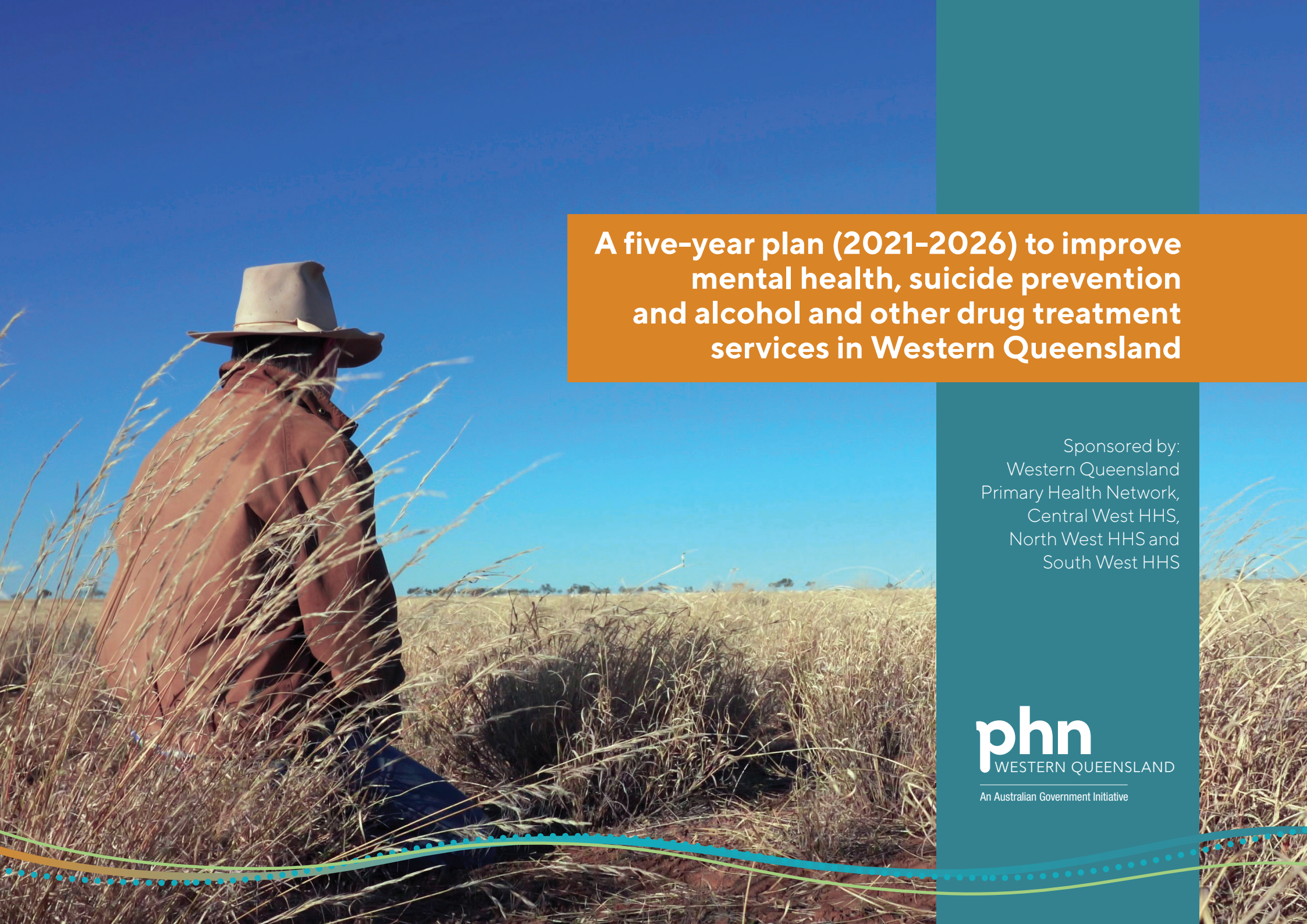


A five-year plan (2021-2026) to improve mental health, suicide prevention and alcohol and other drug treatment services in Western Queensland

Sponsored by:
Western Queensland Primary Health Network, Central West HHS, North West HHS and South West HHS

phn
WESTERN QUEENSLAND
An Australian Government Initiative

Acknowledgement of Country

We wish to acknowledge the traditional custodians of the land on which we share our lives, care for our families, communities and country to create the best possible future for all our children for the generations to come.

We acknowledge Elders both past and present and acknowledge Elders from the Stolen Generation. It is their strength and spirit that makes our work possible. It is to their memory we dedicate our efforts.

Contents

List of acronyms

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
AEDC	Australian Early Development Census
AIHW	Australian Institute of Health and Welfare
AHPRA	Australian Health Practitioner Regulation Agency
AOD	Alcohol and Other Drugs
ASR	Age Standardised Rate
ATAPS	Access to Allied Psychological Services
BAP	Better Access Program
CACH	Cunnamulla Aboriginal Corporation for Health
CWHHS	Central West Hospital and Health Service
COPD	Chronic Obstructive Pulmonary Disease
CWAATSICH	Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health
CWHHS	Central West Hospital and Health Service
ED	Emergency Department
EPC	Enhanced Primary Care
FTE	Full Time Equivalent
GP	General Practitioner
HNA	Health Needs Assessment
HHS	Hospital and Health Service
IRSD	Index of Relative Social-Economic Disadvantage
LGA	Local Government Area
LGBTIQ+ people	Lesbian, gay, bisexual, transgender, intersex, and/or queer people
MBS	Medicare Benefits Scheme
MHNIP	Mental Health Nurse Incentive Program
MHSPAOD	Mental Health Suicide Prevention, Alcohol and Other Drugs
MICRRH	Mount Isa Centre for Rural and Remote Health
NDSS	National Diabetes Services Scheme
NGO	Non-Government Organisation
NHPA	National Health Performance Authority
NMHSS	Nukal Murra Health Support Service
NMHSPF	National Mental Health Service Planning Framework
NWHHS	North West Hospital and Health Service
NWRH	New Ways Real Health
PBS	Pharmaceutical Benefits Scheme
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PP	Private Practice
RACF	Residential Aged Care Facility
RFDS	Royal Flying Doctor Service
SA2	Statistical Area Level 2
SD	Statistical Division
SEIFA	Socio-Economic Indexes for Areas
SMO	Senior Medical Officer
SWHHS	South West Hospital and Health Service
WQPHN	Western Queensland Primary Health Network
WQHSIC	Western Queensland Health Service Integration Committee
WQ HCH	Western Queensland Health Care Home
QLD	Queensland

Introduction

The five-year plan (2021-2026) to improve mental health, suicide prevention, alcohol and other drug (MHSPAOD) treatment services in Western Queensland provides the guidepost for future action and commissioning that support care pathways across settings. It is underpinned by The Fifth National Mental Health Plan and been informed by state and national policy direction, best available evidence, planning frameworks, service providers and most importantly consumers, carers and people with a lived experience.

The Western Queensland Health Service Integration Committee (WQHSIC) of which each of the Chief Executives are members would like to thank local community members and numerous organisations who provided feedback on surveys and shared insights at various roundtable events, meetings and as key informants in more formal evaluations. We also express our deep appreciation to those people with lived experience, their families and carers who shared their stories with us — the insights have been invaluable, and we are forever grateful.

We would like to thank the Western Queensland MHSPAOD Consortia who have undertaken one of the largest analyses of its kind in the region, and for providing the leadership to strengthening regional integration in supporting a more effective, person-centred service system.

The Plan is underpinned by nine targeted priority areas and includes objectives and actions that set the direction for change and provide a foundation for longer-term system reform.

The Plan acknowledges that it is not possible to fix everything at once and instead focuses on significant issues as part of a collaborative approach over the next five years. It therefore complements state and national strategies and focuses on areas where outcomes are best achieved by working together.

Sandy Gillies
Chief Executive Officer
WQPHN

Craig Carey
Acting Chief Executive
South West HHS

Jane Hancock
Chief Executive
Central West HHS

Dr Karen Murphy
Chief Executive
North West HHS

phn WESTERN QUEENSLAND
An Australian Government Initiative

South West Hospital and Health Service
Building better health in the bush

Central West Health
Leaders in far-reaching healthcare

North West Hospital and Health Service

Gayaa Dhuwi (Proud Spirit) declaration

We are committed to working with Aboriginal and Torres Strait Islanders leaders to ensure Australia's mental health system achieves the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples

On 27 August 2015, the National Aboriginal and Torres Strait Islander Leadership in Mental Health launched the Gayaa Dhuwi (Proud Spirit) declaration.

This declaration sets out five themes that are central to the development and implementation of the Fifth National Mental Health and Suicide Prevention Plan and the Western Queensland Social, Emotional and Cultural Wellbeing Plan.

1. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.

2. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

3. Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.

4. Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.

5. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

How mental health impacts us

Over the course of our lifetime, every one of us will be touched by mental health, suicide and alcohol and other drug (AOD) issues.

Getting the right type of support at the right time is essential to improve the mental health and wellbeing of our communities.

We all play a role in recognising the triggers and warning signs of mental health issues in order to access support for ourselves along with supporting friends, neighbours and families to seek help.

All of us have a responsibility to promote protective factors for good mental health and wellbeing, and to support the most vulnerable in our communities, including children and young people whose future health and wellbeing relies on the people around them, and access to services.

Nearly half of all Australians will **experience mental health issues** in their lifetime

Mental health can be affected by **genetics, lifestyle and environment**

Social problems include **poverty, unemployment, homelessness, isolation** and **stigma**

In Western Queensland **people present to emergency departments** with mental health issues 1.6 times more than the rest of Queensland[1]

2x

Suicide and self-inflicted **injury rates are twice as high** in Western Queensland than the rest of Australia[2]

(25%) of young adults aged between 16 and 24 will experience mental health issues[2]

One in five (20%) Australians will experience a common mental disorder **over a 12 month period[2]**

People living in low socio-economic areas are **1.4 times more likely** to have mental health issues[2]

In Western Queensland **risky alcohol consumption is 1.4 times more common** than in other parts of Queensland[3]

Our plan

This comprehensive five year Mental Health Suicide Prevention and Alcohol and Other Drug (MHSPAOD) Plan (herein known as the 'Plan') is a refresh of the first Plan (2017-2020).

Our Plan has been developed using a co-design process with our partners and other key parties who have committed to working together to achieve better health and social outcomes in Western Queensland through integration in planning, service delivery and evaluation.

Importantly, it incorporates the ideas and feedback from consumers, carers and people with a lived experience.

The Plan sets out shared objectives, an agreed set of actions and key responsibilities to address priority areas. It includes a regional approach for collaborative action to improve integrated mental health and related services.

The Plan

Regional approach for collaborative action on mental health and related services.

Consumers, carers, people with a lived experience

WQPHN Consortium representatives

- WQPHN
- North West HHS
- Central West HHS
- South West HHS
- Nukal Murra Alliance
- Health care providers
- Clinicians
- Consumers

Key stakeholders

- Local government
- General Practice Networks
- Aboriginal and Islander Community Controlled Health Services (AICCHSs)
- Peak bodies
- Health care providers
- WQPHN Clinical and Consumer Councils

Western Queensland Community

State and national policy context

Our Plan builds upon the Fifth National Mental Health Plan 2017-2022 (Fifth Plan), existing state and commonwealth MHSPAOD services along with the national health and mental health reforms.[4]

It incorporates reform and system transformation recommended by the PHN Advisory Panel on Mental Health and also considers a range of state and national mental health and suicide prevention policy reviews including:

- Productivity Commission, Mental Health Inquiry Report[5]
- The National Drug Strategy 2017-2026[6]
- Queensland Government, Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023[7] and Every Life: The Queensland Suicide Prevention Plan 2019-2029 [8].

This is a dynamic Plan that will be regularly reviewed and updated to ensure inclusiveness of contemporary material such as the Productivity Commission, the National Mental Health Commission releases, the National Children's Mental Health and Wellbeing Strategy and National Natural Disaster Mental Health Framework.

The Plan was developed following engagement with target groups such as consumers with severe psychosocial disability and alcohol and other drugs (AOD) services, to strengthen their interface with the National Disability Insurance Scheme (NDIS) as mental health reforms are implemented across communities.

Finally, it has been shaped within the context of Queensland Government's Connecting Care to Recovery 2016-2021 Plan[9] for state funded mental health, alcohol and other drug services, and within the vision of My health, Queensland's future: Advancing health 2026.[10]

Our goals and vision align to create a system that works better for individuals, families and communities by strengthening collaboration and promoting effective integration, thus enabling better connected care and recovery oriented services.

Challenges and opportunities

Challenges of delivering mental health care in Western Queensland

Positive social, emotional and cultural wellbeing is important for all people and communities in Western Queensland. Yet the impact of mental ill health, problematic AOD use and suicide across the region presents many challenges.

A significant number of people in Western Queensland continue to experience social dislocation, economic hardship and isolation which contributes to poor mental health and risky AOD use, with the impacts going far beyond the health sector.

