phn DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

Darling Downs Health

West Moreton Health

healthy **minds.**
healthy **lives.**

Healthy Minds, Healthy Lives

Darling Downs and West Moreton Joint Regional Mental Health, Suicide Prevention and Alcohol and Other Drug Plan 2022-2027

Acknowledgement of Country

Darling Downs and West Moreton PHN, Darling Downs Health and West Moreton Health wish to acknowledge Australia's Aboriginal and Torres Strait Islander Peoples as the Custodians of this land.

We pay our respects and recognise their unique cultures and customs and honour their Elders past, present and emerging.

Trigger warning

This document discusses mental health, suicide and alcohol and other drug use. Some may find this triggering and we recommend caution.

We respectfully acknowledge those who have died or have been affected by suicide or intentional self-harm. We are committed to ensuring our work continues to inform system improvements to prevent future suicide and self-harm.

Where to go if you or anyone you know needs help

- Triple zero (000) for police, fire and ambulance in an emergency
- BeyondBlue (1300 224 636) offers brief support, provides information and advice so you can get the help you need
- Headspace (1800 650 890) provides free online and telephone support and counselling to young people 12 - 25 and their families and friends
- Kids Helpline (1800 551 800) provide 24/7 phone and online counselling services for young people (age five to 25 years)
- Lifeline (13 11 14) provides 24/7 crisis support
- MensLine Australia (1300 789 978) offers free professional 24/7 telephone counselling support for men with concerns about mental health, anger management, family violence (using and experiencing), addiction, relationship, stress and wellbeing
- 1300 MH CALL (1300 642255) is a confidential mental health telephone triage service that provides the first point of contact to public mental health services to Queenslanders
- 1800 RESPECT (1800 737 732) is a national service providing 24/7 counselling and support to people impacted by sexual assault, domestic or family violence and abuse
- Suicide Call Back Service (1300 659 467) is a nationwide service providing 24/7 telephone and online counselling to people affected by suicide
- Womensline (1800 811 811) provides 24/7 support for women experiencing domestic, family, or sexual violence in Queensland
- National Alcohol and Other Drug Hotline (1800 250 015) provides confidential support for those struggling with addiction.
- Head to Health (1800 595 212) The Head to Health phone line can be accessed by consumers, their families, carers, GPs, service providers and other health professionals. It is available Monday to Friday, 8:30am to 5pm (except public holidays).

Disclaimer

Contents.

1.
Foreword

The challenges our community and our health system have faced over the past few years have been considerable and the impact on our collective mental health has been significant. To make a difference, in 2021 The Healthy Minds Healthy Lives (HMHL) Joint Regional Mental Health, Suicide Prevention, and Alcohol and Other Drugs Plan (derived from the Joint Foundation Plan), was developed in partnership between Darling Downs and West Moreton PHN (DDWMPHN), Darling Downs Health (DDH), and West Moreton Health (WMH).

Since HMHL development there have been significant levels of additional investment into mental health services across the region through Better Care Together and the Bi-Lateral Schedule on Mental Health and Suicide Prevention. The mental health operating environment has also undergone further significant change, resulting from the COVID-19 pandemic.

These changes provided a unique opportunity for DDWMPHN, DDH, and WMH to come together to refresh The HMHL Plan and adapt it to meet present and future challenges. In reviewing the plan we have updated our governance structure, logic model and horizon actions to better encapsulate the new local context.

The HMHL re-launch continues the co-design and implementation of our joint regional planning for integrated mental health, suicide prevention and alcohol and other drug (MHSPAOD) services. Effective joint planning can enable people living with a mental health condition, suicidality and alcohol and other drug use in our region to access effective and appropriate treatment. It provides a shared vision and approach, setting our collective goals and aspirations for making a difference for people living with mental health conditions, suicidality and alcohol and other drug use and their families.

The Plan aims to achieve positive impact across four focus areas:

- integration and coordination
- availability, awareness and access of service
- workforce and support
- services that meet the needs of individuals, specific populations and changing needs across the lifespan.

HMHL is the result of extensive consultation with a range of stakeholders, including people with lived experience, service providers, clinicians and community stakeholders, and a strong partnership between Darling Downs and West Moreton PHN, West Moreton Health and Darling Downs Health.

This is a person-centred, person-led plan with the aim of empowering individuals with lived and living experience to play a critical role in the future of mental health, suicide prevention and alcohol and other drug services.

We would like to take this opportunity to acknowledge the Queensland Health, Mental Health and Alcohol and Other Drugs (MHAOD) Clinical Excellence Division, Queensland Network of Alcohol and Other Drug Agencies (QNADA), the Queensland Alliance for Mental Health (QAMH), Queensland Aboriginal and Islander Health Council (QAIHC), Nous Group, West Moreton Health stakeholders, Darling Downs Health Stakeholders, Darling Downs West Moreton PHN stakeholders, Rebbeck Consulting and in particular our lived experience representatives for their contributions to the Plan and through their involvement with the Executive Working Group and stakeholder collaborative partnerships as well as all members of the working groups of the Foundational Plan.

Darling Downs and West Moreton PHN, West Moreton Health and Darling Downs Health look forward to continuing to partner with you to nurture healthy communities by strengthening our collective responses in mental health, suicide prevention and alcohol and other drug treatment services in our region.

Lucille Chalmers

Chief Executive Officer

Darling Downs and West Moreton PHN

Hannah Bloch

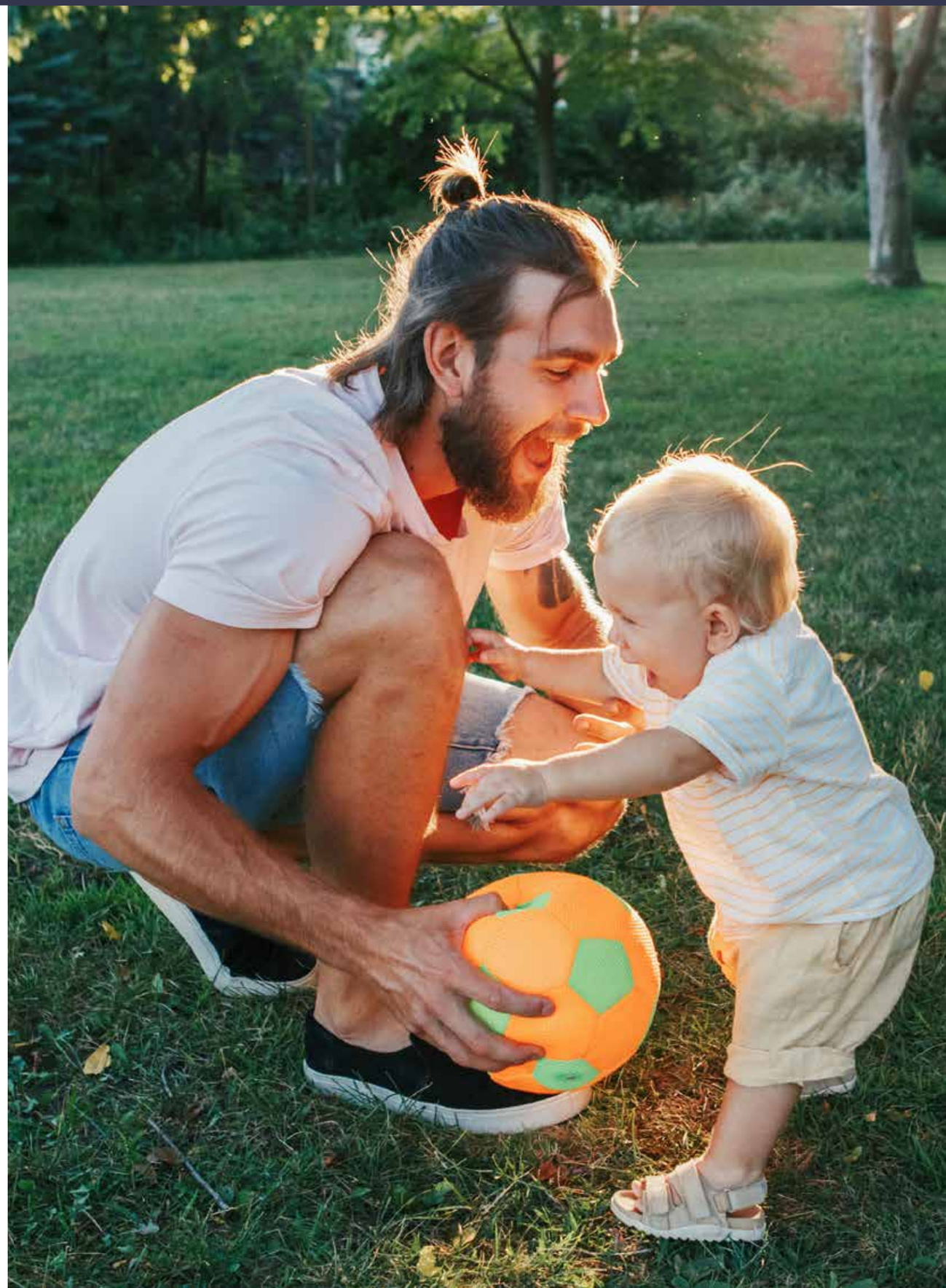
Chief Executive

West Moreton Health

Annette Scott

Chief Executive

Darling Downs Health



2.

Executive Summary

Background to Healthy Minds, Healthy Lives

The national mental health system has been under significant reform in recent years, with several overlapping policies and agreements at the Federal and State levels. These policies are aimed at supporting and facilitating the joint implementation of a stepped care approach to mental health services in order to realise long-term sustainable reform of the system.

At the national level, the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) is the overarching mental health policy, and the National Drug Strategy 2017-2026 provides a framework to reduce health, social and economic harms.

In Queensland, Better Care Together sets the direction and plans for Queensland's state-funded mental health, alcohol and other drug services to 2027. In addition, Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023, Every life: The Queensland Suicide Prevention Plan 2019-2029, Achieving Balance: The Queensland Alcohol and Other Drugs plan 2022-2027, set the direction for whole-of-community and whole-of-government approach to improve the lives of Queenslanders.

Under the Fifth Plan, the Commonwealth, State and Territory Governments have agreed to share responsibility for improving mental health services. This includes shared responsibility to reduce fragmentation in the system and work towards more effective, person-centred care. The Fifth Plan places a priority on integrating regional planning and service delivery.

The purpose of Healthy Minds, Healthy Lives is to establish and work towards a shared vision for the region

The vision for Healthy Minds, Healthy Lives: the Darling Downs and West Moreton Joint Regional Mental Health, Suicide Prevention and Alcohol and Other Drug Plan (the Plan) is that all people living in our region can access the services and support they need for mental health, suicide prevention and alcohol and other drug treatment.

The Plan details a shared understanding of the challenges our region faces, a shared vision for the future and a joint strategic roadmap for service planning and provision. The Plan also sets the foundation for improved collaboration and integration among mental health, suicide prevention and alcohol and other drug services in the Darling Downs and West Moreton region.

The Plan was co-designed with and informed by people with a lived and living experience, service providers, clinicians and community stakeholders. The strong partnership between Darling Downs and West Moreton PHN, West Moreton Health (WMH), and Darling Downs Health (DDH) is at the core of the Plan. This work builds on the Foundational Mental Health Alcohol and Other Drug Plan 2019-2021, which focused on exploring options and identifying potential solutions for this Plan.

The Plan aims to achieve positive impact across four focus areas:

- integration and coordination
- availability, awareness and access of service
- workforce and support
- services that meet the needs of individuals, specific populations and changing needs across the lifespan.

This document contains the context for the Plan, the vision for the region, how we will deliver the vision, and how we will measure our performance.

Healthy Minds, Healthy Lives

Darling Downs and West Moreton Joint Regional Mental Health, Suicide Prevention and Alcohol and Other Drug Plan 2022-2027.

This Plan was co-designed with and informed by people with lived experience, service providers, clinicians and community stakeholders across our region.

OUR VISION

Making a difference for people living with mental health conditions and alcohol and other drug use and improving their mental health, physical health and wellbeing.

OUR PURPOSE

All people living in the Darling Downs and West Moreton region can access the services and support they need for mental health, suicide prevention and alcohol and other drug treatment.

GUIDING PRINCIPLES

Improve understanding	Deliver culturally safe and adaptive services	Empower people to drive their own care supported by carers and families	Support access to care through better communication	Meet people where they are	Take a whole person approach

FOCUS AREAS AND IMPACTS

1. **Integration and coordination**
2. **Availability, awareness and access of services**
3. **Workforce and support**
4. **Services that meet the needs of individuals and populations across their lifespan**

OUR PARTNERS

We commit to a collaborative approach to joint planning for integrated mental health, suicide prevention and alcohol and other drug services to achieve this vision.

