieving improved mental health and wellbeing in our communities. Our ongoing collaboration will enable us to achieve that purpose.

APPENDIX

AIMS AND PRINCIPLES

The key aims of the future mental health and AOD service model are to:

- Keep people well and out of hospital
- Minimise harm from alcohol and other drug use
- Reduce inequalities for Aboriginal and Torres Strait Islanders
- Prevent suicide
- Enhance patients' and families' access and experience of care
- Strengthen the capacity and capability of primary health care
- Maximise the use of available funding
- Promote well-connected, easy to navigate and well-coordinated clinical treatment for mental health and AOD issues across local and regional settings
- Promote joint planning, needs assessment, health intelligence, data systems, performance management and accountability.

The principles listed below will guide the development and delivery of mental health, suicide prevention and AOD services in Western Queensland:

- Evidence informed
- Consumer and carer participation at all levels
- Culturally safe and competent
- Strong clinical leadership
- As close to home as possible
- Coordinated and cohesive to enable ease of navigation for clients, carers and clinicians
- Actively support self-management and recovery focused services
- Intervene early to keep people well
- Greater innovation and engagement with Aboriginal and Torres Strait Islander primary care providers.

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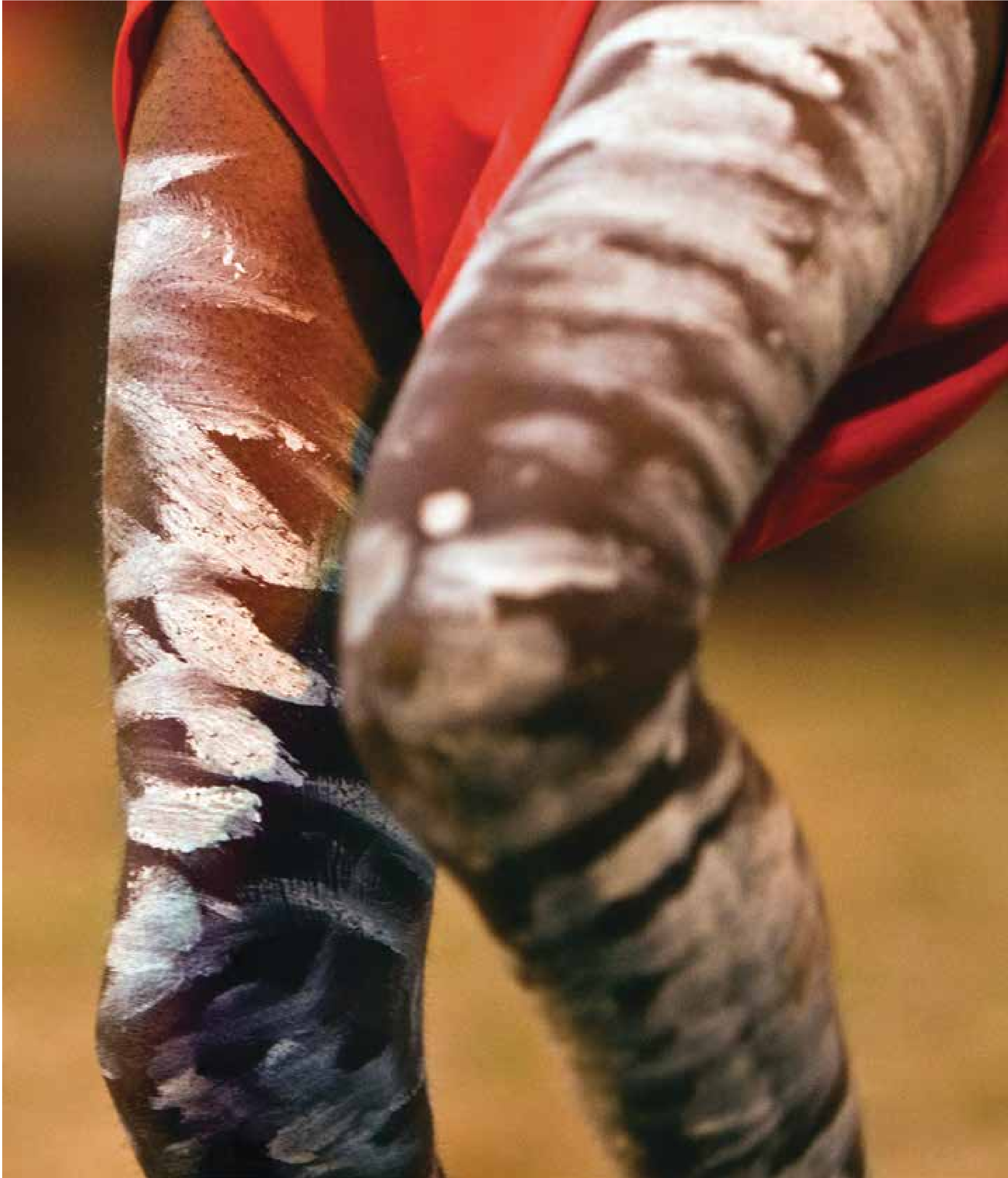
OUR PLANNING CONSORTIUM



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Australian Government

Western Queensland PHN acknowledges the traditional owners of the country on which we work and live and recognises their continuing connection to land, waters and community.

We pay our respect to them and their cultures and to elders past and present.