There is significant health disparity and gaps in access to services and economic participation for the most vulnerable and at-risk populations for Western Queensland compared to city or urban regions.[5; 11]

Vulnerable communities

While there are pockets of social and economic advantage, large areas of Western Queensland experience extreme disadvantage compounded by social determinants which result in high levels of mental health issues or distress, suicide and problematic relationship with AOD use.

The health workforce

The Western Queensland health workforce is predominately generalist in nature. This presents a challenge in providing integrated, specialised and holistic care.

Transient populations with high need

In Western Queensland, there are significant numbers of fly-in/fly-out workers (FIFO), seasonal workers and tourists (particularly grey nomads) leading to skyrocketing demands for health services during the peak seasons.

Geographical challenges

Western Queensland's vast landscape means people travel long distances to access services. Many experience factors that contribute to increased mental health risk including:[12]

- Geographical isolation
- Telecommunication constraints
- Poor access to public transport
- Extreme weather conditions such as flood and drought
- A small population spread across widely dispersed communities.

Opportunities for improving mental health care in Western Queensland

Western Queensland's MHSPAOD system has undergone significant transformation including.[13]

- Emphasis on recovery-oriented practice and widespread adoption of harm minimisation
- Increased focus on creating pathways for consumers, carers and people with a lived experience to participate, influence and lead co-design of a better mental health system for Western Queensland.

There has also been a shift away from siloed, organisational centric care to a focus on a better integrated and coordinated primary mental health system of care.

The region's AICCHO sector has been strengthened through the Nukal Murra Alliance improved social and emotional wellbeing which provides significant cultural leadership capacity and change needed to address entrenched mental health-related stigma, shame and discrimination for First Nations people in the region.[14]

Other opportunities for reform

Place-based approaches

Continue adoption of place-based approaches to harness the strengths and enable communities to lead and support their own wellbeing including wrapping care around the people who need it most.

Partnerships

Continue building on local, regional and state collaborations and partnerships to support improvements and momentum to achieving better mental health and wellbeing outcomes for Western Queenslanders.

Western Queensland Foundation Plan

The Western Queensland Foundation Plan has positioned the sector well to consolidate and build on the important ground work in the MHSPAOD space and lead reform across our region. Learnings and recommendations from the Foundation Plan have helped shape this Plan.

Developing this plan

Review of the Foundation MHSPAOD Plan 2017–2020

WQPHN contracted the Substance Use and Mental Health Unit at the Centre for Health Services Research at The University of Queensland to conduct an independent evaluation of the foundation MHSPAOD Plan 2017–2020.[12] Areas of evaluation included implementation, effectiveness, achievements, strengths and areas for improvement.

The evaluation consisted of semi-structured interviews with key informants involved in a variety of roles related to the planning or delivery of mental health services across Western Queensland. The findings of this evaluation have informed the direction and objectives of this Plan.

Summary of findings

Areas of strength

Overall, the majority of key informants were highly complementary of the Plan's implementation (in particular its focus on place-based implementation and stakeholder input), and emphasis on collaboration, co-design, team care, cross referrals, and consumer input.

In particular, most key informants recognised the WQPHN's significant efforts in co-designing and implementing an innovative Plan that represents substantial progress in improving the mental health and wellbeing of Western Queensland's residents.

Most key informants perceived that the Plan had a strong focus on promoting consumers' and service providers' awareness of Western Queensland's MHSPAOD Services across the continuum of care, and a promotion of General Practice settings as key providers of mental health care.

The majority of key informants believed the Plan had a clear focus on addressing existing disparities in mental health support targeted at Aboriginal and Torres Strait Islander and other priority populations. In particular, several key informants commended the Nukal Murra Alliance for allowing the perspectives of Aboriginal and Torres Strait Islander-led health services in creating and implementing the Plan.

Finally, the majority strongly endorsed the Plan's focus on integration of the Stepped Care model, in particular the model's promotion of cross-referral between services.

Areas of potential improvement

While the majority of key informants praised the implementation and content of the Plan, key informants also highlighted areas of potential improvement for the 2021-2026 Plan in the following areas:

- Greater distinction of:
  - Implementation milestones
  - Service use characteristics
  - Visibility of cross referrals
  - Improved mental health outcomes among priority populations
  - Involvement of Aboriginal and Torres Strait Islander people in the Plan's design and implementation
- Utility and effectiveness of Stepped Care model
- Involvement and activities of the Consumer Advisory Council
- How to measure relevant outcomes
- Occasional lack of integration, communication and collaboration between various agencies and services
- Lack of understanding of some aspects of the Stepped Care model
- Lack of opportunities for consumer feedback.

Recommendations

1. The development of a complementary communication strategy
2. The development of a complementary implementation plan
3. Formation of a new Consortium for the 2021-2026 Plan
4. Inclusion of an executive summary at the beginning of the document
5. Further explanation of the Stepped Care model
6. Review of the Plan by the Consumer Advisory Council
7. Distribution of written and multimedia material promoting the Plan
8. Host in-person and online workshops/training introducing new Plan
9. Review and implementation of Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) systems
10. As part of communication strategy, regular progress updates
11. Continued hosting of mental health round tables
12. Ongoing seminars to disseminate data-driven updates.

Western Queensland Stewardship

The Western Queensland Health Service Integration Committee (WQHSIC) has provided overarching stewardship for this Plan's development and will provide ongoing support for its approval and implementation under the Maranoa Accord.

Plan sponsors

- WQPHN
- North West HHS
- Central West HHS
- South West HHS.

Plan partners

- Nukal Murra Alliance
- Clinical and Consumer Councils
- Health care providers
- Clinicians
- General Practice networks
- Aboriginal and Islander Community Controlled Health Services (AICCHSs)
- NGOs
- Local government
- Peak bodies
- People with lived experience and carers.

Consortium

The Western Queensland Consortium brings together stakeholders and consumer representatives who have considered contemporary evidence, Commonwealth and Queensland policies and our unique local context in order to consider joint approaches that leverage from integrated care, stepped care and joint commissioning.

Our Plan is a road map grounded in evidence and consumer expectations. The Consortium and Implementation Advisory Group are the touch points for implementation and co-design.

Western Queensland Stewardship

Western Queensland Health Services Integration Committee

WQ MHSPAOD Consortium

Nukal Murra Alliance	QAIHC	AOD	WQPHN Clinical & Consumer Council	Western Alliance Mental Health (WAMH)
Headspace	RHealth	Child & Youth	Lived Experience	Queensland Health MHAOD Branch
Qld Mental Health Commission	Older Person's MH	MHNiGP rep	Roses in the Ocean	North West HHS MHAOD
Australian Psychological Society (Telehealth)	QNADA	GP (special MHSPAOD interest)	CheckUP	Central West HHS MHAOD
Health Workforce Qld	University of Qld	RFDS (Qld Section)	NDIA	South West HHS MHAOD

The Plan will not over-ride existing funding agreements, service agreements or broader jurisdictional planning or business protocols. However, it will be used to guide commissioning and delivery of mental health, AOD and suicide prevention services. Having clear roles and responsibilities linked to implementation at a regional level will enable measurement and review of progress against the shared objectives and actions.

Community engagement

Our Plan:

- Aims to improve mental health, reduce the risk of suicide and address AOD issues in a sustainable way
- Is underpinned by the principles of early engagement, inclusivity, transparency, shared power, equity of knowledge and responsibility
- Builds on the strengths and abilities of local communities and services
- Was developed through a 12-month co-design process
- Empowers local communities through co-creation and co-design.

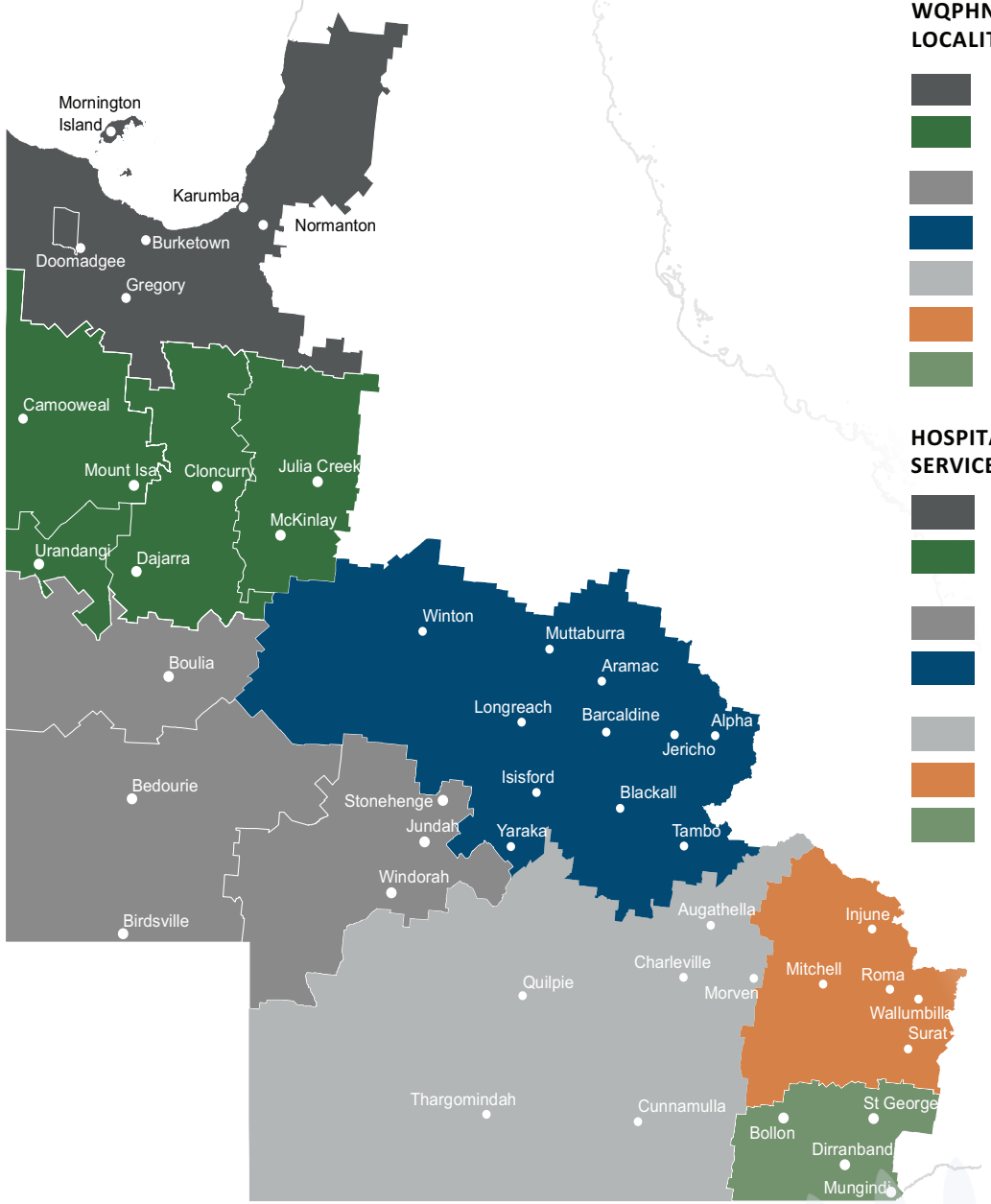
34%
of PARTICIPANTS
were carers and people with a lived experience

31 EVENTS

11 LOCATIONS

2 SURVEYS

3 CONSUMER FACEBOOK CAMPAIGNS



WQPHN COMMISSIONING LOCALITIES

- Lower Gulf
- Mt Isa and Surrounds
- Western Corridor
- Central West
- Far South West
- Maranoa
- Balonne

HOSPITAL AND HEALTH SERVICE BOUNDARIES

- North West HHS
- Central West HHS
- South West HHS

Our population

Geography and demography

WQPHN is the fourth largest PHN in Australia, with a total land area of 956,438 km^2 – equating to 55% of the total land area of Queensland.