West Moreton Health

Darling Downs Health

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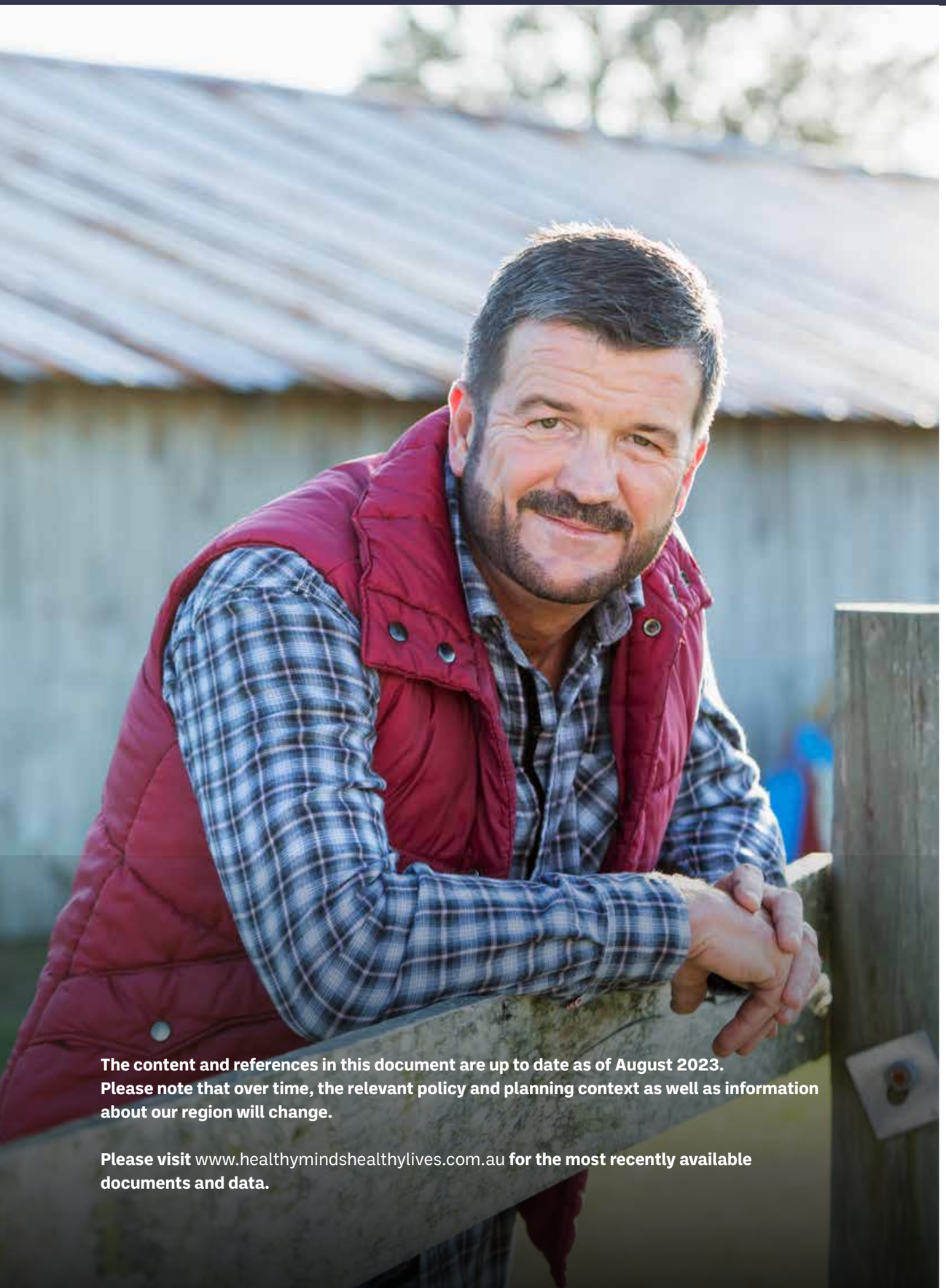


The content and references in this document are up to date as of August 2023. Please note that over time, the relevant policy and planning context as well as information about our region will change.

Please visit www.healthymindshealthylives.com.au **for the most recently available documents and data.**

The whole is greater than the sum of its parts - implementation and success measurement

Collaborative system working approach

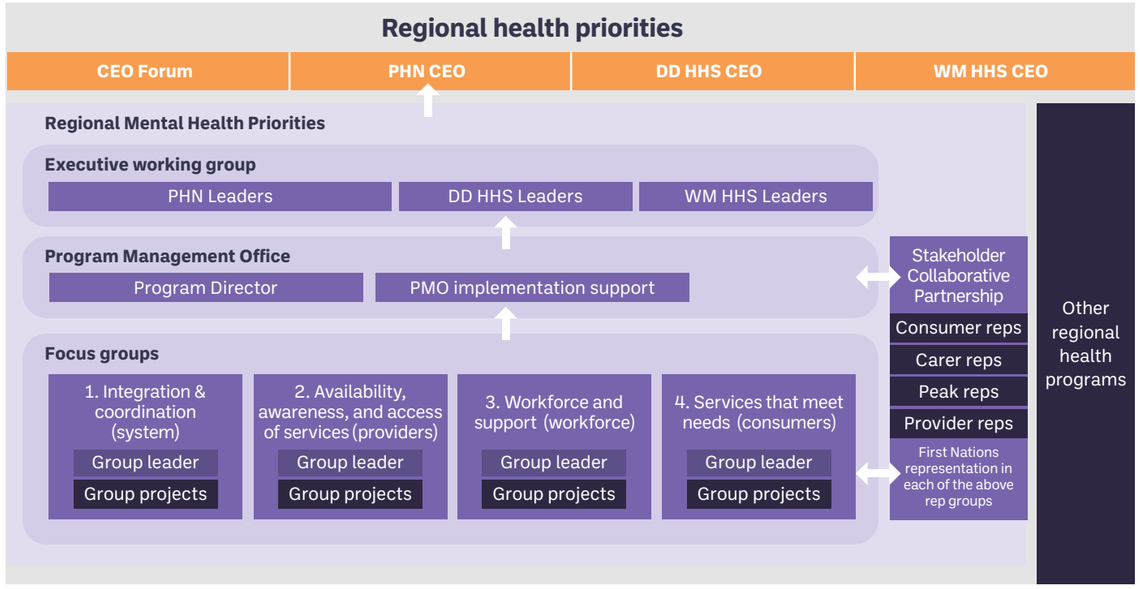
- When organisations and people collaborate effectively, they are able to co-create value that would have otherwise been untapped.
- Effective collaboration enables maximisation of outcomes from the resources available.
- When organisations and individuals from across a regional health system work in partnership to design and improve health services, they can better ensure people receive the right care at the right place at the right time.
- Collaborative system working is characterised by shared decision making and a 'one system' mindset.

The governance framework

Consists of tiers of governance:

1. CEO forum from state and federal funding partners.
2. An executive working group otherwise known as the guiding coalition of change responsible for steering HMHL.
3. A program management office responsible for coordinating the delivery of the plan.
4. Four focus groups, aligned to the focus areas of the plan, who are responsible for leading the delivery of project activities.
5. Stakeholder collaborative partnership representative groups with first nations membership embedded consisting of:
    - consumer representatives
    - carer representatives
    - peak representatives
    - provider representatives.

Leadership and accountability structures required to support a regional shift towards effective governance of mental health systems are outlined below:



3.

Context for the Plan

This section of the Plan outlines the background and contextual information for the Plan. This includes:

- how the Plan was developed
- the policy context surrounding mental health, suicide prevention and alcohol and other drug treatment in Queensland and nationally
- an overview of the stepped care approach to mental health
- the spectrum of responses to alcohol and other drug use, which takes a harm reduction approach.

How this Plan was developed

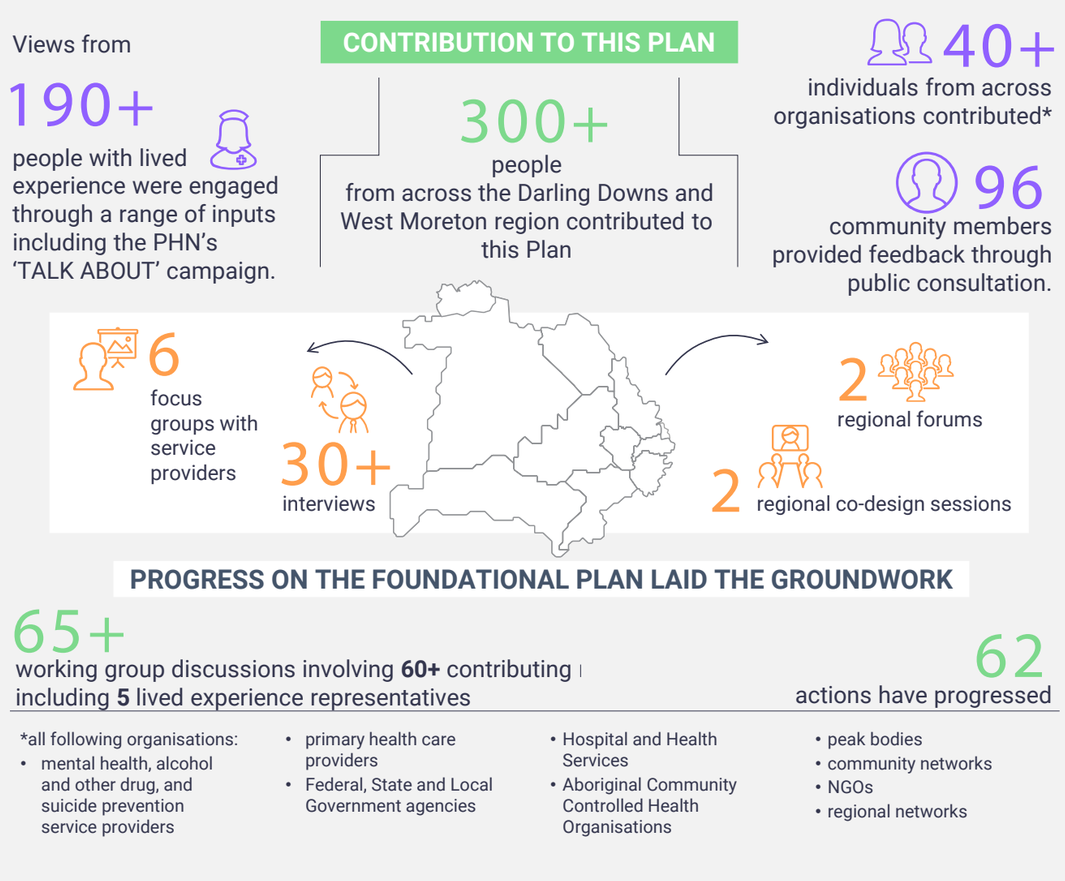
People across the Darling Downs and West Moreton region were involved in the development of this Plan.

This is summarised below.

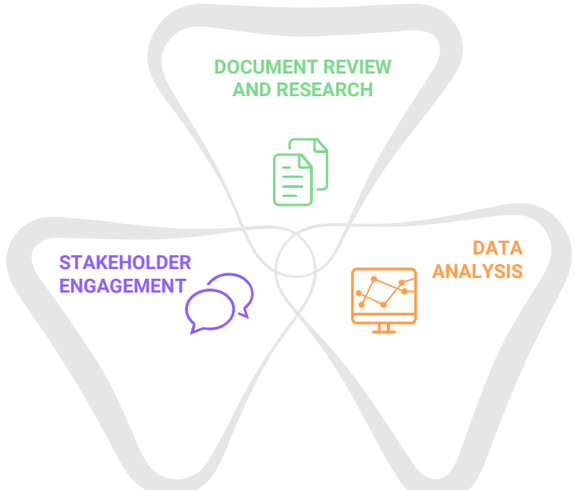
To develop the Plan we combined this extensive stakeholder engagement and co-design with a literature review and various data analysis. We would like to express gratitude to those who contributed.

A summary of the process of triangulating these three categories of inputs is provided on the right.

Overview of the co-design approach that shaped this Plan



How information was gathered to inform this Plan



Conducted a desktop review of document, literature and research, which included:

- national, state, PHN and HHS strategic policy documents, data, consumer feedback and related documents
- published research on MHSPAOD services, commissioning models, effective partnerships, and integration service models
- review of and learnings from the Foundational Joint Regional Mental Health, Alcohol and Other Drug Plan 2019-2021.

Consulted widely across the region to understand diverse perspectives of stakeholders, including:

- Darling Downs and West Moreton PHN, DDH and WMH
- Executive Working Group and stakeholder collaborative partnerships
- National Aboriginal Community Controlled Health Organisation (ACCHOs)
- Queensland Health MHAOD Branch
- QAMH
- QNADA
- other service providers and private practitioners
- people with a lived and living experience, their families and carers
- community stakeholders
- NDIS providers
- government agencies.

Conducted desktop analysis of data, which included:

- service provision data
- demographic data
- prevalence of concerns
- service delivery data (including from HHSs, and Commonwealth programs)
- Primary Mental Health Care Minimum Data Set (PMHC-MDS)
- other service provider, PHN and NDIS data.

This Plan responds to the policy context at a national, state and regional level

In recent years, all levels of government have been exploring how to improve the services and support available for mental health, suicide prevention, and alcohol and other drug use. This has resulted in a number of important strategies and plans which operate at different levels. The list on the following page provides an overview of these policies and their significance to this Plan.

Long term national health strategies & plans

The Fifth National Mental Health and Suicide Prevention Plan

Vision 2030, National Mental Health Commission – Draft

National Preventive Health Strategy

National Children's Mental Health and Wellbeing Strategy

National Drug Strategy 2017-2026

National Disability Insurance Scheme (NDIS)

National strategies & plans

Towards Zero: National Suicide Prevention Plan

National Suicide Prevention Implementation Strategy

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

National Mental Health Workforce Strategy

National Mental Health Research Strategy

National inquiries & reviews

Productivity Commission inquiry into Mental Health

Royal Commission into Aged Care Quality and Safety

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability – Interim Report

Queensland inquiries, strategies & plans

Better Care Together through to 2027.

Shifting Minds Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023

Every life The Queensland Suicide Prevention Plan 2019-2029

Achieving Balance The Queensland Alcohol and Other Drugs plan 2022-2027

Darling Downs & West Moreton strategies & plans

Darling Downs and West Moreton PHN Strategic Plan 2023-2027

Aboriginal and Torres Strait Islander Health Strategy 2021-2025

Darling Downs Health Strategic Plan 2020-2024

West Moreton Health Strategic Plan 2021-2025

Coordination can help address the fragmentation in the health system

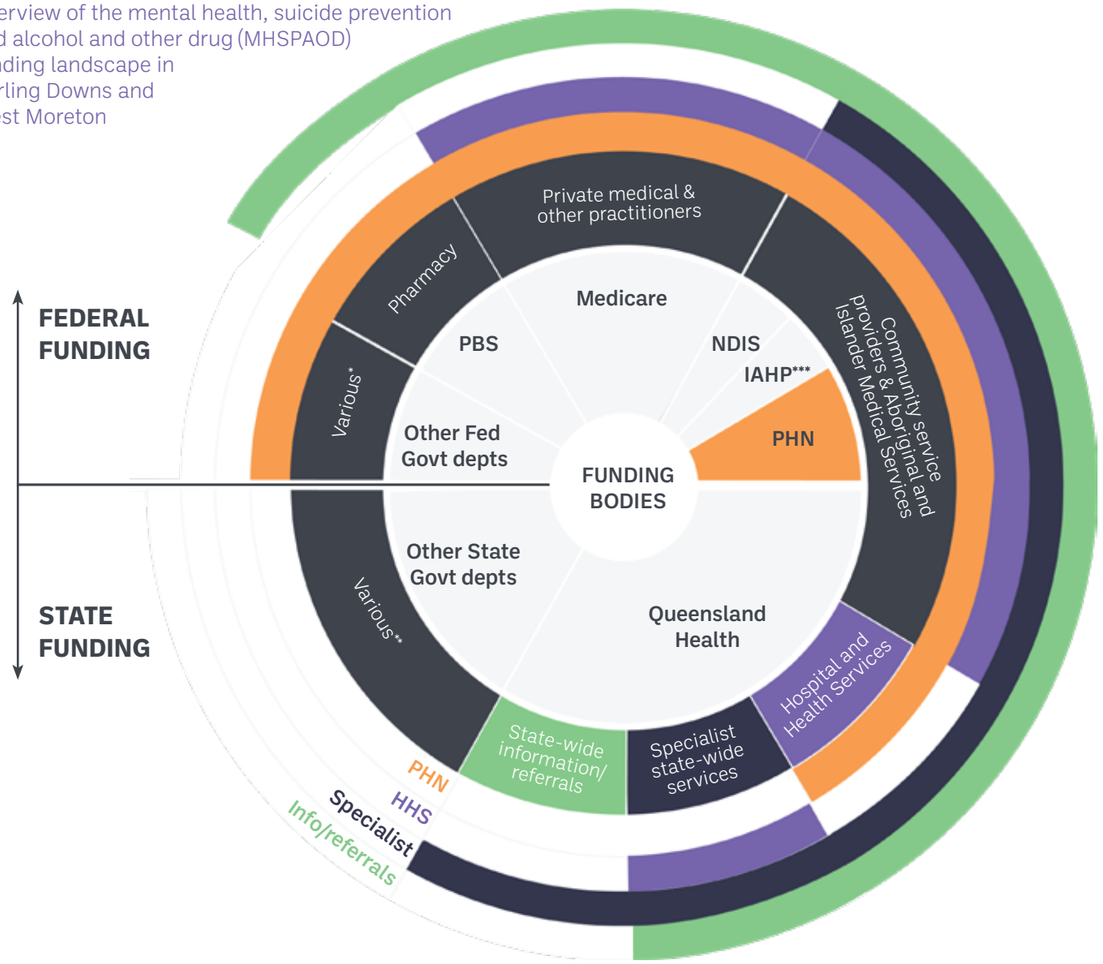
The mental health, suicide prevention and alcohol and other drug treatment funding landscape is complex and highly fragmented. This results in overlaps and gaps in funding and service provision.