Home to:[15]

62,369 people

10,435 17.2% are Indigenous Australians

34 Aboriginal language groups

34% under 25

88% of the population **live in remote and very remote areas**

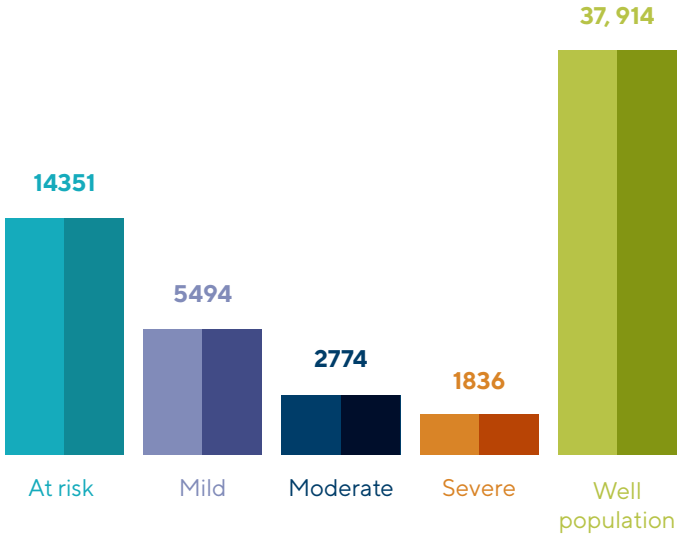
61% of the regions population are in the **two most disadvantaged quintiles (SEIFA)**

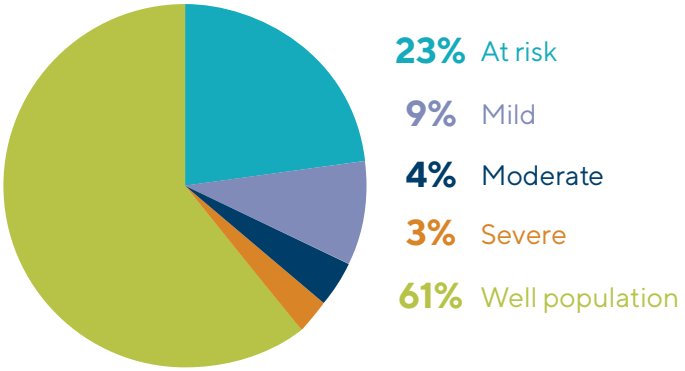
Prevalence rates

The National Mental Health Service Planning Framework (NMHSPF) is a tool developed by the University of Queensland to assist with the prediction of the prevalence of mental health conditions and demand for mental health services.

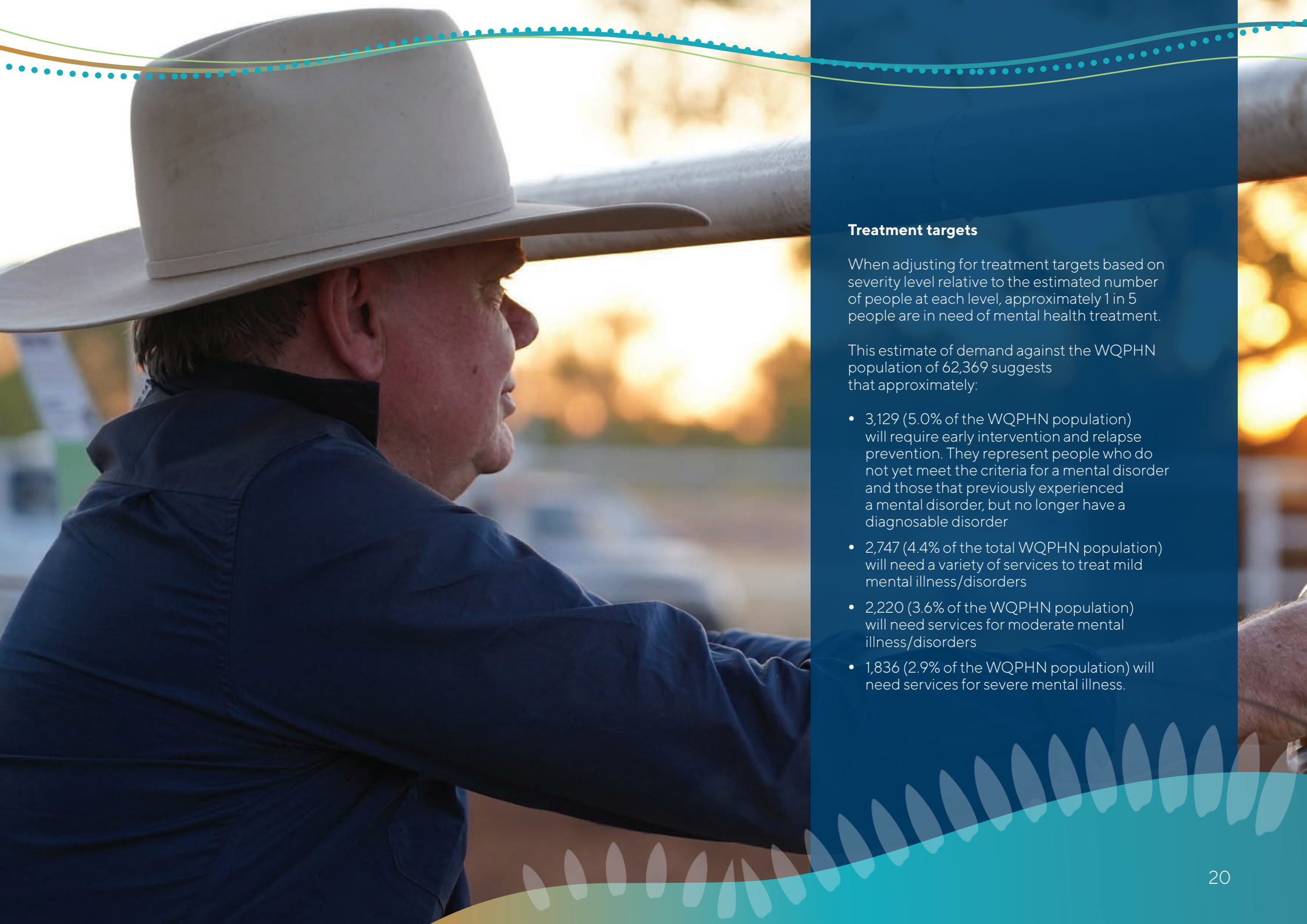
It utilises national averages which are applied to the population of a region (in this case the estimated resident population in June 2018 as determined by the Queensland Government Statistician's Office, Queensland Treasury).[16] These averages do not yet account for rurality and remoteness, Aboriginal and Torres Strait Islanders or people with low socio-economic status – all of which are higher in Western Queensland and are known factors that contribute towards increased mental health prevalence. As such the figures from the NMHSPF are a conservative estimate to assist in planning and coordination of services.

The figure to the right provides the estimated mental health prevalence across severity levels (severe, moderate, mild, at risk and well population) in Western Queensland with the graph showing the estimated number of people in each category and the pie graph showing the percentage of the population.





Estimated prevalence of mental health in the Western Queensland population



Treatment targets

When adjusting for treatment targets based on severity level relative to the estimated number of people at each level, approximately 1 in 5 people are in need of mental health treatment.

This estimate of demand against the WQPHN population of 62,369 suggests that approximately:

- 3,129 (5.0% of the WQPHN population) will require early intervention and relapse prevention. They represent people who do not yet meet the criteria for a mental disorder and those that previously experienced a mental disorder, but no longer have a diagnosable disorder
- 2,747 (4.4% of the total WQPHN population) will need a variety of services to treat mild mental illness/disorders
- 2,220 (3.6% of the WQPHN population) will need services for moderate mental illness/disorders
- 1,836 (2.9% of the WQPHN population) will need services for severe mental illness.

Overview of the Plan

Our Plan incorporates three discreet and complementary areas of work including:

- Mental health
- Suicide prevention
- Alcohol and other drugs (AOD) services.

It identifies significant opportunities for both service and system improvement based on extensive engagement and feedback from people who live and work in the region. This includes improvement to existing services along with enhancements to commissioning approaches and services.

The Plan also identifies opportunities to expand and tailor service delivery in conjunction with ongoing co-design and health planning linked to future service demand.

It makes no commitment to funding for additional future services, but instead commits to shared regional resource planning through the Consortium to consider proposed new or extended services.

Part A: Transforming mental health care

- WQ HCH – supporting a patient centred approach to care
- Embedding stepped care framework for mental health services
- Adopting a place-based, co-designed planning approach
- Making safety and quality central to mental health service delivery
- Addressing stigma and discrimination.

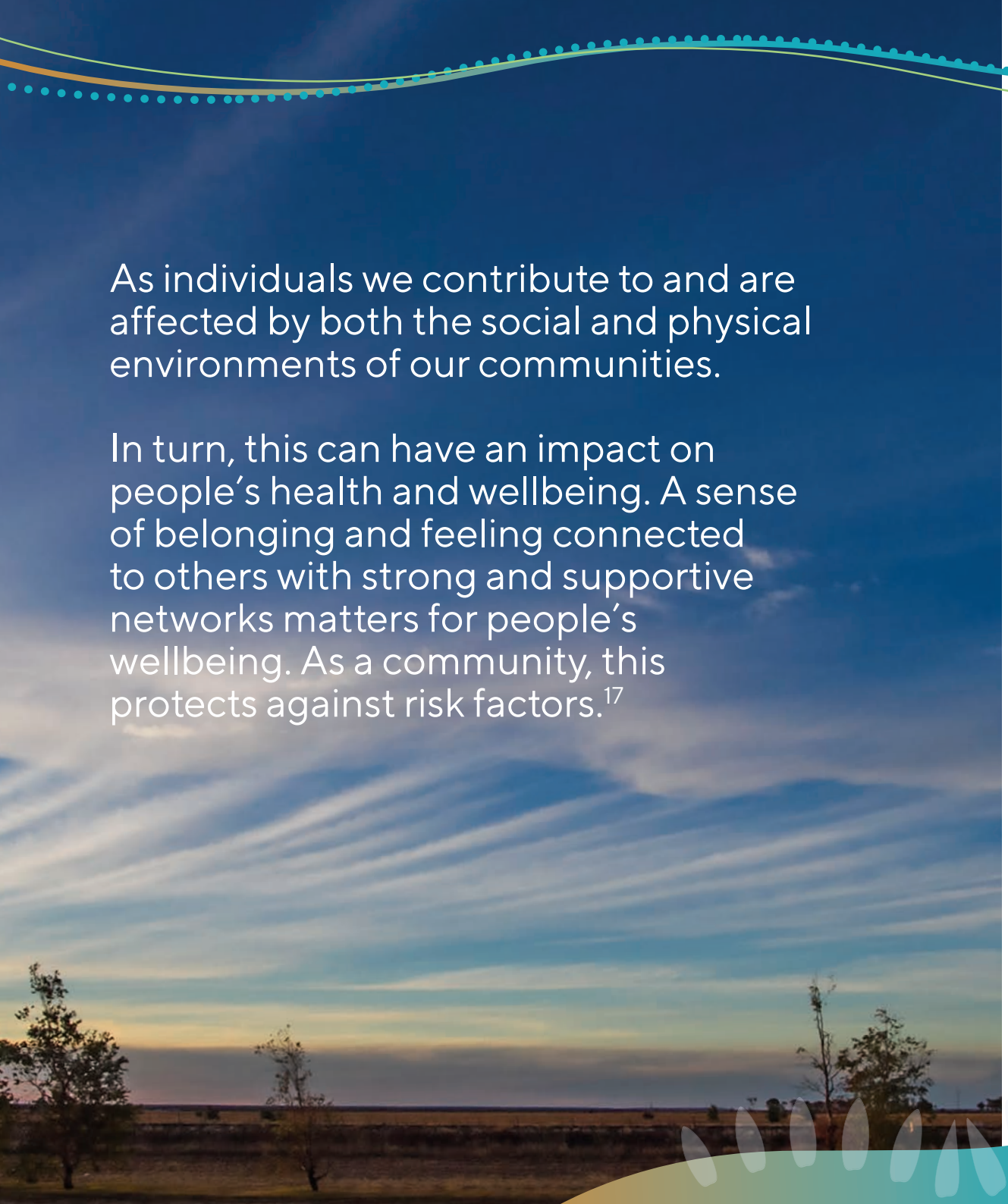
Part B: Delivering change

- Proactive prevention and early intervention
- Providing care across the lifespan
- Supporting Aboriginal and Torres Strait Islander social, emotional and cultural wellbeing
- Strengthening and integrating AOD treatment and harm reduction
- Making suicide prevention everyone's business
- Supporting people who experience severe and complex mental health
- Building workforce capability and grassroots training opportunities
- Responding to climatic extremes and rural decline.

Part C: Measuring change

- Measuring individual and service system outcomes
- Reporting and measuring progress
- Implementing the Plan.

Our vision: Western Queenslanders and their communities experiencing good mental health and wellbeing.



As individuals we contribute to and are affected by both the social and physical environments of our communities.

In turn, this can have an impact on people's health and wellbeing. A sense of belonging and feeling connected to others with strong and supportive networks matters for people's wellbeing. As a community, this protects against risk factors.[17]

Place-based, co-designed planning approach

Western Queensland communities face multiple challenges and often 'wicked' problems that are complex and difficult to solve. These problems often relate to living conditions, societal influences, limited access to services, geographical isolation, and 'siloed' funding models.

To address these problems we require a coordinated and cohesive approach that recognises and champions the important role communities play in shaping services and embedding consumer, carer and lived experience engagement into planning.

This Plan presents our blueprint for implementing stepped care using place-based, co-design approaches.

It harnesses the leadership, resources and opportunities of people and seeks contributions to strategies and ideas to improve health, social, economic and environmental outcomes.[17]

It embeds meaningful public and multi-stakeholder participation into service delivery and offers opportunities for Western Queensland organisations to address challenges and work together.

Ultimately, this is about reducing inequalities by improving the social, emotional and cultural wellbeing of our people and places.

The Western Queensland Health Care Home Model of Care

Western Queensland Health Care Home (WQ HCH) model provides proactive patient-centred, coordinated and flexible care with a team of professionals working together to make sure the patient receives care, based on their needs.