To overcome this, understanding the range of funding sources and how organisations can better collaborate when designing and commissioning services is important to meet the needs of our communities.

Note: While peak bodies are not represented in the diagram, they play a key role in research, planning and policy relating to mental health, suicide prevention and alcohol and other drug treatment services.

- Funding is split across the Federal and Queensland Government inner circle.
- The inner most layer of the circle (mostly light grey) represents the various funding bodies / streams with each level of government.
- The next layer (mostly dark grey) represents the key service providers funded through each funding body.
- The outer four layers demonstrates which organisations provide supports to the service providers. For example, PHNs provide support to improve efficiency and effectiveness of GP practices and to promote integrated care, although they do not fund private medical and other practitioners.

Overview of the mental health, suicide prevention and alcohol and other drug (MHSPAOD) funding landscape in Darling Downs and West Moreton



Services funded by funding body

PHN

Low intensity mental health services: early intervention

Child and youth mental health services

Regional approach to suicide prevention

Regional Approach to suicide prevention and mental health services – Aboriginal and Torres Strait Islander Peoples

Psychological services: under serviced groups, people with mental illness in aged care facilities

Universal Aftercare - the Way Back Support Service

Primary Mental Health Nurse Care and Services Navigation Services

Head to Health Adult Mental Health Centres, Satellites and Phone Assessment and Referral Services

INDIGENOUS AUSTRALIANS HEALTH PROGRAM (IAHP)***

Primary care for Indigenous Australians

Medicare

GPs: intake and referral, care coordination

Psychologist: psychological therapies

Psychiatry: psychological therapy & medication prescription

HOSPITAL AND HEALTH SERVICES

Emergency mental health care

Bed-based services, acute services

Extended care services

AOD withdrawal management

Community bed-based services

Psychosocial interventions

SPECIALIST STATEWIDE SERVICES

Queensland Health Victim Support Service

Queensland Forensic Mental Health Service

Queensland Centre Perinatal & Infant Mental Health

Eating Disorders Outreach Service

Queensland Transcultural Mental Health Centre

STATEWIDE INFORMATION AND REFERRAL PHONELINES

1300 MH CALL: mental health

24 hr triage and referral phone services

13 HEALTH: general health

ADIS: Alcohol and Drug Information Service

OTHER QUEENSLAND GOVERNMENT DEPTS**

MHSPAOD support at schools and prisons

Housing supports

Building social connection and community resilience via local government

PBS

Medication dispensing

OTHER FED GOVERNMENT DEPTS*

Workforce training

Welfare, housing & caring supports

Aged care

NDIS

Psychosocial supports for people with psychosocial disability

Integration requires cooperation between multiple levels of the health system

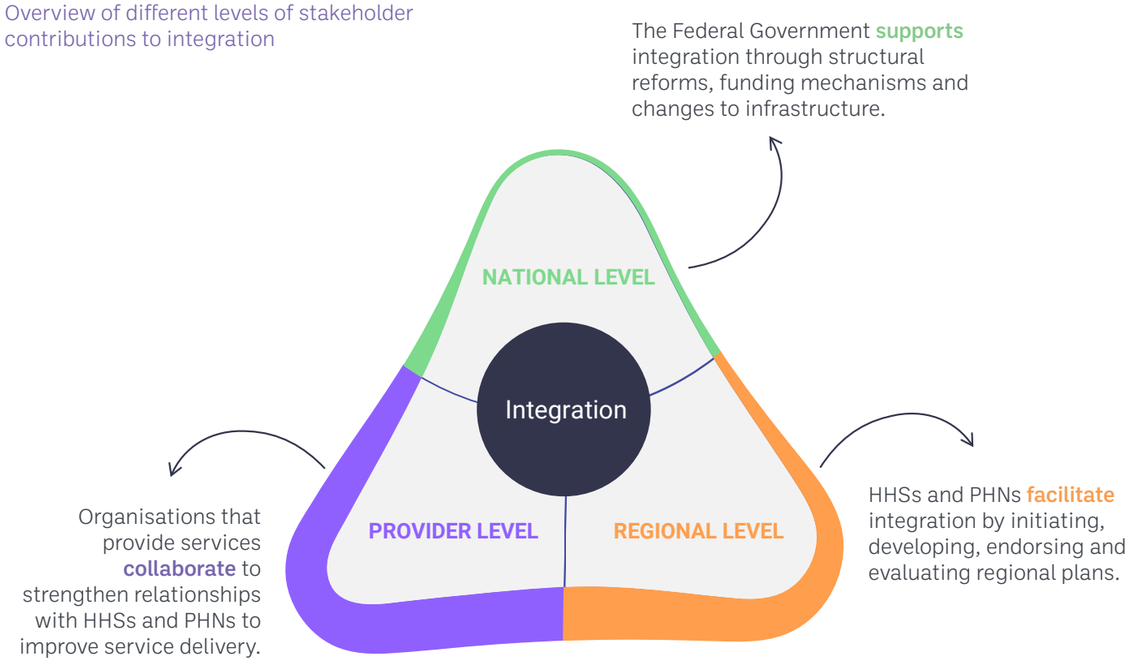
One of the priority areas in the Fifth Plan is integration and coordination between services. Integration in the health system context is the extent to which patient care services are coordinated across the range of existing activities, services, and providers.

All levels of the system must work together to achieve this, which is in part a core purpose and action of joint regional planning. PHNs and HHSs play a pivotal role in establishing a regional framework to achieve integration and ensure its ongoing effectiveness.

This role involves two focal points:

- short term: utilising existing resources and available services
- medium to longer term: identifying and planning to address service gaps and reduce duplication.

Overview of different levels of stakeholder contributions to integration



This Healthy Minds Healthy Lives Plan, builds on the momentum of the Foundational Plan

In 2019, Darling Downs Health, West Moreton Health, and Darling Downs and West Moreton PHN collaborated in the development of the Joint Regional Mental Health, Alcohol and Other Drug Plan 2019-2021 (the Foundational Plan). It focused on exploring options and identifying potential solutions for the future.

This Plan reflects the achievements, progress and learnings from the Foundational Plan. A selection of achievements from the Foundational Plan are summarised below.

- Developed a region-wide approach to suicide prevention, building on the suicide prevention plans of DDH and WMH.
- Commenced implementation of the Project ECHO model, an interactive community of practice. It supports development of GP mental health capability so that people in underserved communities can receive high-quality care and services.
- Continued the implementation of HealthPathways, a web-based portal designed to support clinicians to guide their patients through the local public and private health systems. It provides evidence-based information on the assessment and management of a range of clinical conditions, referral guidance, and locally agreed information to make the right decisions together with patients.
- Explored a range of different options for evidence-informed service models to consider, including:
  - alternatives to presenting to the Emergency Department (ED) for support for people with severe and complex mental health conditions, or seeking intervention for alcohol and other drug concerns
  - models of community-based withdrawal services
  - opportunities to support more peer worker graduates in the region
  - ways to improve the uptake and effective use of telehealth services in the region.

The Healthy Minds Healthy Lives Plan, defines how we can improve MHSPAOD services and support

The Plan offers a shared vision and approach to improve mental health, suicide prevention and alcohol and other drug services and support for people in the Darling Downs and West Moreton region.

The Plan ...

- Helps guide commissioning and delivery of mental health, suicide prevention, and alcohol and other drug services
- Is informed by stakeholder views on what matters most to them and what solutions address their concerns
- Supports collaborative effort between the many stakeholders in the region
- Provides opportunities to test and pilot innovative approaches
- Supports new service development or implementation of existing service models in a new context that is informed by evidence-based practice.

The Plan does not...

- Change the core responsibilities and accountabilities of organisations within the region
- Generate more money or funding directly, so the focus should be on prioritisation and best use of current resources
- Override existing funding agreements, service agreements or broader jurisdictional planning or business processes.

Effective services and support consider the person as a whole

Mental health, suicidal ideation, and alcohol and other drug use often co-occur. The delineation between the three concerns is not always clear. In fact, around one in four people living with a serious mental illness co-experience concerns with substance use.[1] Our system needs to reflect this diversity of needs.

Effective treatment services adopt a 'no wrong door' policy and routinely screen individuals for co-morbid conditions. They also consult and collaborate with other providers who specialise in the relevant area. Alongside this, providers need to be aware of the individual as a whole and their community circumstances, so that treatment responses can address social, economic and environmental context. For example, extreme weather events such as fire, droughts and floods require a unique response from our health system.

A stepped care approach demonstrates how people move across the spectrum of care needs

Stepped care is an evidence-based approach used across mental health systems in Australia. It forms a key part of the Australian Government's response to mental health. For a person accessing services and support, stepped care helps providers consider the person's needs, identify the intensity and type of services that best responds to those needs, and support smoother transitions between different levels or types of service. The Plan has two aims related to stepped care:

1. help people in our communities better understand stepped care and its implications for services and support
2. support service development across the range of stepped care responses.

PHNs are expected to plan for and promote integrated stepped care approaches to mental health services to address a spectrum of needs in an equitable way. Services within this stepped care framework are provided by:

- Queensland Government through Hospital and Health Services
- Aboriginal Community Controlled Health Organisations (ACCHOs)
- private providers, including those supported by Medicare Benefits Schedule (MBS) rebates
- services commissioned by PHNs
- other non-government services.

A stepped care approach ensures that gaps in services are acknowledged and can be better addressed.

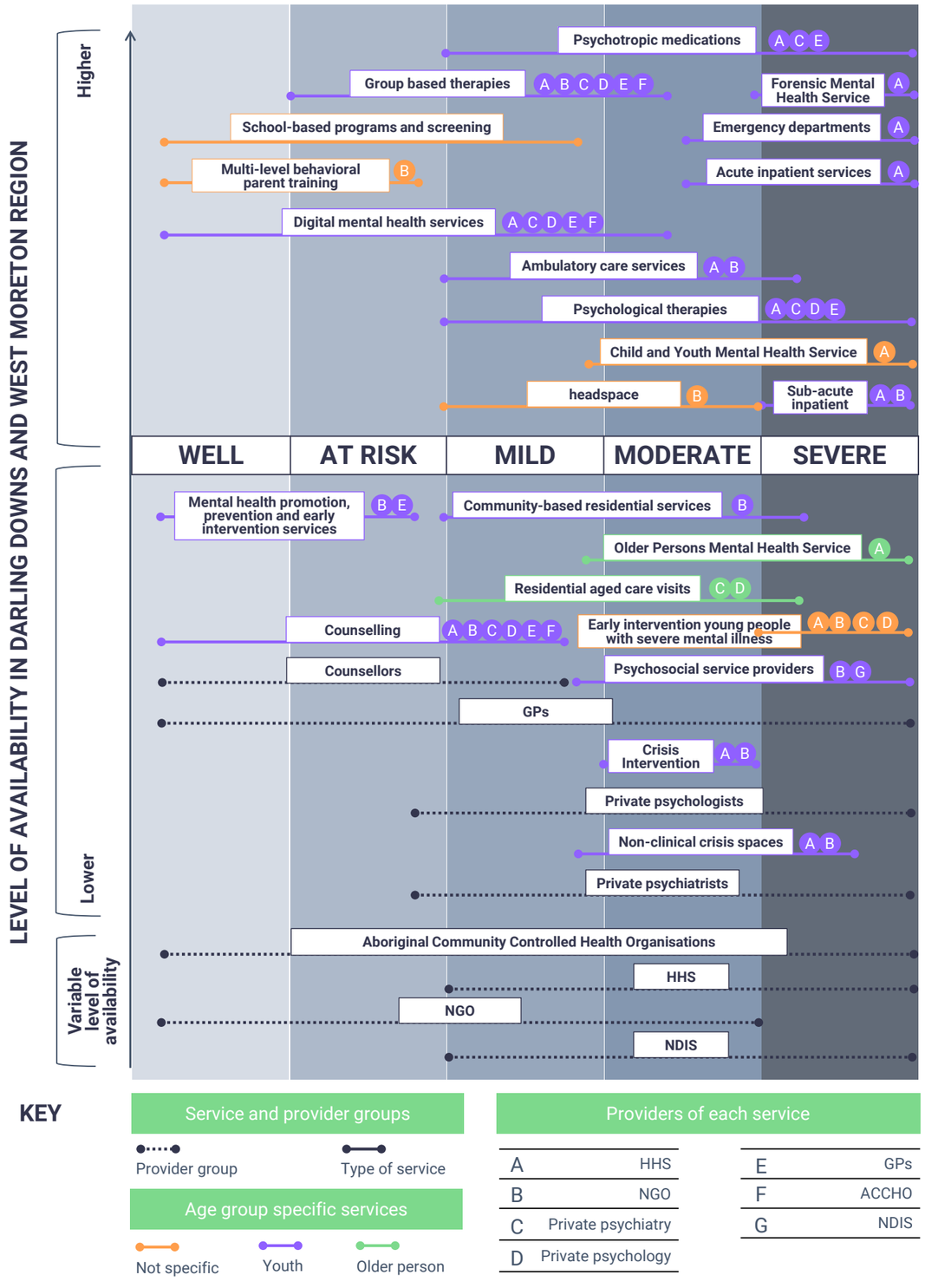
A visual representation of the current stepped care approach in the Darling Downs and West Moreton region is provided at right. This diagram covers at a high-level:

- what types of services are available (indicated by boxes)
- what organisations they are delivered by (indicated by letters)
- their level of availability (indicated by their vertical positioning)
- the age groups supported by the service (indicated by colour of box)
- the provider group (indicated by a dotted line).