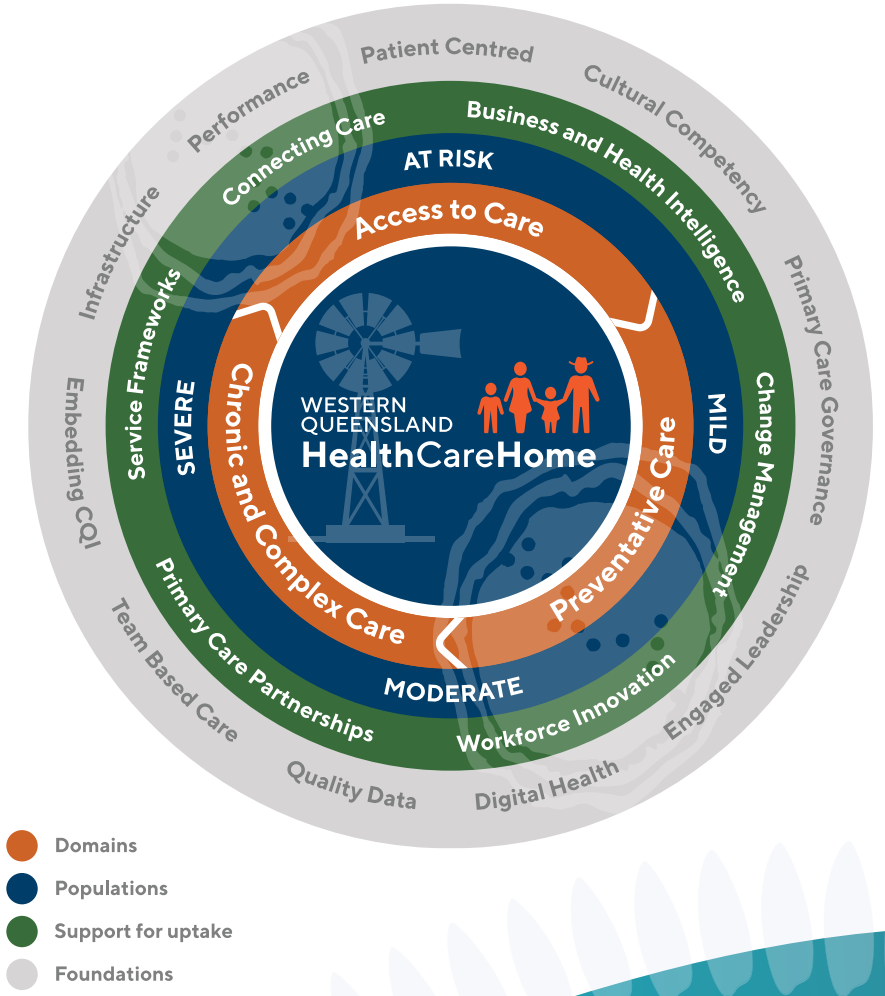
At the heart of this model is a whole-of-system integration approach that is focused on improving patient outcomes and experiences and places consumers at the heart of the local primary care system.

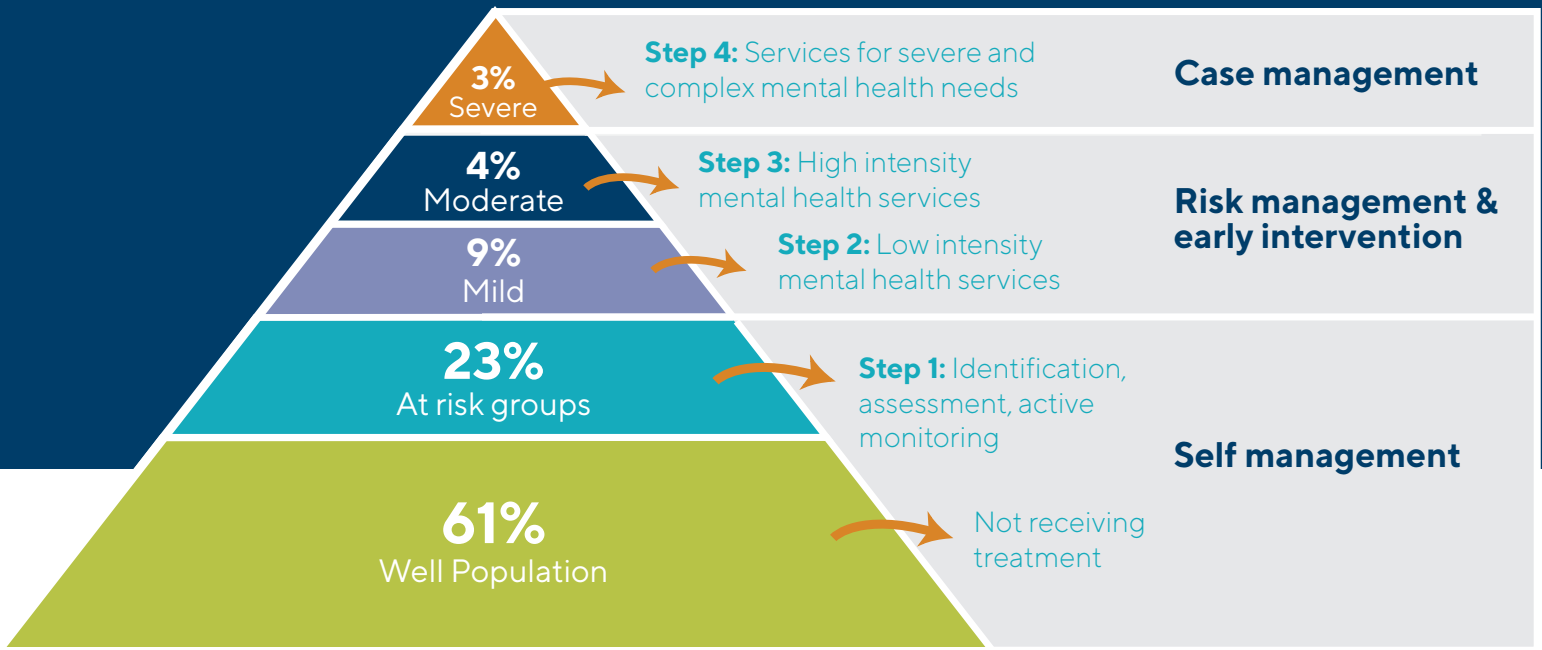
This model of care is conceptualised within three core domains that support general practitioners to deliver holistic assistance close to people's homes; and where individuals, families and carers are active partners in a person's care journey:

- Ready Access to Care
- Proactive Preventative Care
- Engaged Chronic and Complex Care.

WQ HCH provides the gateway to the wider health system through access to community-based multi-disciplinary team-based care, early intervention services, and hospital and specialist services where these are required to:

- Identify lifestyle and other health risk factors early
- Proactively manage people with chronic disease
- Help vulnerable people navigate the health care system
- Support people who are geographically isolated or who suffer economic disadvantage
- Support people with complex mental health care needs
- Remove the organisational and professional barriers that impact care and prevent better coordination across social, primary and acute care settings.





The stepped care approach is flexible – as a person's needs change, the service changes with them, ensuring the service type is right for them.

Stepped Care Framework for mental health services

The Stepped Care Framework describes a hierarchy of interventions. These interventions range from lower intensity steps that support people before illness manifests, to higher levels of care for those who present with severe symptoms.

Under this framework people are assessed on their needs and then allocated appropriate support. Regular monitoring ensures that people continue to receive the right help as their needs change over time.

The service intervention continuum allows people to enter the mental health care system at any level to make best use of workforce and technology.[18]

A stepped care approach to mental health service planning generally involves the following five core elements:[18]

- Use the least restrictive or intensive treatment option appropriate to the individual's needs
- Stratify the population into different 'needs groups', ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions
- Set appropriate interventions for each stratified group (this is necessary because not all needs require formal intervention)
- Define a comprehensive 'menu' of evidence based services required to respond to the spectrum of need
- Match service types to the treatment targets for each needs group and commissioning/delivering services accordingly.

Making safety and quality central to mental health service delivery

Our work across the mental health sector to advance safety and quality in the health sector aligns with the work of the Australian Commission on Safety and Quality in Health Care (ACSQHC).

This Plan focuses on building a recovery-oriented culture across all health services involved in the delivery of mental health, AOD and suicide prevention treatment and care.

This will be achieved by:

- Adopting the safety and quality commitments of the Fifth Plan that include the National Safety and Quality Health Service (NSQHS) Standards (second edition) and National Standards for Mental Health Services (NSMHS)
- Monitoring and improvement of mental health services through measuring progress and reporting on indicators, such as timely access and effectiveness of care as measured by patient experience and continuity of care as measured by follow-up after hospital admissions.

Addressing stigma and discrimination

Reducing stigma and discrimination is at the core of all our efforts to improve mental health and wellbeing, and break down barriers to access support.

Shame and discrimination can contribute to unemployment, social exclusion and poverty and can trap people in a cycle of marginalisation that impacts on their physical, social and emotional health.

Our outback culture, lifestyles and social norms play a very important role in the way we understand and talk about mental health, suicide and AOD use, including how, where and when help is sought.

Whether it's those well recognised stoic behaviours within our farming communities, or the unique intergenerational experiences of our Aboriginal and Torres Strait Islander communities, or even the 'she'll be right' attitudes and mindsets that have prevailed across generations; addressing stigma and discrimination will require disruption and this Plan needs to support and enable Western Queenslanders through understanding and adopting important protective factors and normalising help seeking behaviours linked to recovery and wellbeing.

PART B: Delivering change

Our Plan identifies system redesign priorities through a commitment to nine focus areas for change.

For each focus approach area, we provide:

- **Consultation insights** from this strategy's supporting community engagement program
- **Shared objectives**
- **Priority actions** designed to improve the quality, integration and coordination of MHSPAOD care.

1. Building a connected and person-centred care sector

2. Proactive prevention and early intervention

3. Promote and protect mental health and wellbeing across the lifespan

4. Supporting Aboriginal and Torres Strait Islander social, emotional and cultural wellbeing

5. Strengthen and integrate Alcohol and Other Drug treatment and harm reduction within a stepped care framework

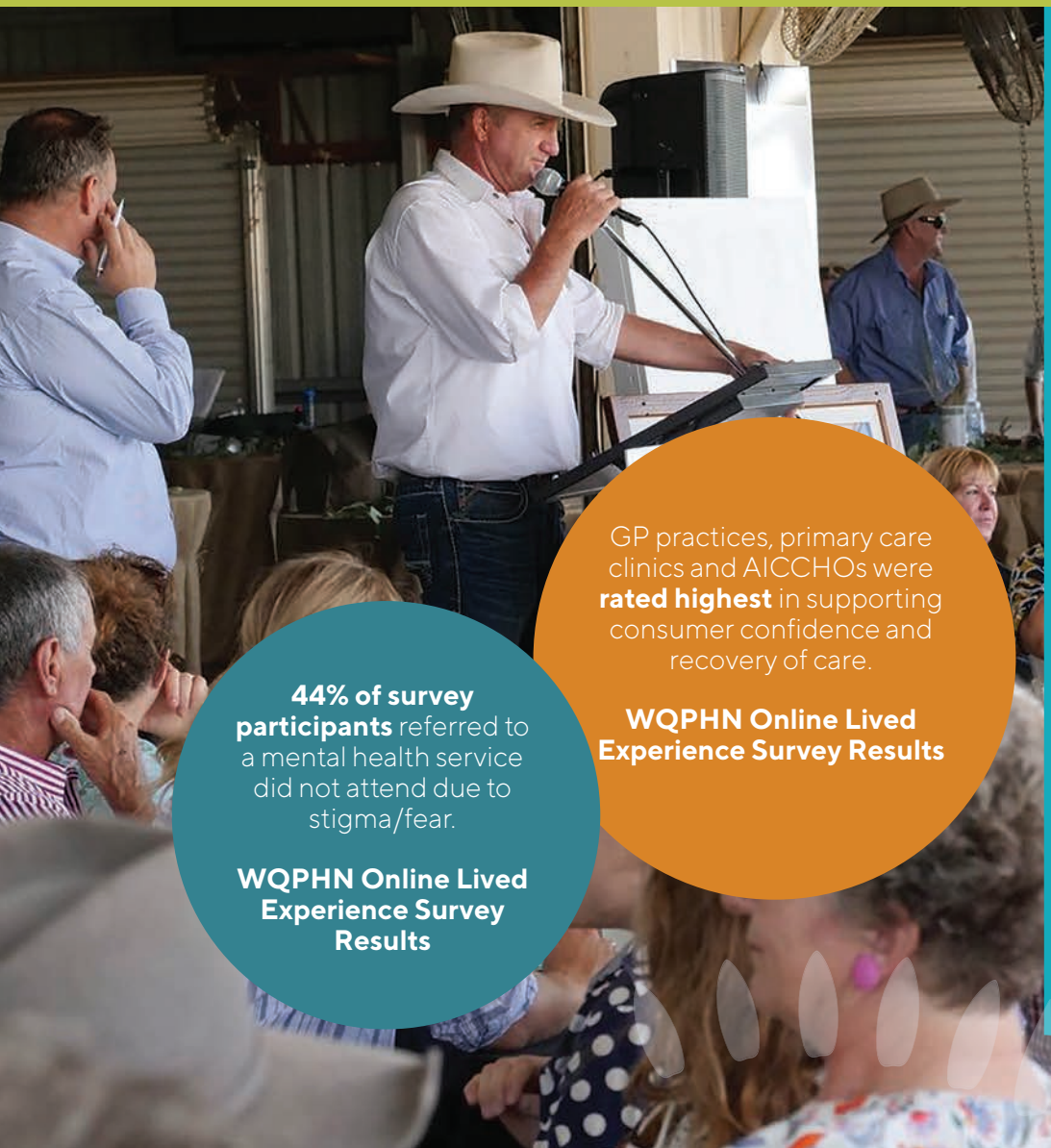
6. Making suicide prevention everyone's business

7. Coordinating treatment and support for people who experience severe and complex mental health

8. Building workforce capability and grassroots training opportunities

9. Responding to climatic extremes and other adversities within rural and remote communities

Focus area 1: Building a connected and person-centred care sector



44% of survey participants referred to a mental health service did not attend due to stigma/fear.

WQPHN Online Lived Experience Survey Results

GP practices, primary care clinics and AICCHOs were **rated highest** in supporting consumer confidence and recovery of care.

WQPHN Online Lived Experience Survey Results

'We need to open doors to care by listening to people with a lived experience'

Lived Experience Participant

'Using information systems that don't talk is problematic and leads to consumers falling through the gaps, lost data and a breakdown in care continuity'

General Practitioner

'We need to recognise and be responsive to the different cultures across Western Queensland from Indigenous, Bush and Mining cultures'

Consumer Forum Meeting

'We need to expand cross agency delivery of care using a partnership model focused on systems, operations, commitment, joint deliverables and outcomes'

Anonymous

'We need 'community of excellence' models with planned services and integration across all providers within one community or place'

NW Mental Health Roundtable Mount Isa

'We need to inter-link culture and clinical responsiveness in order to be able to deliver culturally safe services'

Sigrid Tagaloa, Centre Manager, Headspace Mount Isa

'It's no long a 'taboo' subject and stigma has decreased somewhat, but we still have a long way to go'

Lived Experience Focus Group

'Stop the silo mentality with both funding and service provision'

Senior Executive

Focus area 1: Building a connected and person-centred care sector

Consultation insights

Having access to services centred around a person's needs that are as close to home as possible is essential, for people to be able to remain well and connected to their family and community.
This includes supporting individuals to take proactive steps, so they are not managing symptoms on their own.

Challenges in Western Queensland

- Not a 'one size fits all' approach
- Low population density and tyranny of distance to services and travel required to reach them
- Lack of care coordination particularly for people with more complex healthcare needs
- Lack of available services and long wait times
- Siloed funding models
- Sustainability of private practice settings in rural and remote Western Queensland
- Communication and interoperability challenges across provider networks
- Knowledge and awareness of visiting services
- Higher health care costs.

Breakthrough Opportunities

- Continue to build on strong community leadership to harness expertise to drive reform and to co-design an integrated care agenda
- Strengthen the collective voice of people with a lived experience so the service access points and system can be shaped around these needs
- Strengthen the WQ HCH model in delivering coordinated and efficient primary care
- Facilitating local stepped care reform that engages local commissioned service providers, general practice and wider WQ HCH neighbourhood
- Move towards a shared resourcing model incorporating shared fund pooling, infrastructure and workforce models
- Electronic shared digital referral
- Build on high value care provided by AICCHOs and benefit of the block funding model
- Reform the funding model with a shift to a mixed model of private billing fee-for-service and population-based block funding based on the population served and the health needs of the community
- Support diversity and capability expansions through cultural leaders, trusted advocates and mentors as part of the broader team
- Potential role telehealth and digital eMental Health tools play in addressing access issues relating to distance and travel
- Data sharing for planning, evaluating interventions and performance monitoring
- Development of place-based health intelligence reports that have identified need and potential service improvement strategies for interagency health planning.

Continuing to build on the WQ HCH model in supporting multidisciplinary team-based care that connects individuals with the broader health and social care system is fundamental to driving a person-centred approach.

Focus area 1: Building a connected and person-centred care sector

Shared objectives	Priority actions
Shared objective 1 – Deliver person-centred services through the WQ HCH and Stepped Care Framework	1. Strengthen leadership development and partnerships to embed comprehensive responses across the continuum of care. 2. Implement flexible models of care that support integration of primary and secondary care incorporating the stepped care framework to better connect consumers to services. 3. Broaden digitally enabled models of care, care pathways, information-sharing protocols and electronic health records in coordinating care.
Shared objective 2 – Increase engagement and participation of people who understand the lived experiences of MHSPAOD in place-based co-designed planning and governance	1. Utilise engagement processes outlined in QMHC Stretch2Engage Framework and Lived Experience Framework that support inclusive engagement and incorporate peer workforce tailored for the Western Queensland context.
Shared objective 3 – Making safety and quality central to mental health service delivery	1. Develop an evaluation framework that incorporates safety and quality measures to support planning, monitoring, evaluation and reporting on progress. 2. Adopt place-based, needs-based planning to inform Commissioning Locality funding and service enhancements. 3. Adoption of refeRHealth electronic referral to support coordination and team care.
Shared objective 4 – Address mental health stigma and discrimination including embedding principals of human rights protection	1. Develop a WQ stigma reduction strategy/framework that incorporates priorities around engagement, training, communication, leadership and advocacy. 2. Develop a safe language interagency terminology guide for service providers, consumers, carers and people with a lived experience.

Focus area 2: Proactive prevention and early intervention

'Under investment in prevention and early intervention, means that too many people live with poor social and emotional wellbeing for too long'

WQPHN SW Mental Health Roundtable, Charleville

'We need to take a pragmatic approach and invest in evidence based interventions that we know will work'

CW Mental Health Roundtable, Longreach

'Cannot underestimate the critical role of screening and health checks in early detection and prevention'

Clinician

'Help people understand the warning signs and to not be afraid to seek help in the early stages'

WQPHN Online Survey - Lived Experience

Good mental health builds resilience, buffers against adversity, reduces the chances of physical illness, promotes recovery and increases life expectancy.[21]

Early intervention services were identified as the highest priority area for service development.

Lived Experience and Clinician/Stakeholder

Focus area 2: Proactive prevention and early intervention

Consultation insights

Strengthening positive mental health and wellbeing, and preventing mental health issues, problematic relationship with AOD use and suicide risk contributes to better health, increased life expectancy, education and employment outcomes, increased productivity, community participation, social capital and community cohesion.

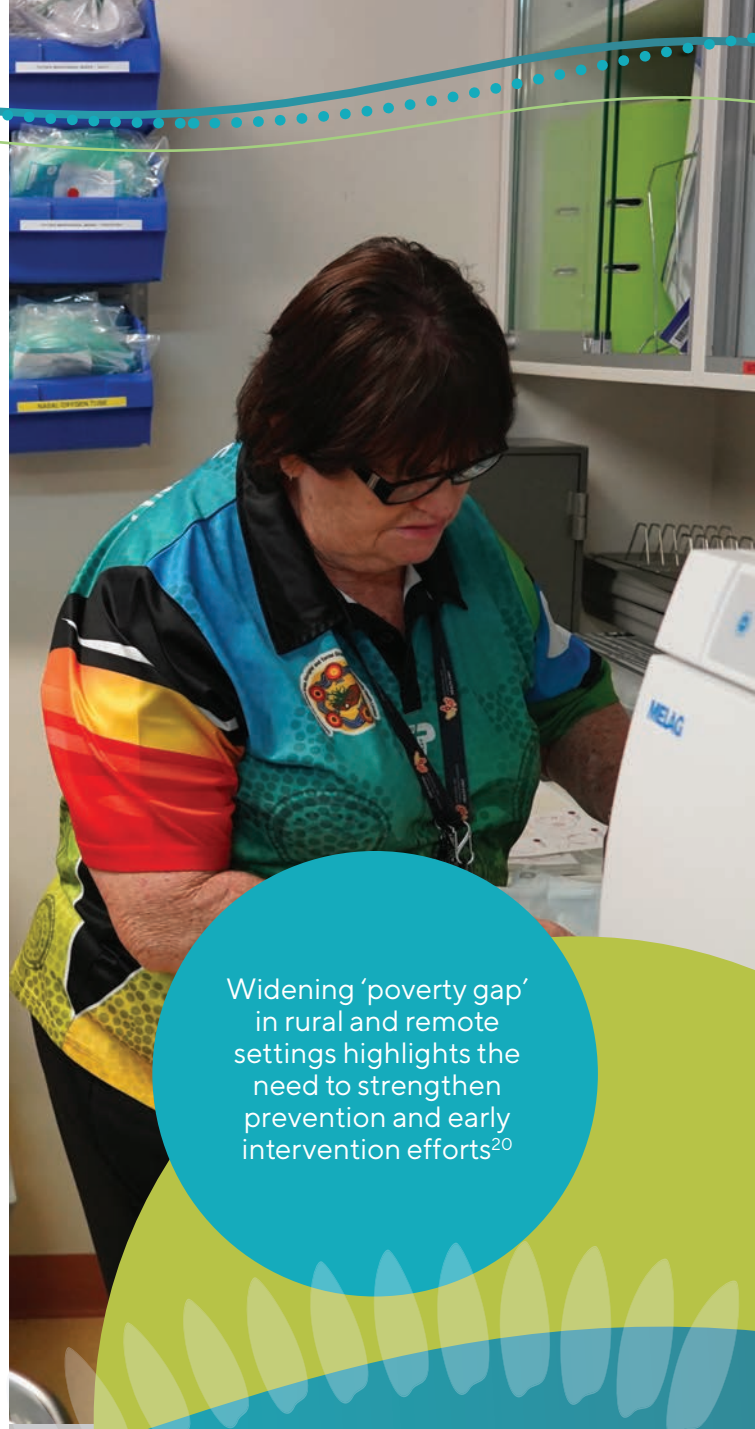
These benefits span generations and highlight how we can help prevent the incidence, severity and impact of mental illness, suicide and harm reduction. When executed well, preventive actions are more effective, less expensive and have a greater population impact than managing and treating ill-health.[19,20]

Challenges in Western Queensland

- Poor understanding of low intensity early intervention primary mental health services
- Residents present late, are diagnosed late and at a more advanced stage of illness, with corresponding physical comorbidities.

Breakthrough opportunities

- Address workforce issues by upskilling local providers
- Empower people to recognise early signs of vulnerability, distress, so they access support at an early stage
- General practice and primary care providers provide ongoing surveillance and ready access to proactive preventative care
- Greater advocacy and promotion by primary care providers of evidence-based early intervention low intensity programs and services
- Identifying risk factors early through universal and targeted screening
- Standardising screening tools to drive prevention efforts
- Building knowledge of what services are available to provide appropriate and timely advice and interventions
- Invest in prevention and early intervention, and build the evidence base for promotion
- Use e-health as an enabler to deliver early intervention services.



Widening 'poverty gap' in rural and remote settings highlights the need to strengthen prevention and early intervention efforts[20]

Focus area 2: Proactive prevention and early intervention

Shared objectives	Priority actions
Shared objective 1 – Increase mental health, AOD and suicide prevention literacy	1. Map existing resources to identify gaps or opportunities to support service delivery for agencies/ councils who provide MHSPAOD information.
Shared objective 2 – Increase early intervention response	1. Expand screening and psychological service delivery through digital health and telehealth, targeted events, GP health checks, workforce capacity, and joint commissioning (and other funding models). 2. Universal adoption of evidence based, strength-based eMental health programs including 'Weathering Well' and 'Stay Strong'.

Focus area 3: Promote and protect mental health and wellbeing across the lifespan

Nearly 1 in 5, 15-24 year olds in WQPHN region were admitted to hospital for Mental and Behavioural Disorders in 2019-2020.[23]

15% of people living in WQPHN region in the active GP population were diagnosed with depression, anxiety, bipolar disorder and/or schizophrenia.[3]

Over one third (36%) of Prep aged children in WQPHN region are developmentally vulnerable in one or more domains of the AEDC (QLD 25%).[22]

'We need to start with our mothers and babies so we can improve the life trajectory of our most vulnerable families'

Anonymous

'Regular health checks in the early years are key to identifying mental health and developmental issues early'

Healthy Outback Kids Coordinator

'It is critical we work with teenagers and young people to enhance their coping abilities, so they are able to respond in positive ways to the risks, stresses and adversities of life'

Police Officer

'We need to give youth and young people agency of choice'

School Counsellor, Mental Health Roundtable

'There is a need to develop better links between schools and agencies to strengthen capacity for early identification of risk'

Psychologist, Health Roundtable

'Active engagement of the client throughout planning of their care plan helps support health seeking behaviour and patient activation'

WQPHN, Online Survey

'Older persons mental health services are really limited in most areas, or simply do not exist'

General Practitioner

Focus area 3: Promote and protect mental health and wellbeing across the lifespan

Consultation insights

Physical, social, emotional, cultural and environmental conditions impact people's mental health from infancy to old age.