The level of individual needs is categorised from 'well' through to 'severe and complex'.

Note: This has been developed based on the situation at the time of preparing the Plan. The availability of services varies in different communities and will change over time.

Stepped care approach to mental health in the Darling Downs and West Moreton region



Understanding the spectrum of responses to alcohol and other drug use

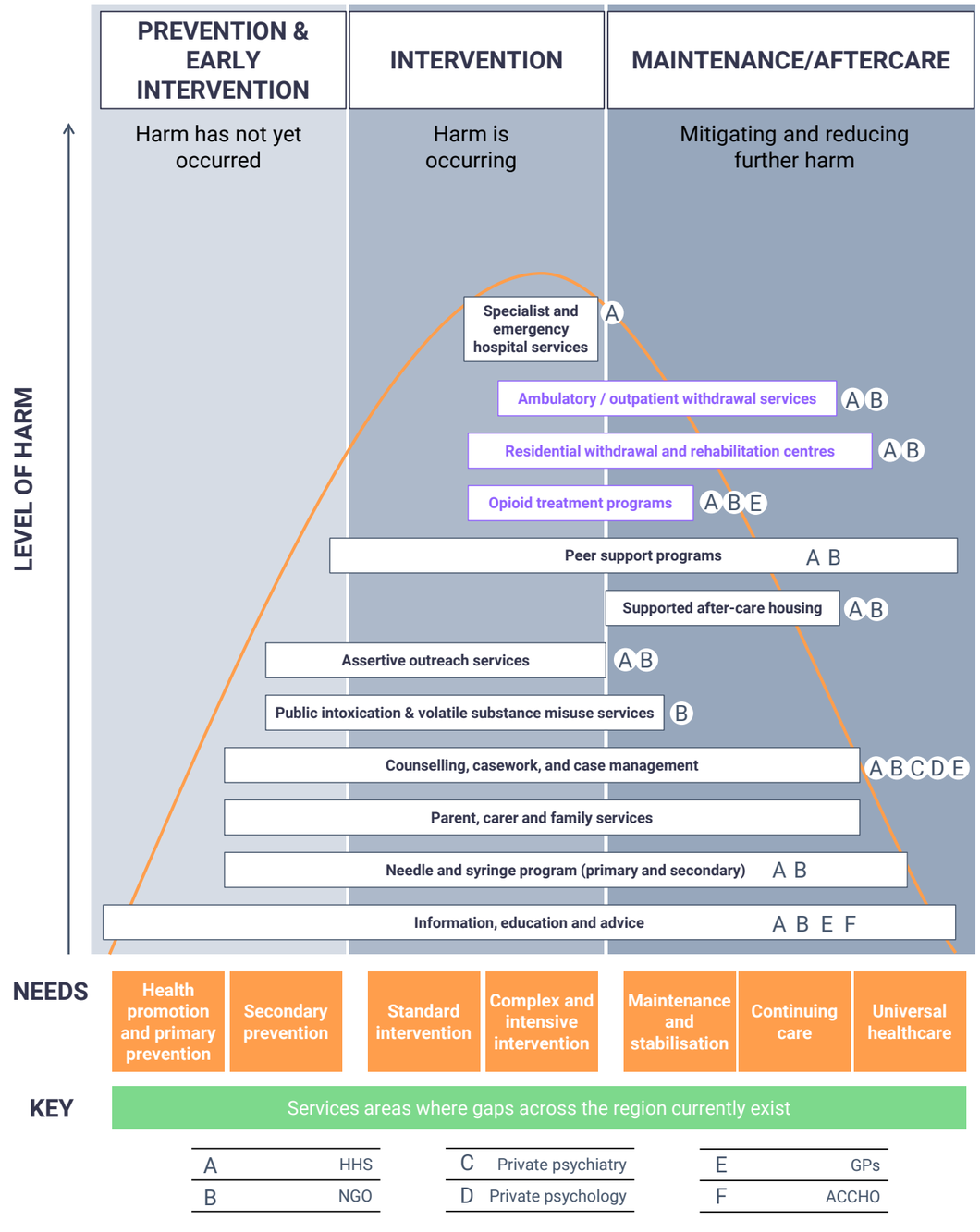
Alcohol and other drug services and support do not fit neatly into the mental health stepped care approach and require a different framework to appropriately map the level of need to relevant services. The spectrum of responses to alcohol and other drug concerns is built upon the guidance on the Queensland AOD Service Delivery Framework.

This diagram is structured around a harm reduction approach (see the Queensland AOD Treatment and Harm Reduction Outcomes Framework for more information[2]). Harm reduction has been the approach adopted by Australia's National Drug Strategy since 1985 and focuses on reducing negative consequences associated with drug use. It is based on recognising that alcohol and other drug use is a part of society, that it occurs across a continuum, and the range of harms can be addressed with various approaches. The focus is on reducing the health, social and economic impacts. This approach has been effective in reducing the morbidity and mortality of drug use.

AOD treatment takes many forms, occurs in a variety of settings, and is delivered at varying levels of intensity[4]. Together, these services comprise a diverse and comprehensive AOD treatment system bridging the primary health sector, early intervention, acute care, community-based and longer-term rehabilitation service spectrum.

Note: This has been developed based on the situation at the time of preparing the Plan, and it is recognised that the availability of services varies in different communities and will change over time.

Spectrum of responses to alcohol and other drug concerns



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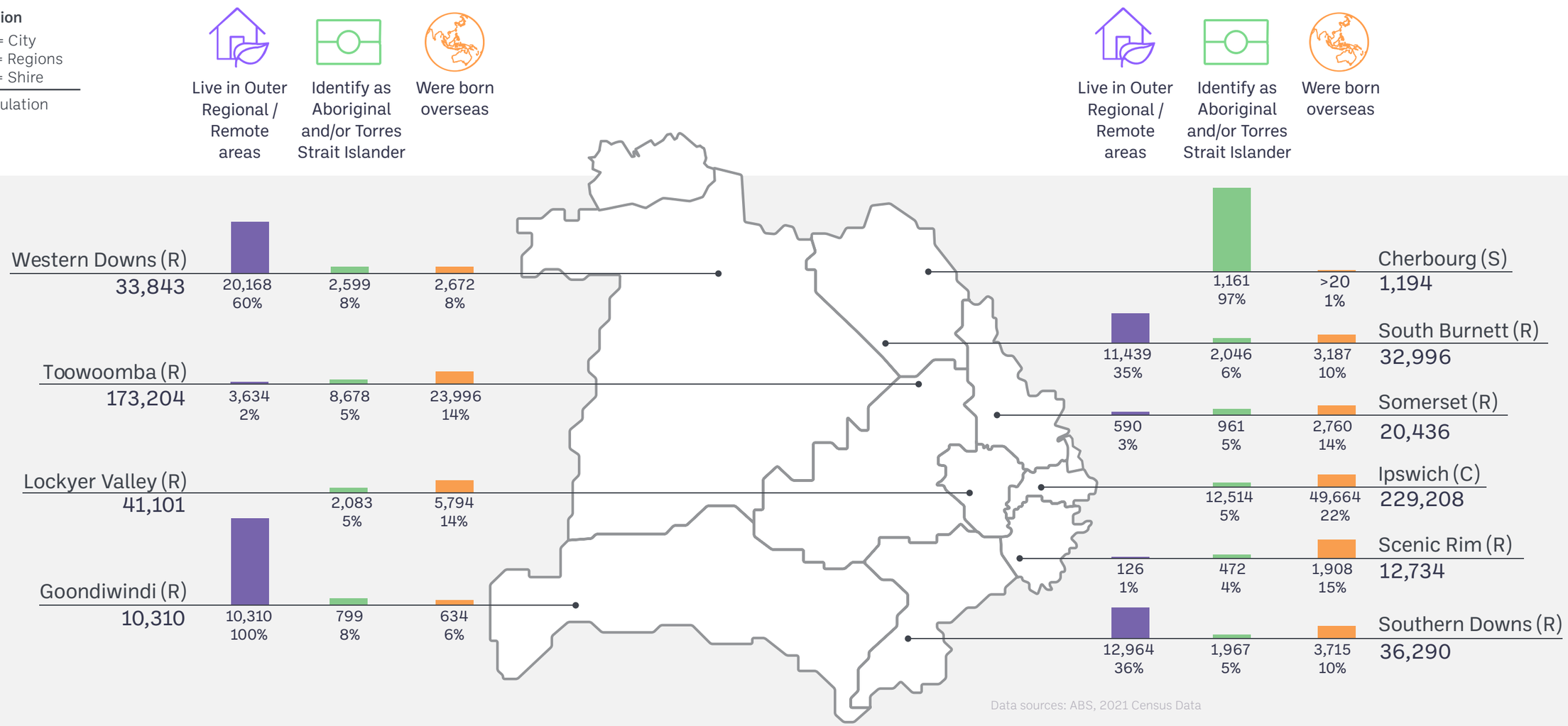
Overview of the region and people in our communities

The Darling Downs and West Moreton region covers 10 local government areas (LGAs), around 98,000km^2. As at June 2021, there are over 599,000 people living in urban, rural and remote areas. The region also includes communities located in the Banana Shire and Brisbane LGA. Due to the relatively small population size, data on these areas is not included in the diagram. The map below illustrates the rich diversity in the region.

Considerations for information presented in this section:

- The information included in these graphics is based on the most recent and relevant information available as at August 2023 – visit **www.ddwmphn.com.au/our-region** for the most up-to-date information. We acknowledge that the statistics shown throughout this report may not indicate the full breadth of prevalence, service demand, or the population demographics in the Darling Downs and West Moreton region.
- Recommendations have been included as part of the Plan to improve data collection to improve future monitoring and reporting.

Population characteristics of the Darling Downs and West Moreton region



Data sources: ABS, 2021 Census Data

Overview of the Darling Downs and West Moreton region

Darling Downs and West Moreton is a region of great diversity, with two hospital and health services (Darling Downs Health and West Moreton Health), numerous Aboriginal Community Controlled Health Organisations (ACCHOs) and other providers. These services work together to provide and meet the needs of the urban, regional and remote areas. The information presented below provides a snapshot of the population characteristics, prevalence of relevant conditions and key themes from stakeholders.

POPULATION PROFILE

599,048 people within the overall PHN region

16% were born overseas

6% identify as Aboriginal or Torres Strait Islander

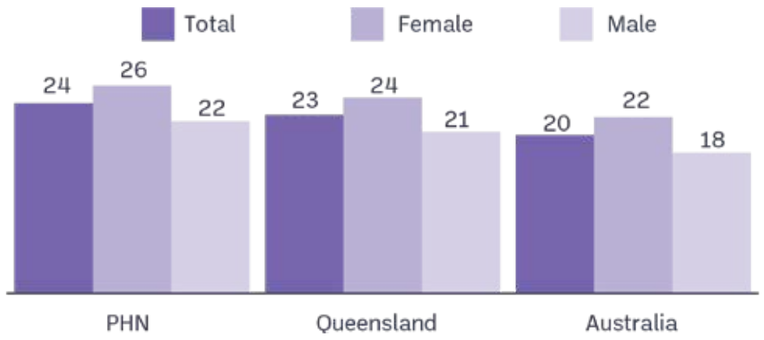
10% live in Outer Regional/ Remote areas

17% are aged 65+

Data sources: ABS, 2021 Census Data

MENTAL HEALTH PREVALENCE

Estimated age standardised rate per 100,000 with mental health and behavioural conditions in total and by sex in the PHN, Queensland and Australia, 2017-18



The percentage of women with mental health and behavioural conditions is greater than men in the PHN region. This is consistent with greater Queensland and Australia.

Data sources: Social Health Atlases, PHIDU, 2023

WHAT WE HEARD

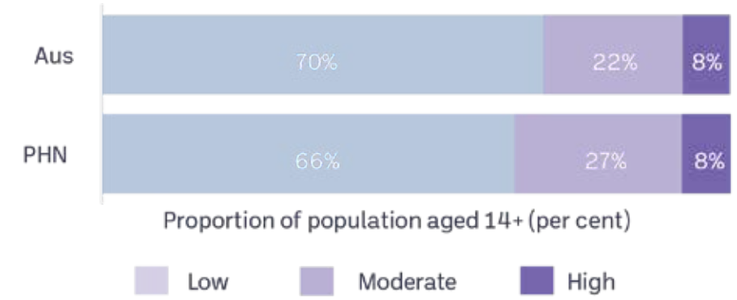
A few themes raised by mental health care service users to improve service provision include:

- therapy and rehabilitation programs rather than prescription programs
- more services for under 16 year olds and more face-to-face services in rural areas
- a focus on follow-up and after care.

Source: Darling Downs and West Moreton PHN: TALK ABOUT Mental Health Campaign

ALCOHOL AND OTHER DRUG RISK PREVALENCE

Proportion of population aged 14+ by alcohol risk score in the Darling Downs and West Moreton region and Australia, 2019

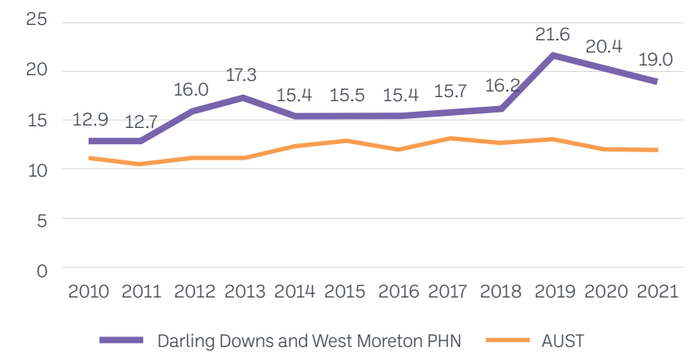


Compared to broader Australia, the region has a slightly higher proportion of people aged 14+ at moderate or high risk of having problematic alcohol use.

Source: National Drug Strategy Household Survey 2019

SUICIDE PREVALENCE

Age-standardised rate of suicides per 100,000 residents in the Darling Downs and West Moreton PHN region and Australia, 2010 to 2021



The region has one of the highest rates of suspected suicides compared to other Queensland PHN catchment areas, and is above the national average rate. The rate differed greatly between men and women, with a rate of 30 male suspected suicides per 100,000 relative to 7 female suspected suicides per 100,000. Suicide rates vary and can impact some populations more intensely. This suggests the service system needs to remain responsive to local needs, as the location and rate of suspected suicides can change each year.

Source: Australian Insitute of Health and Welfare (2022) National Mortality Database; Australian Bureau of Statistics (2022) Causes of Death; Griffith University (2022) Queensland Suicide Register Annual Report.

Overview of the Darling Downs region

The Darling Downs region is characterised by a high number of people living in regional and remote areas and by its large Aboriginal and Torres Strait Islander communities. The information presented below provides a snapshot of the population characteristics, prevalence of relevant conditions and key themes from stakeholders.

POPULATION PROFILE

288,757 people within the Darling Downs region

12% were born overseas

6% identify as Aboriginal or Torres Strait Islander

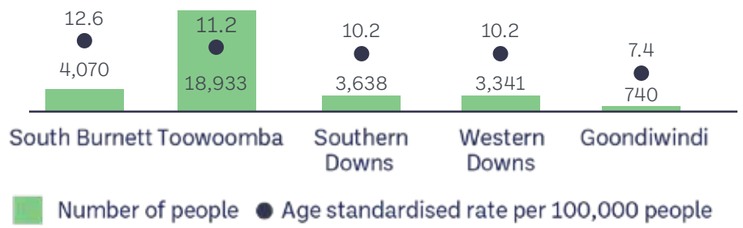
21% live in Outer Regional/ Remote areas

21% are aged 65+

Data sources: ABS, 2021 Census Data

MENTAL HEALTH PREVALENCE

Rate per 100,000 and number of people with mental health and behavioural conditions by LGA in Darling Downs HHS, 2021.



While Toowoomba has the highest number of people living with mental health conditions, the South Burnett region has the greatest rate per 100,000 people.

Data sources: Social Health Atlases, PHIDU, 2023

WHAT WE HEARD

A few themes raised by Darling Downs mental health care service users to improve service provision include:

- researching lived experiences for those living with mental health concerns to inform service delivery design
- considering the access to services available through private billing options.

Source: Darling Downs and West Moreton PHN: TALK ABOUT Mental Health Campaign

ALCOHOL AND OTHER DRUG RISK PREVALENCE

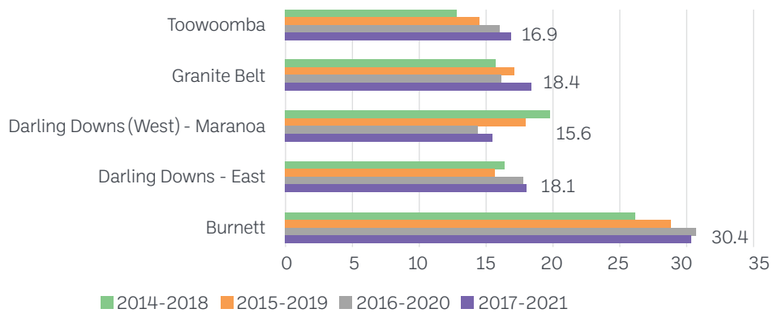
Estimated age-standardised rate per 100,000 and number of people aged 18+ who consumed more than two standard alcoholic drinks per day on average in Darling Downs HHS, 2017-2018

Rural and remote areas have particularly high occurrence of people using alcohol and other drugs. This corresponds with the reflections heard through consultations – that there are higher prevalence rates in rural areas, which are also coupled with less access to services and support for harm minimisation.

Source: Australian Social Health Atlas, 2020

SUICIDE PREVALENCE

Age standardised rate per 100,000 people whose death was suspected suicide and self-inflicted injuries by SA3 in the Darling Downs region, between 2014 to 2021



Suicide is a large concern for Darling Downs. The particular region that requires focus is South Burnett (Burnett SA3) where the rate per 100,000 people is greater than the rate for the overall Darling Downs and West Moreton region (30 per 100,000 people compared to 19 per 100,000) during 2017-2021.

Source: Australian Insitute of Health and Welfare (2022) National Mortality Database; Australian Bureau of Statistics (2022) Causes of Death; Griffith University (2022) Queensland Suicide Register Annual Report.

Overview of the West Moreton region

The West Moreton region is characterised by its range of culturally and linguistically diverse communities, with many community members born overseas. The information presented below provides a snapshot of the population characteristics, prevalence of relevant conditions and key themes from stakeholders.

POPULATION PROFILE

310,611 people within the West Moreton region

20% were born overseas

5% identify as Aboriginal and/or Torres Strait Islander

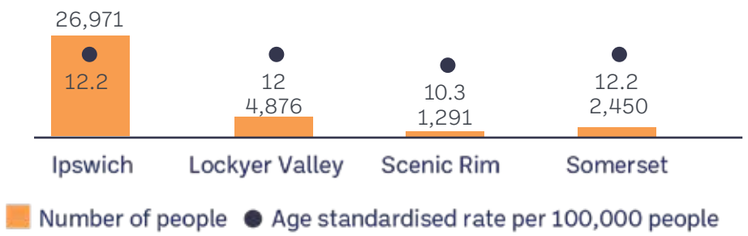
0.2% live in Outer Regional/Remote areas

13% are aged 65+

Data sources: ABS, 2021 Census Data

MENTAL HEALTH PREVALENCE

Rate per 100,000 and number of people with mental health and behavioural conditions by LGA in West Moreton, 2021.



Ipswich has the greatest rate of people living with mental health conditions among the regions in West Moreton. Lockyer Valley is second. Regional areas in the Scenic Rim and Somerset must also be prioritised, given the prevalence is not far behind those in Ipswich and Lockyer Valley. These regional areas frequently lack access to many of the services available in more urban locations such as Ipswich.

Data sources: Social Health Atlases, PHIDU, 2023

WHAT WE HEARD

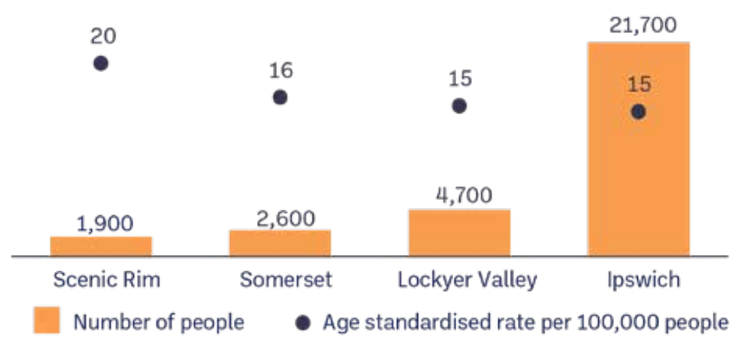
A few themes raised by West Moreton mental health care service users to improve service provision include:

- tailored care
- services separate from hospital admittance
- approaches for acute care need
- reframing “helping recover” to “helping manage” conditions in approaches to care.

Source: Darling Downs and West Moreton PHN: TALK ABOUT Mental Health Campaign

ALCOHOL AND OTHER DRUG RISK PREVALENCE

Estimated age-standardised rate per 100,000 and number of people aged 18+ who consumed more than two standard alcoholic drinks per day on average in West Moreton HHS, 2017-2018

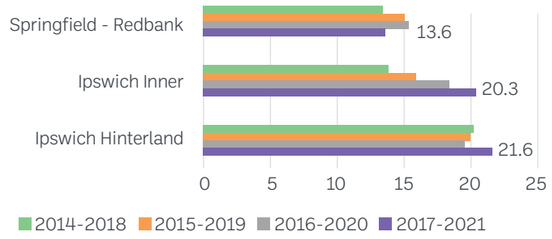


The prevalence of high alcohol risk is higher in Scenic Rim – whereas Ipswich has more people living in it and thus a greater number of people experiencing a high risk of problematic alcohol use.

Source: Australian Social Health Atlas, 2020

SUICIDE PREVALENCE

Age standardised rate per 100,000 people whose death was suspected suicide and self-inflicted injuries by SA3 in the West Moreton region, between 2014 to 2021



Relative to the overall age standardised rate in the Darling Downs and West Moreton region of 19 per 100,000 people, two regions of particular focus in West Moreton are Somerset and Lockyer Valley (Ipswich Hinterland) as well as Inner Ipswich, with rates above 20 per 100,000 people.

Source: Australian Insitute of Health and Welfare (2022) National Mortality Database; Australian Bureau of Statistics (2022) Causes of Death; Griffith University (2022) Queensland Suicide Register Annual Report.

This Plan focuses attention towards five specific populations

People who access mental health, suicide prevention and alcohol and other drug support come from diverse backgrounds, with a variety of life experiences. Community engagement and data analysis identified five specific population groups who require particular focus in the Plan, with the rationale outlined below.

- People in one or more of these population groups are often disproportionately affected by mental health conditions, suicide and alcohol and other drug use. In some cases, this is a result of systemic disadvantage.
- Services may not take into account the needs of these population groups, which can create barriers for people who could benefit from services and support. This means that:
  - appropriate services may not be available
  - people may not be able to access services. For example due to long waiting lists or travel distance, or they may not experience cultural safety when they do access services.

We acknowledge that these categories are not mutually exclusive and are not all-encompassing. They provide a reference point and a way to group similar challenges faced by many unique individuals.

Presented below and over the following pages is an overview of these specific populations and the unique needs and challenges they face.

Please note:

- Where data is available, this information is contextualised to the Darling Downs and West Moreton region, or Queensland overall.
- The language used in the detail is applied specifically as it is defined by the relevant research. We acknowledge this may be different from the language used in other parts of this report.

The five population groups for particular consideration in the Plan are outlined below and further covered in the following pages:

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

LESBIAN, GAY, BISEXUAL, TRANSGENDER, INTERSEX, QUEER/ QUESTIONING, ASEXUAL (LGBTIQA+) COMMUNITIES

OUTER REGIONAL AND REMOTE COMMUNITIES

PEOPLE LIVING WITH DISABILITIES

6%
of the population identify as Aboriginal and/or Torres Strait Islander[8]

There is a serious workforce shortage of people who identify as Aboriginal and/or Torres Strait Islander, and who are culturally aware.

We need increased cultural and social support for Aboriginal and Torres Strait Islander people accessing mainstream primary health services.

ABORIGINAL AND/OR TORRES STRAIT ISLANDER PEOPLES

Aboriginal and Torres Strait Islander peoples hold a strong, unique view of a whole-of-life focus for wellbeing and connection. It is crucial for services to acknowledge the importance communities place on relationships between individuals, family and community, and of connection to land, culture, spirituality and ancestry.

Population needs

In 2021-22, 15.5% of total presentations for mental health related conditions (people who presented to the emergency department who received a primary diagnosis of a mental health-related condition) identified as an Indigenous Australian in the Darling Downs and West Moreton region. This has grown by 7.1% from 2019-20.

As of June 2023, there were more than 29,000 Indigenous Australians who accessed GP services in the Darling Downs and West Moreton region, of which approximately 24% had an AOD risk. Over 30% had a mental health concern.

Other context

Nine per cent of PHN commissioned services are provided to Aboriginal and Torres Strait Islander peoples.

Unique challenges and considerations

- Culturally safe and appropriate services respect and align with the individual's priorities and goals.
- Some Aboriginal and Torres Strait Islander people indicated that while they experience a degree of safety, there is a lack of knowledge about Indigenous Australians' customs. They feel like they are being labelled and judged due to their heritage and culture and not individually assessed on their health care needs.[10]
- The need to travel away from communities is a significant barrier to access and use of services.

CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

People from multicultural backgrounds may be at greater risk of experiencing mental health conditions and suicide, which is compounded by facing barriers to access for services and support. Research indicates that many people from culturally and linguistically diverse backgrounds are more likely to experience risk factors associated with poor mental health and mental illness and are less likely to access services and support.

Population needs

The prevalence of mental health concerns within the population of culturally and linguistically diverse backgrounds is largely unknown, with considerable gaps in the monitoring and reporting for these communities.

Generally, immigrants, refugees and asylum seekers have lower rates of mental health service utilisation than the Australian-born population. However, many factors (e.g. a history of trauma, loss of family bond, racism and discrimination, stress of migration) contribute to increased risk of mental health conditions in people from culturally and linguistically diverse populations.[12]

Refugees and asylum seekers are at greater risk of developing suicidal behaviours than the general Australian population.[12]

Compared with people who mainly speak English at home, people from culturally and linguistically diverse backgrounds are more likely to abstain from alcohol (age standardised percentages: 53% compared with 19.2%) and less likely to have recently used illicit drugs (6.4% compared with 18.7%).

Other context

Culturally and linguistically diverse communities are often underrepresented in service access. For example, 12.1% of Queenslanders with a disability were born in non-English speaking countries but only 2.6% of people who accessed disability services were born in non-English speaking countries.

Unique challenges and considerations

- Access to interpreters when seeking help from primary health care can be limited and, in some instances, underutilised.[11]
- Health and support services do not consistently reflect diverse cultural understandings of mental health.[11]
- Lack of consistent data to identify and respond to needs of different culturally and linguistically diverse communities.[11]

16%
of the population in the Darling Downs and West Moreton region were born overseas[8]

It's hard enough getting the right service and then you have to find one that works with an interpreter on top of that.

Many of the refugees in our communities require services to adapt their approach to better support trauma [previously or currently experienced by the individual].

10%
of the population live in Outer Regional/ Remote areas[8]

There are some great services, but we often must travel far to access them.

Stigma is particularly bad in our rural areas and the drought has impacted the livelihoods of many. So we must address stigma now.

PEOPLE LIVING IN OUTER REGIONAL AND REMOTE AREAS

People living in outer regional and remote areas face issues accessing services in their local area. Although they may be provided with travelling or transportation services, these do not always fulfil the demand requirements. This leads to other services filling gaps or requiring people instead travel to access services in urban areas, turn to private health services, or utilise virtual care services, where appropriate.

Population needs

The Darling Downs and West Moreton region is primarily comprised of Inner Regional, Outer Regional and Remote communities.[13]

On average, an estimated age standardised rate 9.4 per 100,000 people have mental health conditions in outer regional/remote areas, and some outer regional/remote areas can have rates as high as 12.6 and 10.2 per 100 people. This is greater than the Queensland average in outer regional areas of 9.2 per 100,000 people.[13]

Although prevalence rates look lower in some regional areas, limited access to local services compounds the issues faced by people experiencing mental health and AOD issues.

Other context

Many outer regional communities and remote areas only have access to services on a periodic basis based on mobile service delivery models.