Supporting families through the early years of a child's life provides strong foundations for life-long physical, mental, social and cultural wellbeing.

Challenges in Western Queensland

- Suitably skilled local health workforce to support the uptake and engagement of health services by children and their families
- Coordination between visiting and local health and social care services in remote communities
- Collaboration between health and education sectors to support prevention and early intervention
- Enhanced co-design of services with youth and young people
- Interdependencies of social determinants on equitable access to services, resources and clinical care
- Engagement and support for older peoples mental health
- Loneliness and social isolation is an issue for older people and for people who are geographically isolated.

Breakthrough opportunities

- Integrated school-based assessment to connect young people to care
- Practical support tools for students and families
- Implement the WQ HCH model of care to help identify risk factors and strengthen referral pathways and care coordination
- Older persons enrolment and health check to ensure wellbeing and is part of individual needs, including access to psychosocial support
- Adoption of a child-aware parent-sensitive approach to help parents create a solid foundation for their children's health outcomes later in life
- Messaging around healthy ageing topics such as dementia
- Connectivity between the health sector and schools to identify at risk children (and young people) and demystifying mental health
- Stigma reduction strategy
- A Young Persons Positive Mental Health Strategy that engages young people in its design and delivery
- Expanded access to Headspace in the South West
- Grow local health workforce through increased participation in education
- Increase access to services such as active transport and telehealth-care.

Photo courtesy of Gidgee Healing

Focus area 3: Promote and protect mental health and wellbeing across the lifespan

Shared objectives	Priority actions
Shared objective 1 – Promote the best start in life	1. Review existing WQPHN Child and Family Framework and Early Years Plan and existing programs such as Healthy Outback Kids to ensure alignment and improved pathways to care. 2. Promote screening and early intervention to support good perinatal mental health.
Shared objective 2 – Embed proactive planning and support for young people	1. Support key agencies to deliver place-based young person's reference groups' that links into an overarching youth strategy. The group would help to inform workforce capacity building and support for vulnerable groups. 2. Embed proactive planning and support for children and young people involved in child protection and/or youth justice system focusing on SEWB and pathways to participation and inclusion.
Shared objective 3 – Strengthen the WQ HCH model of care to support planned and structured care for the adult population	1. Increase care coordination capacity to increase uptake of better access and more proactive management of people with mental health issues. 2. Configure primary mental health services to support stepped care approaches and meet the needs of the region. 3. Develop a WQ HCH place based neighbourhood strategy to support integrated person-centred care.
Shared objective 4 – Expand the reach and diversity of MHSPAOD prevention services specifically for older Western Queenslanders (65+ years and 55+ years for Aboriginal and Torres Strait Islander populations)	1. Improve mental health and quality of life for older people, including early detection and intervention through measures such as risk screening, telehealth and increased training. 2. Expand and develop psychosocial support to increase social connection and reduce impacts from social isolation and loneliness.

Focus area 4: Supporting Aboriginal and Torres Strait Islander social, emotional and cultural wellbeing

'Words are powerful, we need to use our stories to carry hope and possibility.'

Aboriginal Health Worker

'We must consider and harness our unique cultural strengths to deliver effective solutions for our people'

Stephanie King, Health Advocate

'Shame for our People still exists and continues to be a barrier to help seeking behaviour'

SEWB Worker

'We need to address the interdependence of the socioeconomic and cultural factors that contribute to risk factors for poor mental health outcomes for Indigenous people'

WQPHN Clinical Advisory Council member

'Need to create opportunities for non-clinical support to be recognised as equally important in care approaches'

WQPHN Roma Mental Health Roundtable

'Creating a culturally competent and safe workforce with training in trauma-informed care must be a priority moving forward'

Mount Isa Mental Health Forum

65% of all Mental Health ED presentations for 15-24 year olds were for Indigenous young people.[1]

Focus area 4: Supporting Aboriginal and Torres Strait Islander social, emotional and cultural wellbeing

Consultation insights

Building a Plan that identifies the strengths and builds protective factors within Aboriginal and Torres Strait Islander populations is a fundamental driver to preventing the onset and exacerbation of mental health, problematic substance use and other issues. Through the Nukal Murra Social and Emotional Wellbeing (SEWB) Framework[14] we have built the foundations for implementing strengths-based primary health care approaches within our Aboriginal and Torres Strait Islander communities in Western Queensland. It has been designed in close collaboration with Aboriginal Community Controlled Health Organisations (ACCHOs) and Alliance partners and draws on the intelligence and knowledge of these institutions, but importantly also harnesses the cultural resilience within our Aboriginal and Torres Strait Islander peoples.

Challenges in Western Queensland

- Impacts of intergenerational trauma, institutional racism and poor experiences of care
- Poverty and economic barriers that impact access to care such as transport, telecommunications, affordability and remoteness
- Low health literacy that impacts capacity of a person to understand and apply information to make effective decisions
- Integrating culturally safe and responsive MHSPAOD care into mainstream services.

Breakthrough opportunities

- Nukal Murra Social and Emotional wellbeing Framework to expand capacity of AICCHO services
- Culturally safe services and holistic family care emphasises wellness, harmony and balance rather than illness treatment and symptom reduction
- Wrap care around families to reduce risk factors and enhance protective factors for social, cultural and emotional wellbeing
- Expand leadership and governance structures to ensure a strong presence of Aboriginal and Torres Strait Islander peoples
- Co-design all aspects of regional planning and service delivery with people who have lived experience
- Integrate clinical and culturally informed services which are supported by staff who understand the interconnections of a holistic approach
- Understand the service gaps in psychosocial therapies encompassing digital and strengths based social and emotional wellbeing services such as the Stay Strong App
- Promote Aboriginal and Torres Strait Islander mental health as a career pathway to build local capacity and to address workforce shortages
- Recognise and value the role and function of Health Workers and other similar type roles so the workforce is well positioned to work at the top of its scope of practice. This also includes creating opportunities for clinical and non-clinical support to be recognised as equally important in care approaches.

Indigenous people in WQPHN have nearly double the number of mental and behavioural episodes of hospital admitted care compared to non-Indigenous.[23]

Approximately 60% of the MH ED presentations are for people from Indigenous backgrounds.[1]

Focus area 4: Supporting Aboriginal and Torres Strait Islander social, emotional and cultural wellbeing

Shared objectives	Priority actions
Shared objective 1 – Continue to foster Indigenous self-determination and leadership through the Nukal Murra Alliance	1. Support 'Stay Strong' eMental Health Tool and promote routine screening wellbeing support, recovery and complementary therapy. 2. Empower self-determination through culturally centred processes of decision making (incorporating lived experience) that deliver solutions that respond to local context (in alignment with the Guyaa Dhuwi declaration). 3. Increase profile and role of Indigenous cultural mentors or consultants to ensure they have cultural authority to guide culturally responsive service delivery.
Shared objective 2 – Improve culturally safe and responsive MHSPAOD services	1. Promote a culturally competent workforce with training in trauma-informed care and in identification of risk to deliver services to Aboriginal and Torres Strait Islander people. 2. Adopt healing-informed approaches by service providers in their communication, policies and practices.
Shared objective 3 – Expand and integrate new care roles into Aboriginal and Torres Strait Islander Health Workforce	1. Support and build the Aboriginal and Torres Strait Islander health workforce, including Aboriginal and Torres Strait Islander Health Workers, Health Practitioners and community researchers as important cultural brokers. 2. Broaden non-clinical care connector and wellbeing roles into multidisciplinary team care arrangements.

Focus area 5: Strengthen and integrate alcohol and other drug treatment and harm reduction within a stepped care framework

WQPHN region has the highest rates of AOD closed treatment episodes per population in Australia (2017-2018).[24]

11% recorded as binge drinkers (> 6 drinks on any occasion).[3]

'Early intervention and withdrawal management (detox) were the top 2 service areas that survey respondents believe need to be strengthened'

WQPHN Online Survey Results

'Stop parachuting single drug and alcohol services into community and instead build critical mass through collaboration and co-location'

WQPHN Roma Roundtable Participants

'We need a coordinated, collaborative service that ensures continuity of care for recovery journey'

WQPHN Online Survey - Clinician

'Alcohol has been an unhealthy coping mechanism for myself for a number of years'

WQPHN Online Survey - Lived Experience

'My ice addiction has had a severe impact on all family members'

WQPHN Online Survey - Lived Experience

Nearly half (47%) of Western Queensland adults are recorded as drinkers (more than 2 standard drinks a day).[3]

1 in 5 14yrs + in remote and very remote regions have had recent illicit drug usage.[24]

Focus area 5: Strengthen and integrate alcohol and other drug treatment and harm reduction within a stepped care framework

Consultation insights

Preventing and minimising Alcohol and Other Drug (AOD) harm in Western Queensland cannot be achieved by one agency, and close coordination across sectors and community is essential. AOD harm can often be closely linked with mental health issues, lack of social connection, experiences of trauma and worsened by financial stress caused by lack of housing and employment opportunities.[9]

Effective harm reduction and treatments require cross sector integrated response grounded in local insight and needs, evidence based practice and guidance from national and state Frameworks including the policy context:

- Department of Health (2019) National Framework for Alcohol, Tobacco and other Drug Treatment, Canberra, Department of Health (2019)
- National Alcohol Strategy 2019-2028, Canberra, Department of Health (2018)
- National Quality Framework for Drug and Alcohol Treatment Services, Canberra and the Queensland Alcohol and Other Drugs Sector Network (2019)
- Queensland Alcohol and other Drug Treatment and Harm Reduction Outcomes Framework, Brisbane (2019).

Challenges

- Higher risk behaviours and attitudes in AOD use
- Limited alcohol free social events and community activities
- Access to detox and local residential rehabilitation support
- Complexity of dual diagnosed co-morbid conditions
- Poor integration of AOD services with other lifestyle risk factor management strategies
- Access to low intensity health coaching support for lifestyle modification
- Confidence and experience of general practice networks to better support AOD issues.

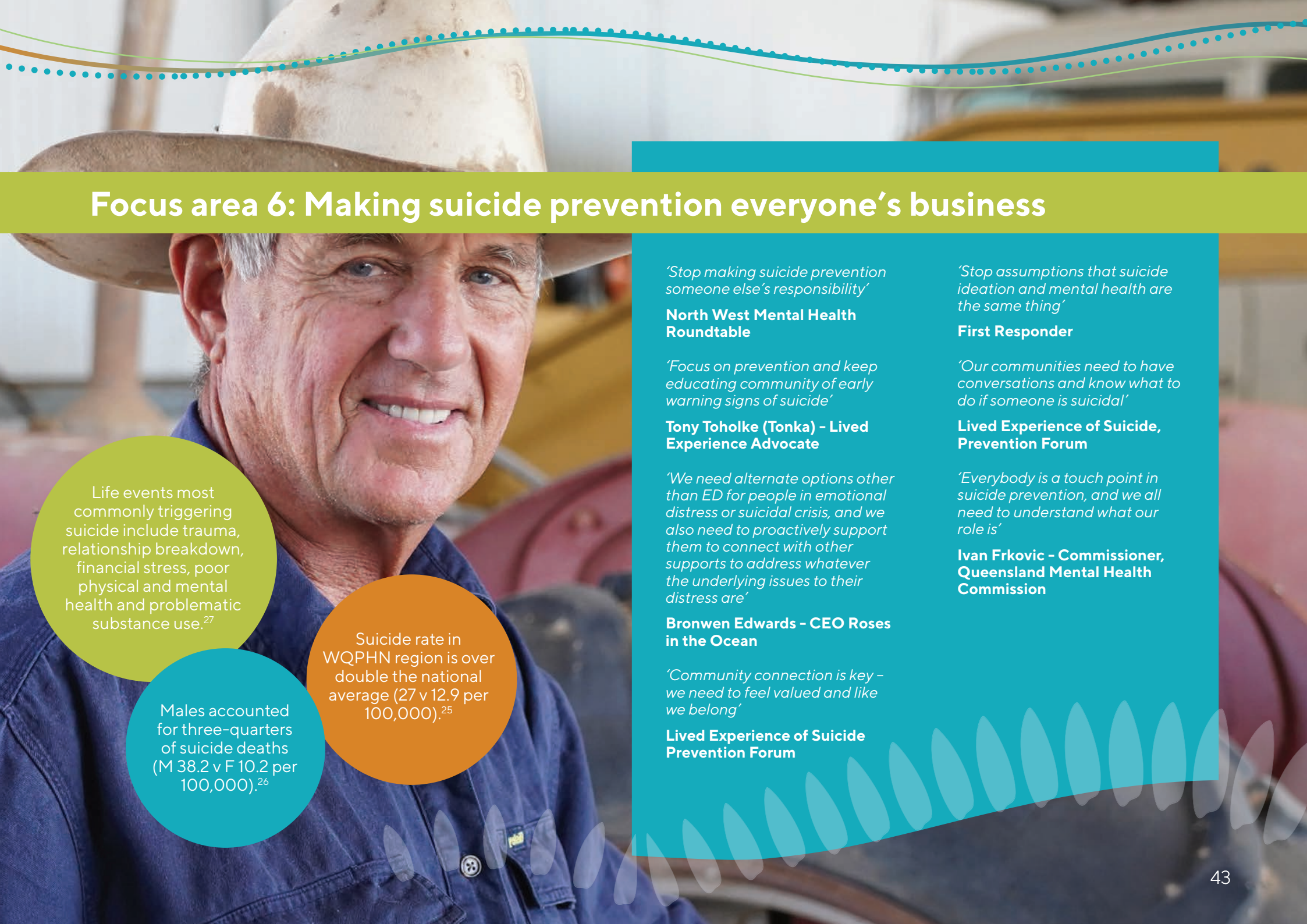
Breakthrough opportunities

- Increase investment and build critical mass through collaboration, co-location and co-design that delivers a service that ensures confidentiality and continuity of care from prevention through to recovery
- AOD First Aid training and tailored programs and resources for general practice
- A well-connected, interagency approach (including first responders; WQPHN commissioned AOD service providers; local schools; HHS MHAOD services; and youth representatives etc.)
- A ‘road map’ to address AOD issues across the service continuum that includes non-clinical services in a holistic social care context including a stronger focus on working with families
- A workforce strategy that promotes working in the AOD sector as a career of choice
- Balanced investment in residential detox, home detox and day detox.