Telehealth is slowly improving, which is providing more access to services. However, not all treatments can be administered via telehealth. There are additional challenges to service delivery in this format.[16]

Nurses often fill the gap when there are not enough GPs to meet demand.[16]

Unique challenges and considerations

- Feedback from community members reflects the need for a local drop-in engagement with community members to improve visibility and raise awareness for mental health and wellbeing. This will provide an opportunity for referral and interim support, which is particularly important when services are located elsewhere.[16]
- While virtual care is becoming more readily available, there are still connectivity issues to consider for people in particularly remote areas, along with preferences (from both clients and clinicians) for face-to-face services.[16]
- Transportation costs can be a significant barrier, particularly for people on lower incomes when they are required to travel to access services due to waiting lists or service gaps close to home.[16]

LGBTIQA+ COMMUNITY

People who identify as lesbian, gay, bisexual, transgender, intersex, queer/questioning and/or asexual (LGBTIQA+) are more likely to ideate or attempt suicide, engage in self-harm, and experience and be diagnosed with a mental health disorder.

Population needs

Nationally, 41.1% of homosexual and bisexual people aged 16 and over met the criteria for a mental disorder and had symptoms in the last 12 months.

Nationally, 37.1% LGBTIQ+ people aged 16 and over reported being diagnosed or treated for any mental disorder in the past three years.

Nationally, 16% of LGBTI young people aged 16 to 27 reported that they had attempted suicide.

LGBTIQA+ people are more likely to have thoughts of suicide, specifically:

- lesbian, gay and bisexual people aged 16 and over are more than six times more likely
- transgender people aged 18 and over are nearly eighteen times more likely
- LGBTIQA+ young people who experience abuse and harassment are even more likely to have thoughts of suicide.

Other context

GPs, private psychologists and psychiatrists are the main services accessed for mental health support.

Unique challenges and considerations

- Cost, heteronormativity and homophobia and attitudes of self-reliance are seen as the major access barriers (heteronormativity and homophobia are both viewpoints that negatively impact LGBTIQA+ people. The terms are further defined in the glossary).[20]
- Treatments and interventions (both medical and psychosocial) are often not effective and are highly medicalised with little social support.[20]
- Stigma of LGBTIQA+ people is directly associated with poorer mental health outcomes and a higher risk of suicidal behaviours.[20]
- Training and development of the health workforce is needed to overcome the lack of LGBTIQA+ knowledge and cultural competence in services.

0.6%
reported couples in the PHN are in same-sex relationships[17]

The LGBTIQA+ communities are some of the most at risk because many service providers lack the level of understanding required.

More can be done in terms of understanding how we can support the LGBTIQA+ people in our communities.

Note: for the figures we use the acronym drawn from the relevant sources to ensure the research methodology is appropriately reflected.

6.3%
of Queenslanders are living with disabilities[23]

NDIS has increased demand for services but there is no increase in service availability.

Currently, the service system is not sufficiently flexible and responsive to support people with a disability.

PEOPLE LIVING WITH DISABILITIES

The challenges of living with disabilities can lead to anxiety, depression and harmful alcohol and other drug use due to issues such as social isolation, lack of employment opportunities, discrimination and financial difficulty.

Population needs

The region has a high proportion of people living with profound or severe disabilities: 7.4% compared with 6.3% for Queensland and 6% for Australia in 2021[1]. Some regional areas have higher proportions, for example 14.3% for Riverview, 12.2% for Nanago, 10.8% for Tara, 10.6% for Wilsonton and 10.1% for Leichardt-One Mile and Esk (Statistical Area Level 2) (SA2).

Department of Social Services forecast the number NDIS participants could more than double between 2023 and 2025 in the region to around 31,500 people.

Almost one in five young people living with disabilities aged 15-24 years (18.9%) and 25-34 years (18.2%) experienced discrimination, while overall among people living with disabilities aged 15+ years, one in 10 (9.6%) had experienced discrimination.

Over half (51%) of people aged 15-24 years, and two-thirds (67%) of people with psychosocial disability, avoided situations because of their disability.[23]

Other context

People with disabilities often require additional healthcare services, and assistance to be able to access services.

Stakeholders recognised the benefits of strong relationships between the hospital and broader health system, including primary and community services and general practices, to deliver services in partnership or outside the acute healthcare system.[22]

Unique challenges and considerations

- The contextual factors surrounding living with disabilities (income, discrimination, isolation, etc.) should be considered as part of the holistic care approach to ensure early intervention access to resources are provided.
- Service delivery needs to take into consideration challenges such as transport and access barriers, specific needs for people with vision, hearing and cognitive disabilities.
- People living with a psychosocial disability (the disability experience of people with impairments and participation restrictions related to mental illness) as well as another disability require integrated care provided across the spectrum of clinicians involved in their case.

5.
Our vision for MHSPAOD services and support in the region

Our vision is that all people living in our region can access the services and support they need for mental health, suicide prevention and alcohol and other drug treatment.

This section establishes the overarching principles, enablers, and focus areas that will guide the implementation of the Plan to achieve this vision.

Guiding principles state the Plan's overarching outcomes

Brief definitions of each guiding principle are provided below.

- **Improve the understanding of mental health, suicide and alcohol and other drug use, and encourage people to ask for support.** Individuals feel comfortable and supported to access the services they need by normalising conversations and improving community awareness of mental health, suicide prevention and alcohol and other drug use.

- **Deliver culturally safe and adaptive services.** A system that embeds cultural competency for its workforce to provide welcoming and culturally safe services for everyone in the Darling Downs and West Moreton region.

- **Enable individuals to drive their own care, supported by carers and families**. Individuals and their support networks are treated as equals by being active partners in their own care.

- **Support service access, continuity of care and the person's experience by appropriately communicating and sharing information.** Individuals seeking support get to decide what information is shared, with whom and when. Information is shared respectfully with relevant providers maintaining individuals' privacy. This works to increase quality of services, awareness of available services and improves individual's overall experience.

- **Meet individuals where they are.** Services meet people where they are, both in their physical location and where they are on their treatment and recovery path.

- **Take a whole person approach.** Services need to consider the whole individual. This includes their physical, mental and social wellbeing while taking into account their socio-economic situation. Providers recognise that mental health, suicide and alcohol and other drug use frequently co-occur.

Enablers to support delivery of the Plan

Factors that will support effective implementation of the Plan and its actions are outlined below:

- **Meaningfully embed the voices of people with lived experience.** Individuals with lived and living experience are meaningfully engaged to provide input into the design, governance, implementation and monitoring of all areas of the Plan.

- **Establish effective governance and accountability.** The Plan will define accountabilities and responsibilities for all those involved to build a broader understanding of the Plan and its activities throughout the region. Collaborative partnerships and relationships will be established amongst stakeholders to successfully implement the Plan.

- **Develop and apply evidence-informed and responsive solutions.** New service models or ways of working are informed by evidence, with room to explore, test and refine through action-learning projects to meet the specific and unique needs of individuals in both Darling Downs and West Moreton. Solutions are based and built on proven models. Evidence and experience from other regions in Australia or overseas are explored when implementing initiatives.

- **Maximise access to and use of available funding.** The current demand on resourcing in mental health, suicide prevention and alcohol and other drug sectors exceeds available support. Therefore, maximising access to and effective use of funding available is crucial to the success of the Plan. Planning and commissioning of services is improved through enhanced coordination of existing funding streams and by identifying potential funding sources that are available through local, state and national programs.

- **Embrace digital health and ways of working to improve access and service continuity, to complement face-to-face models of care.** Digital health and digital ways of working are not always a substitute for face-to-face models of care, but can help improve access to services in circumstances where availability of face-to-face care is limited. The Plan will consider how digital approaches can support people to access care and complement face-to-face care. The Plan will also consider how to use digital ways of working to increase awareness of mental health, suicide prevention and alcohol and other drug services, support communication between services and to evaluate service effectiveness, and the success of the Plan.

- **Clearly define, monitor and evaluate success.** The Plan will be supported by clear indicators of success for the overall Plan and for the individual actions. This will include continuous monitoring of the implementation and impact as well as formal evaluation of the Plan. Individual actions and projects supported under the Plan will include continuous measuring and evaluation into any new services or projects to support continuous improvement and refinement of service design to allow for greater innovation and a more adaptive system.

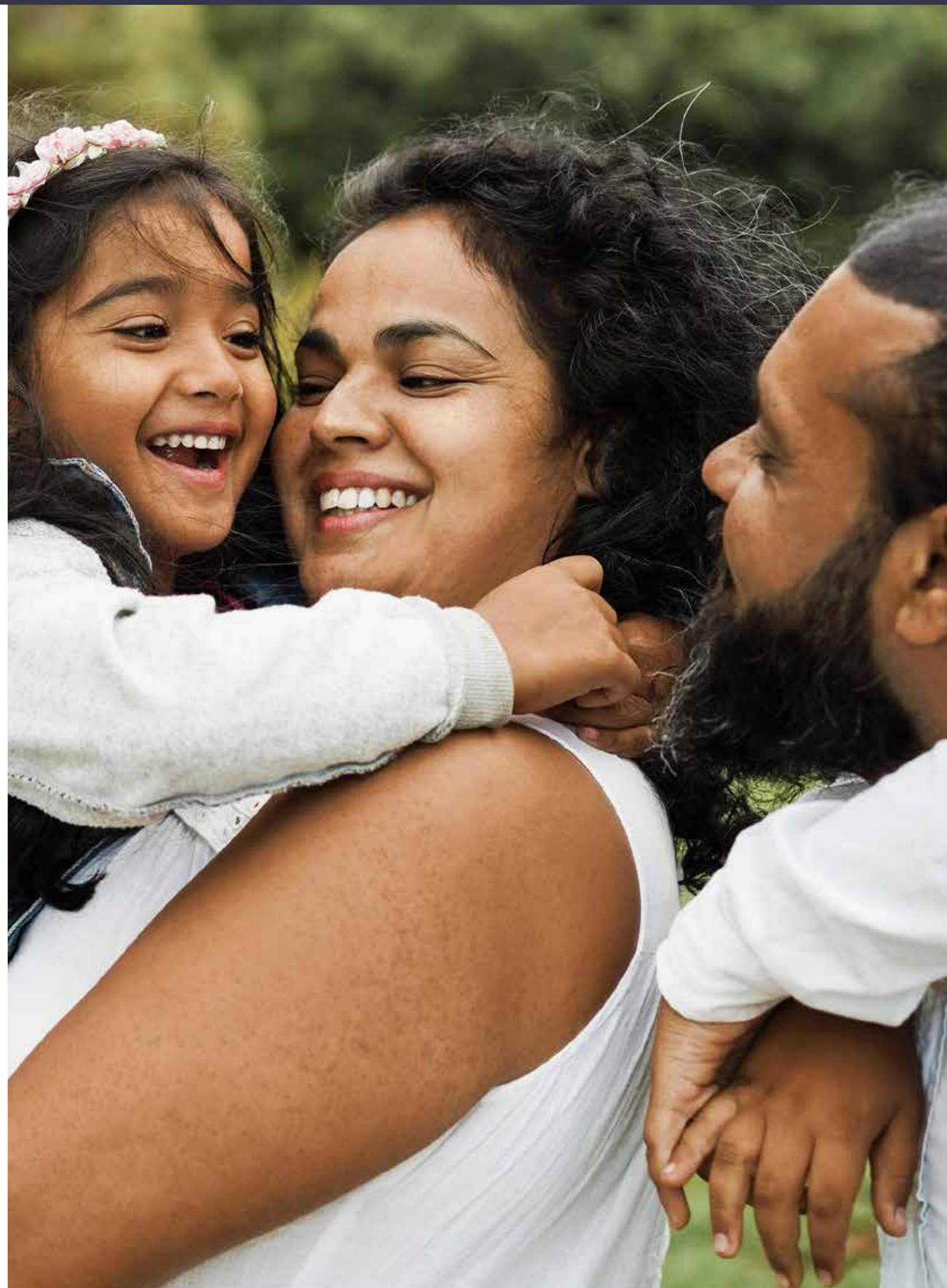
6.
Delivering on the vision for our communities

This section of the Plan introduces the four focus areas for the Plan.

1. **Integration and coordination**
2. **Availability, awareness and access of services**
3. **Workforce and support**
4. **Services that meet the needs of individuals and populations across their lifespan**

For each focus area, we outline:

- an overview of what we heard from stakeholders in our communities
- the key challenges the focus area will address
- the objectives, which define the outcomes we want to achieve within the focus area
- what achieving the objective looks like in practice
- the actions that will help us achieve the related objectives. Each action has the relevant sector(s) indicated – mental health (MH), suicide prevention (SP) or alcohol and other drug (AOD).



FOCUS AREA 1
INTEGRATION AND COORDINATION

Bringing everything together

Overview

A system that is integrated and coordinated delivers the most effective experience and outcomes for individuals throughout their journeys. Continually striving to improve at working together across different funding and governance contexts will help reduce gaps and overlaps; smooth transitions for individuals between services; and improve information sharing between services where appropriate.

National and state level policies and strategies identify integrated regional planning and service delivery as key.

Core to this approach is to work with individuals and communities to understand their needs and co-design services.

There still needs be more coordination between services. The more gaps, the more people fall through the cracks.

Red tape across institutions prevents ease of transferred care access.

HealthPathways will become a priority of the health service as it becomes more integrated.

What we heard

Individuals and providers are feeling the impacts of a lack of integration

Service providers and referrers indicated that although there are positive relationships across the region, there are barriers to working together effectively. Some of these challenges include a lack of awareness of services; limited time and resources for collaboration; and communication challenges.

There is limited shared understanding of how the system fits together

To integrate and coordinate across services, stakeholders need to understand how the system currently connects. Including what services exist, what needs they address, where they fit, and where there are gaps. Stakeholders currently lack a shared understanding of these things.

Lack of culturally safe services in the region

The lack of culturally safe services is a barrier to integration and coordination of services for Indigenous people. Stakeholders have indicated that mainstream services, including general practices, are highly variable in terms of their capability and approaches.