Focus area 5: Strengthen and integrate alcohol and other drug treatment and harm reduction within a stepped care framework

Shared objectives	Priority actions
Shared objective 1 – Improved AOD specialist and generalist workforce development and training in AOD issues	1. Increase investment in workforce that is able to respond to complex AOD use and dual diagnoses (including peer support and active professional practice networks). 2. Commission training in dual diagnosis; family inclusive practice and Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and brief intervention tools.
Shared objective 2 – Enabling individuals and families to obtain timely support across AOD prevention, screening and early intervention, assessment and coordinated care and recovery	1. Support GP and Nurse Practitioner engagement in evidence based assessment, brief and early interventions, and medical management for people with AOD issues, withdrawal support and recovery. 2. Enhance treatment options to meet the needs required including counselling, information and education, support and case management, withdrawal management, rehabilitation, pharmacotherapy and at home medically supervised withdrawal and follow up services (as part of wider recovery support).

Focus area 6: Making suicide prevention everyone's business



Life events most commonly triggering suicide include trauma, relationship breakdown, financial stress, poor physical and mental health and problematic substance use.[27]

Males accounted for three-quarters of suicide deaths (M 38.2 v F 10.2 per 100,000).[26]

Suicide rate in WQPHN region is over double the national average (27 v 12.9 per 100,000).[25]

'Stop making suicide prevention someone else's responsibility'

North West Mental Health Roundtable

'Focus on prevention and keep educating community of early warning signs of suicide'

Tony Toholke (Tonka) - Lived Experience Advocate

'We need alternate options other than ED for people in emotional distress or suicidal crisis, and we also need to proactively support them to connect with other supports to address whatever the underlying issues to their distress are'

Bronwen Edwards - CEO Roses in the Ocean

'Community connection is key - we need to feel valued and like we belong'

Lived Experience of Suicide Prevention Forum

'Stop assumptions that suicide ideation and mental health are the same thing'

First Responder

'Our communities need to have conversations and know what to do if someone is suicidal'

Lived Experience of Suicide, Prevention Forum

'Everybody is a touch point in suicide prevention, and we all need to understand what our role is'

Ivan Frkovic - Commissioner, Queensland Mental Health Commission

Focus area 6: Making suicide prevention everyone's business

Consultation insights

Suicide takes an immeasurable toll on individuals, families and entire communities. Deaths from suicide and self-inflicted injuries in WQPHN region are the highest in the country.[25]

We need to drive positive change in destigmatising attitudes and culture so that communities can thrive. There was also an expressed desire to build community connections, so people have the confidence to engage and 'ask the right questions' and know what to do if someone is experiencing suicidal thoughts (using clear and easy to understand language).

Challenges

- Care is difficult to access, of inconsistent quality and often inadequate for suicide crisis and recovery
- Lack of access to out of hours care following a suicide attempt
- 'Shame' associated with having a police officer sitting nearby when in the Emergency Department
- Lack of clear pathways and follow-up when people experience suicidal thoughts, attempt or when there is a death from suicide
- Poorly coordinated follow up post hospitalisations and coordination back into community settings
- Lack of access to relationship and trauma counselling
- Siloed services and limited active care management create a 'revolving door', with a recurring patterns of discharge and re-admission to hospital
- Gap in coordinated postvention services that are structured and tailored to individual and family needs
- Access to screening tools for assessing suicide risk to better identify and respond to trauma and psychosocial vulnerability.

Breakthrough opportunities

- Whole of community responses that are family orientated, inclusive and have capacity to 'open doors' to access
- Adoption of culturally appropriate approaches and 'soft approaches' such as a presence at community activities events such as cattle sale days, community sporting events, cultural celebrations and field days to get conversations going
- Building a safe, trained and supported Lived Experience 'Workforce' with the skills needed to bring the lived experience of suicide voice of change in all aspects of suicide prevention
- Improved training for the existing health workforce, including education around language and stigma (including 'onboarding' and orientating new providers)
- Implement peer support models that include both paid and volunteers
- Coordinated postvention services through a dedicated postvention coordinator
- Alternate non-clinical recovery spaces where people feel safe and where people can access a range of peer and community support workers
- 'Retreat' programs that provide people with a safe place to recover and seek therapeutic support close to their community
- Schools based preventative health programs to build resilience and coping skills and provide an opportunity for greater inter-sectoral engagement and co-design, including with people with a lived experience of suicide.

Over one third (36%) of hospital ED presentations for 15-24 year olds were for suicidal ideation (2019-2020).[1]

Indigenous suicide rates are roughly triple that of non-Indigenous suicide rates (40.5 v 12 per 100,000).[26]

Focus area 6: Making suicide prevention everyone's business

Shared objectives	Priority actions
Shared objective 1 – Embed lived experience in co-design and planning	1. Establish governance mechanisms for engagement and participation of people with Lived Experience of suicide based on the Lived Experience (LE) Framework (by Dr Michelle Banfield) to support their involvement in co-design and planning, and the establishment of a LE Network. 2. Facilitate access to training to better prepare people with a lived experience of suicide in planning activities.
Shared objective 2 – Increase Workforce Capacity Building and Skills Development	1. Build suicide prevention peer workforce by developing skills and competencies through identified training pathways. 2. Support and embed Lived Experience capacity building workshops across the region.
Shared objective 3 – Reduce stigma through education, training, social marketing and change in language	1. Increase education and training for front line workforce (including orientation), management and executive staff, led by people with a lived experience of suicide such as Living Perspectives (frontline). 2. Expand community wide social marketing campaigns to increase knowledge of risk factors and how to have difficult conversations (led by LE Network) such as including sharing stories (voice of lived experience), 'Are You Okay Day', 'Are You Bogged Mate' and World Suicide Prevention Day activities.

Focus area 6: Making suicide prevention everyone's business

Shared objectives	Priority actions
Shared objective 4 – Enhance access to acute and crisis interventions	1. Improve responsiveness and expand options that are appropriate for people experiencing suicidal crisis including expanding co-responder models. 2. Put in place appropriate responses for individuals (and their families) who are at-risk or have self- harmed/attempted suicide or those bereaved by suicide (including postvention support). 3. Provide workforce innovative development to establish peer workforce positions integrated in supportive roles including collaboration with hospital, primary and social care interventions (i.e. ED, proactive outreach, safe haven cafes, Safe Retreats, online and afterhours support).
Shared objective 5 – Supporting care continuity and recovery	1. Adopt shared protocols between the HHS and general practice (inclusive of other key partner agencies) to support referral pathways and proactive follow-up, case management and connection to psychosocial support. (i.e. Beyond Blue, The Way Back Service). 2. Strengthen support by recognising and addressing unresolved trauma through targeting at-risk populations including men, Aboriginal and Torres Strait Islander populations, culturally and linguistically diverse populations, LGBTIQ+, young persons and older persons who are socially isolated. 3. Improve responsiveness for those being paroled or released from the criminal justice system through proactive planning.
Shared objective 6 – Support increased access to school-based suicide prevention and early intervention resources, training and programs	1. Collaborate with secondary schools to support capacity building (resource and training such as Be You [https://beyou.edu.au/]), and tailored programs where appropriate in-reach support arrangements are available. 2. Increase place-based approaches (i.e. LifeSpan model) and young persons specific initiatives (i.e. Headspace and Orygen) including disengaged youth not attending school.

Focus area 7: Coordinating treatment and support for people who experience severe and complex mental health

'Persistent mental ill-health impacts everything, every thought, day-to-day function, social isolation, loneliness and ability to have any kind of joy'

WQPHN Lived Experience – Online Survey

'We need more opportunities to facilitate service coordination, cooperation and collaboration to better support people with severe and persistent mental health'

Roma Mental Health Roundtable

'Greater need for shared care to support patient navigation of the system'

Longreach Mental Health Roundtable

'On-ground workers need rapid access to specialist and/or peer advice in real time to rapidly assess and refer to appropriate local or outreach services. This would make a significant difference in people's lives and reduce the number of flight retrievals out of remote communities'

Anonymous

4 out of 5 people living with mental illness have a co-existing physical illness.[25]

People with severe and complex mental ill-health are[2]:

- dying on average up to 18 years earlier than the general population
- more likely to have diabetes, obesity, heart disease and some cancers.[25]

Focus area 7: Coordinating treatment and support for people who experience severe and complex mental health

Consultation insights

People with lived experience of severe and persistent mental ill health often require several concurrent supports at a higher frequency. Fragmentation of care is often reported in trying to navigate a complex system across multiple providers. People with a lived experience of severe and complex issues are among the most marginalised and disadvantaged in our communities[7] and are more likely to die 14–23 years earlier, and experience more chronic conditions than the general population.[28]

Psychosocial support services can help enable people with severe mental illness to build skills to manage their health, improve their relationships with family and others, and increase social and economic participation.[29]

Policy context

- The Fifth National Mental Health and Suicide Prevention Plan (2017)
- Mental Health Inquiry Report (2020)
- Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023.

Challenges

- Inadequate access to psychosocial support services which adds burden on carers and consumers, thus impacting ability to maintain and optimise recovery and self-management
- Lack of integrated recovery focus that includes restoring individual ability to be responsible in directing their own recovery journey through patient activation and empowerment
- Lack of uptake of the rural and remote telehealth consultancy service funded under MBS for psychiatry
- Lack of private psychiatrists
- Increased non-billable GP workload as a result of supporting patients with severe and persistent mental illness, those with co-morbid physical conditions and people in crisis (along with at-risk patients)
- Fractured system with poor coordination impacting service delivery
- Coordination of NDIS reforms for people with severe and complex mental illness.

Breakthrough opportunities

- Better coordination between primary care and specialist mental healthcare to manage co-morbid mental and physical health conditions
- Better integration of clinical and psychosocial supports to broaden access to services
- Adoption of peer workforce models to support care coordination
- Build local network capacity through interagency orientation and induction, support, supervision, mentoring as well as education and sharing of resources
- Specialist registration system for GPs with advanced skills
- Virtual Rapid Response Clinic to support access to moderate to high intensity care, through video conference to provide point of care responsive services.

Focus area 7: Coordinating treatment and support for people who experience severe and complex mental health

Shared objectives	Priority actions
Shared objective 1 – Increase models of integrated care for people with severe and complex mental illness (and physical health needs)	1. Clarify roles and responsibilities across the health and community support service sectors including exploring shared care models (e.g. UK midwifery model). 2. Improve the physical health of people living with mental illness by prioritising coordinated treatment supports and wider access to essential services such as housing. 3. Improve responsiveness and expanded options that are appropriate for people experiencing psychiatric, AOD emergencies and suicidal crisis.
Shared objective 2 – Explore moderate to high intensity rapid response virtual clinic and access to state-based services	1. Explore model to develop a virtual rapid response clinic to support access to moderate to high intensity care, face-to-face and through video conference to provide point of care responsive services. 2. Explore incorporation of models where general practice and psychology workforce have access to state-based services such as National Eating Disorder Service (NEDs) service and Perinatal Infant Mental Health (PNMHs) to improve access to secondary consultation services.
Shared objective 3 – Support for referral pathways	1. Build clinical shared referral pathways through refeRHEALTH and Health Pathways as they come online in the region. 2. Promote referral pathways to the National Psychosocial Support Measure and the National Disability Insurance Scheme (NDIS) to ensure access to psychosocial recovery services and stimulate the market.
Shared objective 4 – Advocate timely access for crisis care through funding reform	1. Advocate for funding reform of the MBS system to better service remote locations where there is no current private workforce. 2. Develop shared care arrangements between HHS and primary care providers that allow for out of hours presentations and admissions to halt escalation.