Objectives	Actions	Horizon Timeframe
1. Work together across organisations to co-design and commission services Service providers routinely work together to design and commission services to support greater coordination of services, more effective use of resources and improved community outcomes.	1.1.1 Develop a governance framework that outlines leadership and accountability to support a shift towards more collaborative commissioning of services across funders (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	1.1.2 Develop different approaches to identify the support required in different parts of the Darling Downs and West Moreton region and co-design service models to address those needs (MH, SP, AOD).	H3 - 1 July 2024 – 30 June 2025
	1.1.3 Promote business opportunities for services to develop service offerings with capacity for longer-term income earning, which can support defined funding periods as set by the Commonwealth and State Governments, to support greater service stability and development of the regional workforce (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
	1.1.4 Utilisie digital health as an enabler to effective regional planning implementation (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	1.1.5 Targeted Regional Initiatives for Suicide Prevention (SP).	H1 - 1 July 2022- 30 June 2023
	1.1.6 Pilot Queensland Ambulance Service MH Co Responders to reduce ED presentations for individuals (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	1.1.7 Integrate the MH service system by establishing Head to Health Phone Line, Centre and Satellite (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
2. Support timely and reliable transitions of care between services for young people When people move between services, transfers are well planned and follow up care is in place to improve continuity of care.	1.2.1 Improve coordination of care for young people between key stakeholders in the broader network, such as schools, youth justice and child safety (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
3. Improve information sharing between providers to improve service continuity When individuals have provided informed consent to service providers, providers share information quickly and effectively to support coordination of care and service consistency.	1.3.1 Engage and educate providers on evidence-informed information-sharing and utilise existing guidelines (e.g. GP Mental Health Standards Collaboration) to provide advice to improve internal protocols (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
	1.3.2 Support providers and GPs to engage in shared care, informed by evidence and best practice, such as through use of templates and plans (MH, SP).	H3 - 1 July 2024 – 30 June 2025

FOCUS AREA 2
AVAILABILITY, AWARENESS, AND ACCESS OF SERVICES

Identify what support you need, what is available, where the service or support is and how you access it

Overview

Improving mental health, suicide prevention and alcohol and other drug treatment services requires consideration for availability, awareness and access of services.

This includes:

- understanding and identifying the needs of individuals and communities
- working together to determine what services and support are required to meet those needs
- making services available
- building awareness of available services, for individuals, referrers and providers
- supporting access to services, which can include overcoming physical barriers (e.g. transportation, distance) as well as other personal barriers (e.g. convenience, fees, discrimination).

We [those seeking care] don't know where to start. It's not easy to find information on what's available.

Not enough rehabs or knowledge of where they are.

We need more community support groups to cover service gaps.

What we heard

Inpatient care is primarily available only in urban areas

Those who require inpatient care often transfer to urban areas, creating challenges including transportation and moving away from community. This gap includes the lack of rehabilitation (rehab) and detox services outside metropolitan areas.

New touchpoints offer a chance to identify and refer people to services and support, who may otherwise fall through the 'cracks'

There is a strong appetite to consider new interaction points to act as soft referrals into services. The Plan will need to investigate how providers can use existing touchpoints within communities or at times of crisis to identify and refer people who may not be picked up by traditional pathways (for example, disaster support crisis staff in council or state call centres).

For people who live in regional areas, the travel distance to access services (particularly tertiary services) can be prohibitive

Individuals from outer regional and remote communities who require certain services (e.g., detox services) often travel to the nearest metropolitan hub which may be several hours away. In some cases, this may result in higher rates of people leaving their service prior to completing treatment as many people find it difficult being isolated from their families and communities when receiving treatment.

Telehealth has increased the accessibility of many support services

The ease of access that digital solutions like telehealth have created has been beneficial for some people. Although there are outstanding issues to address with telehealth, it can provide increased access to services (in particular for outer regional and remote communities).

Objectives	Actions	Horizon Timeframe
1. Increase providers and consumers understanding of how the system fits together, service availability and access to up-to-date information Providers and community members understand which services are available and how they fit in with the broader service system. Referrals are made to the most appropriate service.	2.1.1 Develop and distribute an overview of the system and services in the Darling Downs and West Moreton region highlighting the federal and state policy and funding context and information about the region and its communities (MH, SP, AOD).	H5 - 1 July 2026 – 30 June 2027
	2.1.2 Identify options and implement preferred way to improve discovery and awareness of services that are currently dispersed across differentservice directories (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
	2.1.3 Consult with service providers to ensure information about mental health services, suicide prevention services, and alcohol and other drug services, including low intensity services and peer workers, is appropriately and correctly presented in HealthPathways (MH, SP, AOD).	H2 - 1 July 2023 – 30 June 2024
2. Make it easier for people to access the services they need, when they need them Barriers to access for different services and in different parts of the region are understood. Actions are taken to improve access – meaning people can access the services they need, when they need them.	2.2.1 Use existing touchpoints, entry points and contacts within communities (e.g. sporting clubs, community centres) to help identify and refer people to services for support (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	2.2.2 Develop tailored strategies to normalise support seeking for the local needs of the region for mental health, suicide ideation, and alcohol and other drug use – noting that each will require a different approach as they face unique challenges (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
	2.2.3 Develop and implement care models to support communities following suicide or suicide attempts (SP).	H4 - 1 July 2025 – 30 June 2026
	2.2.4 Refine and implement models of support: • Test and implement options for people experiencing a suicidal crisis including non-clinical recovery spaces and co-responder models (SP). • Develop and implement care models to provide alcohol and other drug intervention alternatives when clinical risk does not justify the need for the Emergency Department (AOD). • Explore and implement virtual care support that integrates with and augments on-the-ground service delivery (MH, SP, AOD). • Explore and develop dual diagnosis treatments within communities to better support those who present with a combination of mental health experiences and harmful alcohol and other drug use (MH, AOD).	H1 - 1 July 2022- 30 June 2023
	2.2.5 Improve and increase access to existing services, including: • Increase capacity for local GPs and pharmacies to provide opioid replacement therapy services (AOD). • Develop local capability to provide support during after-hours periods or where specialist service coverage is not available (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	2.2.6 Explore, develop and implement shared care arrangements between HHS and primary care providers that allow for out of hours presentations and admissions (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
	2.2.7 Bolstering existing child and youth mental health services in line with contemporary approaches and models of service through the Child and Youth Consultation Liaison Model Enhancement (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	2.2.8 Adolescent day program build and refurbishment to improve access to specialist treatment alongside educational and vocational programs (MH, SP, AOD).	H3 - 1 July 2024 – 30 June 2025

FOCUS AREA 2
AVAILABILITY, AWARENESS, AND ACCESS OF SERVICES

Objectives	Actions		Horizon Timeframe
2. Make it easier for people to access the services they need, when they need them Barriers to access for different services and in different parts of the region are understood. Actions are taken to improve access – meaning people can access the services they need, when they need them.	2.2.9	Ongoing and Expanded implementation of Universal Aftercare (SP).	H1 - 1 July 2022- 30 June 2023
	2.2.10	Delivering new and enhancing AOD residential treatment services to improve access to rehabilitation and withdrawal management (AOD).	H1 - 1 July 2022- 30 June 2023
	2.2.11	Establish an Assertive Mobile Youth Outreach Service (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	2.2.12	Establish new acute response teams focused on providing timely and assertive treatment and care for children and adolescents experiencing mental health crisis and suicidality, and their families – supporting new acute hospital beds for young people (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	2.2.16	Expanding Prison Mental Health Services in adult correctional settings (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	2.2.17	Establish new Eating Disorder Hub (MH).	H1 - 1 July 2022- 30 June 2023
	2.2.18	Specialist AOD responses in Emergency Department and hospital Setting (DABIT) (AOD).	H1 - 1 July 2022- 30 June 2023
	2.2.19	Support Community Resilience for Disaster Floods and Recovery (MH, SP, AOD).	H1 – 1 July 2022- 30 June 2023
	2.2.20	Strengthening delivery of withdrawal management, opioid dependence treatment and harm reduction in the hospital health system (AOD).	H3 - 1 July 2024 – 30 June 2025

FOCUS AREA 3
WORKFORCE AND SUPPORT

Right person in the right place

Overview

The mental health, suicide prevention and alcohol and other drug treatment workforce is crucial to delivery of effective support. There are a number of challenges currently affecting the workforce in our region, including:

- a lack of certain professions and clinicians
- difficulty recruiting and retaining a workforce with the required skills and capabilities
- providing appropriate training to staff
- addressing workforce stigma (the negative views or attitudes from people that staff may experience based on their work in mental health, suicide prevention and alcohol and other drug sectors)
- high levels of turnover, in some instances due to burnout.

While not unique to Darling Downs and West Moreton, these challenges are exacerbated by the regionality of some communities. Putting the 'right person in the right place' requires targeted action to attract, retain, train and support staff.

"There is a lack of psychologists and psychiatrists across the region.

On our funding level it is difficult to attract new staff from outside of our area. We cannot compete.

It is easy to burnout working in this space. The work is stressful, and its hard to keep staff motivated."

What we heard

Difficulty in recruiting and retaining staff in regional areas

Several individuals said that locum practitioners did not always meet their needs. For example, some locum GPs may be earlier in their careers and less experienced; and by their temporary nature do not have the opportunity to develop the meaningful relationships necessary to address mental health concerns. This means some areas may receive the services that are available, rather than the services that they need.

The MHSPAOD workforce faces stigma due to the nature of their work

Providers said that some members of their workforce face stigma for working in mental health, suicide prevention and alcohol and other drug treatment services. There are two main aspects to this stigma. First, some people stigmatise workers with the same stigma that exists for those individuals seeking MHSPAOD services. Second, workers in the MHSPAOD sectors often face additional cultural barriers to seek help for their own MHSPAOD-related concerns. This can limit the number of prospective people interested in a career in MHSPAOD support and can increase the likelihood of burnout.

Burnout is a common issue amongst the MHSPAOD workforce

Many service providers highlighted the drain on staff from working in a challenging environment which often results in burnout or skilled staff leaving the MHSPAOD sector. This problem indicates that staff may benefit from additional support during and outside of work.

Individuals indicated that peer workers and programs effectively provide support

Some people who access services have acknowledged the increasing availability and effectiveness of peer support programs.

Objectives	Actions	Horizon Timeframe
1. Determine what workforce is needed and achievable to provide in different areas The region has an understanding of the workforce required to meet the service needs of our communities. It also understands the actions required to build this workforce capacity and capability.	3.1.1 Develop local workforce plans that identify achievable local workforce models based on the needs and resourcing of specific areas within the region (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	3.1.2 Develop targeted local workforce training, recruitment and retention plans to address identified gaps and areas for development (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
2. Improve the recruitment, retention and wellbeing of the workforce Support the growth and wellbeing of the workforce to reduce the burnout and turnover of staff.	3.2.1 Promote existing and develop new communities of practice. Ensure access to effective clinical and practice supervision, peer support and professional development. This includes for the lived and living experience workforce (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	3.2.2 Identify, promote and tailor existing self-care and team care frameworks to support staff of mental health, suicide prevention, and alcohol and other drug service providers (MH, SP, AOD).	H5 - 1 July 2026 – 30 June 2027
	3.2.3 Identify opportunities to support organisations employing lived or living experience workforces to be clear on requirements and establish support mechanisms (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
	3.2.4 Culturally safe and capable MHAOD services by growing the Indigenous Workforce (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	3.2.5 Community Mental Health Treatment workforce growth (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	3.2.6 Community Treatment Infant Mental Health workforce growth (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	3.2.7 Community Treatment – Perinatal Mental workforce growth (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	3.2.8 Build Capable MHAOD services by growing the Peer and Lived Experience Workforce (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	3.2.9 Together in Mind Day Program workforce growth (MH, SP, AOD).	H3 - 1 July 2024 – 30 June 2025
3. Build a tailored curriculum for providers and increase training opportunities to better align the target workforce profile to needs across the region The workforce receives the training and support it requires to provide high quality, whole-of-person care to individuals.	3.3.1 Define priority content (e.g. stepped care approach) to include in workforce orientation or ongoing training on mental health, suicide prevention and alcohol and other drug use topics (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
	3.3.2 Provide information and support to improve GP confidence in alcohol and other drug early intervention, assessment and referrals (AOD).	H4 - 1 July 2025 – 30 June 2026
	3.3.3 Develop a consolidated view of mental health, suicide prevention and alcohol and other drug formal tertiary or VET education and training programs currently available in the region (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
	3.3.4 Continue to further develop and implement Project ECHO and similar programs to provide specialist support (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	3.3.5 Explore, develop and implement models that improve the access to specialist consultation services for GPs and psychologists (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026

FOCUS AREA 4
SERVICES THAT MEET THE NEEDS OF INDIVIDUALS, SPECIFIC POPULATIONS AND CONSIDER CHANGING NEEDS ACROSS THE LIFESPAN

A system that meets the needs of the people in our region

Overview

Our system is only strong when it meets the needs of all the people in the region. To do this we should improve the availability and access of services for:

- people living in outer regional and remote areas
- culturally and linguistically diverse populations
- LGBTIQA+ people
- Aboriginal and Torres Strait Islander peoples
- people across the lifespan
- those seeking psychosocial support.

These populations face unique problems that require tailored solutions. We should also increase the recognition of the links between physical health and mental health, suicide ideation and alcohol and other drug use.

"Services need to be more culturally capable.

We need to better service First Nations people and the refugee community.

There is a lack of consideration for how we improve physical health for people living with mental health."

What we heard

Services are not always accommodating for the needs of diverse groups

The needs of groups such as culturally and linguistically diverse populations, LGBTIQA+, and Aboriginal and Torres Strait Islander peoples are not always met by the services that exist.

Cultural safety of services has room to improve

Community members and providers both highlighted concerns about cultural safety, particularly for Aboriginal and Torres Strait Islander peoples, which acts as a significant barrier to the accessibility and effectiveness of services.

There are limited services for children and youth

We heard from some stakeholders that they experience a lack of services for youth. The tailored services that do exist are overwhelmed by demand.

Limited services exist for those who do not meet the NDIS requirements

Stakeholders indicated a gap in services available for those individuals who require ongoing psychosocial supports but who may not be eligible for NDIS funding. Some individuals commented on the value that psychosocial services provided to local communities. These services are especially important for supporting people currently accessing services on the lower intensity side of the stepped care spectrum, to limit progression to more severe concerns.