Focus Area 8: Building workforce capability and grassroots training opportunities

'Regions need different approaches, as the policies designed to work in metropolitan populations simply do not translate where populations are small and dispersed'

Service Provider

'Building local capacity by employing locally and targeting workforce training and up-skilling is key'

Sharon Varela - Psychologist and Centre for Rural and Remote Health, JCU

'We need to bring roles into general practice like social workers to support more holistic coordinated care'

General Practitioner - WQPHN Clinical Council

'Outback Futures style of engagement was good even though it took families all year to "trust" them and accept they were not a "turn style" service. The face-to-face contact reassured families they were "staying put'

Anonymous

Focus area 8: Building workforce capability and grassroots training opportunities

Consultation insights

Contemporary models of rural and remote service delivery require a workforce that is dynamic, adaptable and able to work alongside a multidisciplinary approach focused on strength based methodologies linked to recovery in community. The Western Queensland provider setting is complex and varied, magnified by limited access to infrastructure, geographic distance, workforce shortages and unique community profiles.

Challenges

- Workforce availability
- High staff turnover impacts continuity of care and capacity for clients to build rapport and trust
- Protracted recruitment processes
- Attracting senior clinicians into remote areas
- Existing personnel suffer high workloads
- Lack of clinical supervision support
- Reluctance for service providers to utilise digital platforms
- Long wait lists in some communities are impacting access signalling the challenges associated with recruitment and retention.

Breakthrough opportunities

- Better access to professional development opportunities in private practice
- Telehealth
- Cross agency professional networks
- Clinical Care Coordinators to deliver better care coordination in General Practice
- Expansion of non-clinical 'connector/liaison' type roles
- Grassroots approach to training for Aboriginal, Torres Strait Islander and other local people through school based apprenticeships, CERT III and IV training roles
- Alignment of workforce models within the stepped care approach to increase investment in expanded workforce roles
- Expand well-integrated peer workforce.

Fragility of the rural and remote workforce is revealed through[30]:

- maldistribution
- long term vacancies
- high reliance on visiting and outreach services
- high turnover and an over representation of a young graduate workforce lacking the clinical leadership and mentorship they need to stay and succeed in an isolated environment
- difficulty in recruiting and retaining a stable medical workforce within general practice.

Focus area 8: Building workforce capability and grassroots training opportunities

Shared objectives	Priority actions
Shared objective 1 – Enhance the capacity of the workforce to deliver integrated, personalised and trauma-informed care	1. Strengthen clinical leadership and professional networks across general practice, nursing and allied mental health services with academic partnerships to enable local career pathways, student placements and cross agency supervision. 2. Increase care coordination and connector type roles (including peer workforce) within general practice to build better linkage to psychosocial supports.
Shared objective 2 – Grow local workforce capabilities	1. Develop an Integrated Mental Health Workforce Strategy with service investment and Infrastructure planning. 2. Develop contemporary interprofessional shared care models for hard to reach populations and those experiencing more severe illness that support stepped care and strengthen local cross-agency partnerships.

Focus area 9: Responding to climatic extremes and other adversities within rural and remote communities

'This thing called drought is an insidious burn that drags on an on. Burns into your budget, burns your relationships, and burns a hole in the heart and soul of our communities'

Mark O'Brien - Drought Commissioner

'Unlike other natural disasters, the effects of drought are felt over the long-term, so tackling regional adversity through wellbeing services and rural financial counselling has helped drought affected farmers navigate these extremely stressful situations'

Council Member

'We need to encourage Primary Producers to "reset" their head to address the core problem which are mainly financial or relational – the two go hand-in-hand'

Glenn Budden - Rural Financial Counsellor

'Don't underestimate the importance of 'connector roles' the people in the field at grassroots level who link the people to the mental health services'

Denise Price - TRAIC Worker

In excess of 600,000 head of cattle lost across North West Queensland during the monsoonal floods of 2019.

Focus area 9: Responding to climatic extremes and other adversities within rural and remote communities

Consultation insights

Longstanding harsh drought, extreme monsoonal floods and other more frequently occurring and extreme climatic events not only have a devastating environmental impact but can severely adversely affect both a community's socio-economic wellbeing, and mental, physical and emotional health.

The extreme weather events seen in Western Queensland have resulted in economic losses, rising operational costs, stressed stock, reduced feed and water availability, reduced earning capacity, fewer recreational outlets and higher incidents of heat stroke. Increased anxiety, depression, and stress on intimate and family relationships is also linked to these events.

The direct and indirect impacts ripple more strongly through small closely knit rural and remote communities than they do through others.

Challenges

- People already experiencing bereavement, including through suicide, have a heightened sense of their loss during times of adversity such as flood, drought and bushfire
- Financial pressures such as debt means one partner is often seeking off-farm work and income, leaving one partner to run the property
- Pervasive bush culture, including a so-called 'strong men syndrome', that positions help or support seeking as a 'sign of weakness' and stopping men (in particular) seeking needed supports.

Breakthrough opportunities

- Soft touch approaches that engage primary producers and those working in the beef, agricultural and associated industries such as trucking, and shifting the culture to one where support seeking is what 'strong men' do
- Weathering Well App that engages hard to reach populations such as primary producers and the associated industry's workers.

Strong competition between Australian restockers, processors and feedlotters for a smaller supply of animals have led to record high stock prices in 2020 creating stress and additional financial risk.

Australian males between 15 and 45 years of age are in the highest risk category for suicide, with country men approximately three times more likely to take their own life than women.[8;27]

Focus area 9: Responding to climatic extremes and other adversities within rural and remote communities

Shared objectives	Priority actions
Shared objective 1 – Expand capacity building to manage mental health associated with climatic impacts	1. Develop and implement a multi-agency capacity building plan. 2. Strengthen access to low intensity options and promoting their availability to support people with or at risk of mild mental illness.
Shared objective 2 – Strengthen connections and relationships to support proactive access to rural mental health services	1. Strengthen partnerships and capacity building activities with mental health provider networks and other agencies such as rural financial counsellors. 2. Enhance access to integrated and coordinated service delivery models that match intensity of support to the complexity of the health need. 3. Expand digital wellbeing tools (including training) to support strengths-based conversations.
Shared objective 3 – Respond to rural decline through building workforce capacity, sustainable business models and shared opportunities	1. Build workforce capacity and career pathways (e.g. such as care coordination roles, SEWB roles) to reduce professional isolation and by stimulating private practice through improving MBS billing and working with general practice to improve business models to promote sustainability. 2. Improve orientation and induction to service providers who have not lived and worked in an outback rural setting including 'bush culture' awareness training as part of staff training.

Part C: Measuring change

Reporting and measuring progress

This Plan acknowledges that responsibility for MHSPAOD policy extends across all government and non-government portfolios and requires collaboration to effectively report and measure progress against the Plan.

The reporting will incorporate performance monitoring indicators recommended by the Evaluation Working Group. These will be drawn from The Fifth National Mental Health and Suicide Prevention Plan, Frameworks such as the Queensland AOD Treatment and Harm Reduction Framework and agencies such as the National and Queensland Mental Health Commission. The Reporting on progress of the Plan will be undertaken annually and monitored by the MHSPAOD Consortium.

Implementing the Plan

To progress work outlined in each priority focus area of the Plan, implementation plans will be developed by the Implementation Advisory Group and include more detail to meet objectives and actions. Work will continue with the Consortium and Implementation Advisory Group to further refine and prioritise actions.

Bibliography

1. Queensland Department of Health. (2020). Emergency Department (ED) Health Information System (EDIS), Mental health ED Presentations 2019-2020. Brisbane: Queensland Health.

2. Australian Institute of Health and Welfare. (2020). Australia's Health. Retrieved from: https://www.aihw.gov.au/reports-data/australias-health

3. Western Queensland Primary Health Network. (2020). QlikSense Aggregated WQPHN Data Report - unpublished. Mount Isa.

4. Council of Australian Governments. (2017). The Fifth National Mental Health and Suicide Prevention Plan. Canberrra: Council of Australian Governments.

5. Productivity Commission. (2020). Mental Health Inquiry Report. No. 95, 30 June, 2020. Canberra: Commonwealth of Australia.

6. Department of Health. (2017). National Drug Strategy 2017-2026. Canberra: Commonwealth Department of Health.

7. Queensland Government. (2018). Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023. Brisbane.

8. Queensland Government. (2019). Every life: The Queensland Suicide Prevention Plan 2019-2029. Brisbane.

9. Queensland Health. (2016). Connecting Care to Recovery 2016-2021: A Plan for Queensland's State-funded Mental Health, Alcohol and Other Drug Services. Brisbane: Queensland Government.

10. Queensland Health. (2016). My Health, Queensland's Future: Advancing Health 2026. Brisbane: Queensland Government.

11. Australian Institute of Health and Welfare. (2020). Mental Health Services in Australia. Retrieved from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia Retrieved October 16, 2020

12. Western Queensland Primary Health Network. (2018). WQPHN 2017-2018 Health Needs Assessment Summary. Mount Isa. Retrieved from: https://www.wqphn.com.au/uploads/documents/MHSPAOD%20Regional%20Plan_low%20res%20FINAL%207%20Nov%2017.pdf Retrieved October 16, 2020

13. Pulveric, C., & Feris, J. (2020). Evaluation of WQPHN existing MHSPAOD Plan 2017-2020. Brisbane: University of Queensland (unpublished report).

14. Western Queensland Primary Health Network (2018) Nukal Murra Social and Emotional Wellbeing Framework. Mount Isa. Retrieved from: https://wqphn.com.au/uploads/documents/SEWB-Framework-SPREADS-10_8_18.pdf Retrieved November 21, 2020

15. Australian Bureau of Statistics. (2016). Census of Population and Housing, 2016, General Community Profile - G51 and unpublished data. Canberra.

16. Queensland Government Statistician's Office. (2020, June 22). Queensland Treasury, Queensland Regional Profiles: Resident Profile for WQPHN Region. Brisbane, Queensland.

17. Moore, T., McHugh-Dillon, H., Bull, K., Fry, R., Laidlaw, B., & West, S. (2014). The Evidence: What We Know About Place-Based Approaches to Support Children's Wellbeing. Parkville: Murdoch Childrens Research Institute and The Royal Children's Hospital Centre for Community Child Health.

18. Department of Health. (2018). National PHN Guidance: Initial Assessment and Referral for Mental Healthcare. Canberra.

19. Health and Wellbeing Queensland. (2020). Our Role in Prevention. Retrieved from: https://hw.qld.gov.au/our-approach/prevention/ Retrieved November 22, 2020

20. Mental Health Australia and KPMG. (2018). Investing to Save, The Economic Benefits for Australia of Investment in Mental Health Reform Report. Canberra

21. Roberts, R. (2019). The physical health of people living with mental illness: A narrative literature review. Charles Sturt University. ISBN: 978-1-86-467344-9.

22. Australian Early Development Census. (2020, July 21). Australian Early Development Census Data Explorer. Retrieved from: https://www.aedc.gov.au/data/data-explorer?id=-1&term=western%20queensland%20phn Retrieved October 17, 2020

23. Queensland Department of Health. (2020). Queensland Hospital Admitted Patient Data Collection. Brisbane: Queensland Health, Statistical Services Branch.

24. Australian Institute of Health and Welfare. (2019). PHN Alcohol and other drug treatment services in Australia 2018–19. Canberra

25. Public Health Information Development Unit. (2020). Avoidable mortality by selected cause 0-74 yrs - Suicide and Self Inflicted Injuries Av. Annual ASR per 100,000 (2013-2017). Social Health Atlas, Torrens University, Australia.

26. Australian Bureau of Statistics. (2018). 3303.0 - Causes of Death, Australia, 2018. Canberra

27. Leske, S., Crompton, D., & Kõlves, K. (2019). Suicide in Queensland: 2019 Annual Report. Brisbane: Australian Institute for Suicide Research and Prevention, Griffith University.

28. National Mental Health Commission. (2019). The 2019 Report on Mental Health and Suicide Prevention. Sydney.

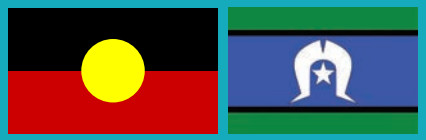
29. Department of Health. (2020). Psychosocial support for people with severe mental illness. Canberra. Retrieved from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/psychosocial-support-mental-illness Retrieved November 22, 2020

30. Health Workforce Queensland. (2020). Health Workforce Needs Assessment: Summary of the Primary Care Workforce Needs in Remote and Rural Queensland. Brisbane. Retrieved from: https://www.healthworkforce.com.au/media/Healthworkforce/client/4.%20Workforce_Planning/2020_HWNA_Web.pdf Retrieved November 22, 2020

Australian Government

phn
WESTERN QUEENSLAND
An Australian Government Initiative

Western Queensland PHN
07 45731900
admin@wqphn.com.au
www.wqphn.com.au
11 Barkly Hwy (PO Box 2791)
Mount Isa QLD 4825



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.

Version: June 2021