Objectives	Actions	Horizon Timeframe
1. Improve cultural safety, accessibility and quality of services for diverse groups Service providers have increased understanding of their local communities and diverse groups, including Aboriginal and Torres Strait Islander peoples, LGBTIQA+ people, culturally and linguistically diverse communities, outer regional and remote communities, people living with disabilities and those exiting the criminal justice system. All members of the community feel safe to access and receive culturally safe services.	4.1.1 Improve cultural competency of workforce to create culturally adaptive and sensitive services (MH, SP, AOD).	H1 - 1 July 2022- 30 June 2023
	4.1.2 Improve understanding of the culture, needs and context of local communities for providers and workers and embed in induction for services (MH, SP, AOD).	H5 - 1 July 2026 – 30 June 2027
	4.1.3 Improve awareness and responsiveness of services for LGBTIQA+ communities (MH, SP).	H3 - 1 July 2024 – 30 June 2025
	4.1.4 Develop or adopt and implement safety plan templates that reflect culturally appropriate language, informed by best practice (MH, SP, AOD).	H5 - 1 July 2026 – 30 June 2027
	4.1.5 Promote access to and effective use of available national interpreters for services (MH, SP, AOD).	H3 - 1 July 2024 – 30 June 2025
2. Improve availability of and access to quality services for Aboriginal and Torres Strait Islander peoples Service providers have improved cultural sensitivity. The Aboriginal and Torres Strait Islander workforce is expanded. Use of existing guidelines, standards and tools is increased.	4.2.1 Support the development of the Aboriginal and Torres Strait Islander workforce, including health practitioners and support workers (MH, SP, AOD).	H5 - 1 July 2026 – 30 June 2027
	4.2.2 Strengthen models of service that promote active partnership between ACCHOs and mainstream services (MH, SP, AOD).	H5 - 1 July 2026 – 30 June 2027
	4.2.3 Explore options to improve local access to social and emotional wellbeing programs (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
	4.2.4 Promote use of evidence informed national services, for example the Stay Strong app (MH, SP, AOD).	H5 - 1 July 2026 – 30 June 2027
3. Increase the availability of services tailored to the needs of people at different points across the lifespan People across their lifespan can access the specialised support they need.	4.3.1 Promote the use of screening tools to identify opportunities for early intervention to support perinatal mental health (MH, SP, AOD).	H5 - 1 July 2026 – 30 June 2027
	4.3.2 Increase perinatal and early childhood service capability and availability (MH).	H4 - 1 July 2025 – 30 June 2026
	4.3.3 Develop opportunities to further support the mental health of children and young people involved in the justice system with or at risk of development of mental health conditions (MH, SP, AOD).	H5 - 1 July 2026 – 30 June 2027
4. Improve availability of and access to private and public psychosocial support services Access to psychosocial support services in the region increases for people who require this support.	4.4.1 Develop and implement care models to improve access to psychosocial support services for those who do not meet NDIS requirements (MH, SP, AOD).	H4 - 1 July 2025 – 30 June 2026
	4.4.2 Trial and evaluate referral and discharge mechanisms with providers of psychosocial support services (MH, SP, AOD).	H3 - 1 July 2024 – 30 June 2025
5. Improve physical health in conjunction with mental health, suicide prevention and alcohol and other drug support and services Links between physical health, mental health and alcohol and other drug use are understood. Providers and individuals work to improve the physical health of communities.	4.5.1 Promote the use of good practice around physical health as outlined in the Equally Well National Consensus, including regular reviews of medications and regular physical health care checks (MH, SP, AOD).	H3 - 1 July 2024 – 30 June 2025
	4.5.2 Encourage providers to discuss healthy lifestyles with young people living with mental illness and those experiencing their first episode of psychosis (MH, SP, AOD).	H3 - 1 July 2024 – 30 June 2025
	4.5.3 Increase provider awareness of a harm reduction approach to alcohol and other drug use (including protecting physical health) to providers (AOD).	H4 - 1 July 2025 – 30 June 2026

7.
Implementing the Plan and measuring our success

Implementation approach and timeframes

The Plan is designed to translate desired actions and outcomes into tangible projects. This project-based approach reflects the learnings of the Foundational Plan. It provides project teams with flexibility and more clearly defined success measures.

The Plan will be delivered in a staged approach through 'horizons' and smaller groups or sub-sets of projects to ensure manageability of the program of work and to acknowledge the many competing priorities of partner organisations and stakeholders.

TIME

Horizon 1

The first horizon includes priority projects.
Years 1 and 2 - 1 July 2022- 30 June 2023

Horizon 2

The second horizon includes projects for delivery in the medium-term.
Years 2 and 3 - 1 July 2023 – 30 June 2024

Horizon 3

The third horizon includes projects that require greater planning and/or resourcing.
Years 3 and 4 - 1 July 2024 – 30 June 2025

Horizon 4

Years 4 and 5 - 1 July 2025 – 30 June 2026

Horizon 5

Years 5 and 6 - 1 July 2026 – 30 June 2027

Approach to measuring outcomes and reviewing performance

Performance measurement enables us to measure and monitor progress towards the delivery of the Plan, understand the extent to which our efforts are contributing towards intended outcomes, and identify opportunities for continuous improvement.

Performance of the Plan will be measured at three levels: the effects of individual projects, the impact of the overall Plan (referred to as a 'program' of work), and contextual factors at a population level.

Given the complexity of the mental health, suicide prevention and alcohol and other drug sectors and services there are likely to be challenges of attribution related to:

- determination of the real impact of the Plan
- sensitivity to change, given many measures are longer term are unlikely to change in the timeframe of the Plan
- data availability, given the update frequency of certain data sets.

A program logic links the Plan's activities to outcomes. Program logics are applied by many public and private sector organisations to evaluate programs and policies. Program logics enable us to think deliberately about how we can influence the change we seek. They help to draw linkages between inputs, activities, outputs, outcomes and the goals of the Plan. An explanation of the elements of a program logic and how they relate to the Plan, and the performance measurement approach, are outlined in the Program logic for the Plan, right.

Program logic for the Plan

Regional mental health logic model – journey across the client care continuum						
System level 1	**Social determinants**	**Health promotion and prevention**		**Primary healthcare**		**Specialist acute care**
System level 2	**Education, employment, income Family and community, rural and remote, First Nations**	**Well**	**At risk**	**Mild**	**Moderate**	**Severe**
Needs	**Systematic social and economic disadvantage can:** • Increase the risk of mental health concerns, problematic substance abuse and suicide / suicidal ideation • Reduce access to appropriate care	• Significant mental health stigma (self and external) • Social exclusion and poor support networks • Difficultly navigating system with few choices of services		• High levels of psychological distress, substance dependence, suicidal ideation • Challenges accessing culturally safe, timely, high-quality services in primary care and in the community		• High levels of acute mental health and alcohol & other drugs admissions • High incidence of suicide
Responses	**Whole of government approaches**					
	Commonwealth Department of Health and Ageing					
	Queensland Health					**Queensland Health**
			General practice			
				Pharmacists, allied health		
				Psychiatrists and psychologists		
		DDWM PHN				
		Head to Health				
					TPT	
					Youth Enhanced Services	
						DD HHS and WM HHS
						Emergency departments
						Acute inpatient services
Experiences	• Clients are linked to appropriate social services	• Client are supported navigating the system with greater choices of services		• Clients able to access culturally safe, timely, high-quality care in primary care and in the community		
Outcomes	• Reduced impact of social and economic disadvantage on the risk of mental health concerns, problematic substance abuse and suicide / suicidal ideation	• Reduced mental health stigma (self and external) • Increased social inclusion and Improved support networks		• Reduced levels of psychological distress, substance dependence, suicidal ideation		• Decreased acute mental health and alcohol other drugs admissions • Reduced incidence of suicide
Potential indicators	**Need and outcome:** • Social and economic lead indicators, e.g.: • Financial and non-financial barriers to care **Prevalence of:** • Mood, anxiety, personality, psychotic, eating and trauma-related, substance abuse disorders **Prevalence of:** • Suicide or self-harm	**Need and outcome:** • Alcohol consumption • Illicit drug use • Tobacco smoking • Severity **Response:** • Service navigation **Experience:** • Consumer experience		**Need and outcome:** • Psychological distress • Problematic substance abuse **Experience:** • Consumer experience		**Need and outcome:** • Non-urgent — presentations for mental and behavioural disorders • Incidence of suicide

The performance measurement of the Plan is based on the approaches and frameworks used by the core organisations involved in the Plan, including DDH, WMH and Darling Downs and West Moreton PHN.

These are summarised below.

PHN

The PHN's approach is outlined in the PHN Program Performance and Quality Framework. The key outcome themes in this framework are:

- addressing needs
- quality care
- improving access
- coordinated care
- capable organisations.

This framework is closely connected to the Quadruple Aim which monitors the PHN's progress towards achieving optimal health system performance.

The goal of the Quadruple Aim is to enhance patient experience, improve population health, reduce costs, and improve the work life of health care providers.

HHS

The HHS approach is outlined in the Queensland Health Performance and Accountability Framework. The key performance domains in this framework are:

- safe
- effective
- patient-centred
- timely
- efficient
- equitable.

The overall performance measurement of the Plan links with the approaches and frameworks used by the partner organisations involved in the Plan. It addresses eight categories which are aligned to the focus areas and objectives of the Plan:

1. integration
2. service awareness
3. service access
4. service availability
5. workforce experience
6. consumer experience
7. service quality
8. population health outcomes.

The plan website will provide horizon updates as part of the review cycle.

Program-level and population-level performance measures

Cateogory	KPI
Program level	
1. Integration	Proportion of services that are co-commissioned across commissioning agencies*
2. Service awareness	Volume of contacts and referrals through navigation services in the region
3. Service access	Waiting times to access key services for each of mental health, suicide prevention and alcohol and other drug
4. Service ability	Number of mental health, suicide prevention, and alcohol and other drug professionals providing services in specific locations (e.g. outer regional and remote; areas identified as having particular needs)
5. Service quality	Number of lived-experience workers in mental health, suicide prevention, and alcohol and other drug workforces*
6. Workforce experience	Turnover rate of mental health, suicide prevention, and alcohol and other drug workforces*
7. Consumer experience	Number of PHN and Queensland Health funded services with reported completion rates of cultural safety training
Population level	
8. Population health outcomes	Prevalence of mental health conditions Rate of suicide Change in mental health consumers clinical outcomes Rate of drug use in people with mental illness Physical health of people with mental illness Rate of problematic alcohol and other drug use; and/or rate of alcohol and other drug use Readmission to hospital within 28 days of discharge after being discharged for MH, SP or AOD Proportion of mental health consumers in suitable housing* Consumer experience of mental health, suicide prevention, and alcohol and other drug services*

*Indicator and/or information source to be developed as a part of Plan implementation

8.
Acronyms and Glossary

Aboriginal Medical Services (AMS) / Aboriginal Community Controlled Health Organisations (ACCHOs): primary health care services that deliver holistic, comprehensive and culturally appropriate health service to the Aboriginal and Torres Strait Islander community.

ABS: Australian Bureau of Statistics

ACCHS: Aboriginal Community Controlled Health Service

ADIS: Alcohol and Drug Information Service

AHPRA: Australian Health Practitioner Regulation Agency

AIHW: Australian Institute of Health and Welfare

AOD: Alcohol and Other Drug

Carer / support: a person who cares for or otherwise supports a person living with mental illness and/or alcohol and other drug use. A carer has a close relationship with the person they support and may be a family member, friend, neighbour, support worker or member of a broader community.

Consumer / client / individual / person / community member: a person who accesses, has accessed mental health, suicide prevention and/or alcohol and other drug treatment services and support.

ED: Emergency Department

FTE: Full Time Equivalent

General practitioner (GP): a doctor based in the community who primarily treats patients with minor or chronic illnesses and refers individuals to secondary and tertiary care.

HCQ: Health Consumers Queensland

Heteronormativity: the assumption that heterosexuality is the normal mode of sexual orientation and other forms of sexual expression and relationships are 'abnormal'. This view impacts the structures of institutions of society, including things like marriage, and produces a set of ideas that favour a specific view on sexual orientation.

HNA: Health Needs Assessment

Hospital and Health Service (HHS): independent statutory bodies, funded by the Queensland Department of Health. There are 16 HHSs in Queensland. Particularly relevant to this plan are the Hospital and Health Services in Darling Downs and West Moreton: Darling Downs Health and West Moreton Health. HHSs provide public health services, including mental health, suicide prevention and alcohol and other drug services, for individuals with severe and complex conditions.

HWQ: Health Workforce Queensland

Indicator / measure / KPI: a quantitative measure that is used to assess the extent to which a given objective has been achieved.

LGA: Local Government Area

LGBTIQA+: lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual

Living and/or lived experience: people who have lived or living experience of suicide, mental health concerns and/or alcohol and other drug use.

Locum practitioner: a physician who works in place of a regular physician when they are absent or when filling a gap in the workforce.

MBS: Medicare Benefits Scheme

Mental health: the World Health Organization defines mental health as a state of wellbeing in which every person realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.

Mental illness: a clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders, and schizophrenia.

MH: Mental Health

MHSPAOD: Mental Health Suicide Prevention, Alcohol and Other Drug

National Disability Insurance Scheme (NDIS): provides eligible participants with a permanent and significant disability with the reasonable and necessary supports they need. The NDIS also connect people with a disability and their carers, including people who are not NDIS participants and their carers, to supports in their community. The National Disability Insurance Agency (NDIA) is an independent statutory agency that implements the NDIS.

NDIA: National Disability Insurance Agency

NMHSPF: National Mental Health Service Planning Framework

Non-Government Organisation (NGO): a not-for-profit, non-government organisation. NGOs range from single-focus, locally based organisations to large national and international organisations working across a range of areas including but not limited to mental health.

PBS: Pharmaceutical Benefits Scheme

Peer worker: workers with lived experience who provide valuable contributions by sharing their experience of illness and recovery. Peer workers are employed across a range of service settings and perform a variety of roles, including providing individual support, delivering education programs, providing support for housing and employment, coaching, and running groups and activities.

Primary care: the first point of contact for people living with mental health conditions or mental illness and their carers. Primary care providers include general practitioners, nurses, allied health professionals, pharmacists, and Aboriginal and Torres Strait Islander health workers.

Primary Health Networks (PHNs): independent primary health care organisations largely funded by the Australian Government in many locations around the country. The role of PHNs is to commission health care services, rather than provide the services. The Darling Downs and West Moreton PHN (the PHN) operates in Darling Downs and West Moreton.

Psychological therapies: a group of therapies provided by psychologists, counsellors, and psychiatrists. It involves exploring thoughts and feelings in an effort to increase understanding and address negative behaviours. It is used to treat a number of conditions (e.g. depression, anxiety, bipolar disorder).

Primary Mental Health Care Minimum Data Set (PMHC-MDS): provides the basis for PHNs and the Department of Health to monitor and report on the quantity and quality of service delivery, and to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Government.

Psychosocial disability: the disability experience of people with impairments and participation restrictions related to mental illness. These impairments and restrictions can include reduced ability to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives.

Psychosocial support: psychosocial support services offer both one-on-one and group support activities to help people with severe mental illness. These services can support people to improve their skills in dealing with their mental health, help them with daily living tasks, improve their social skills, and to access housing and education.

QAIHC: Queensland Aboriginal and Islander Health Council

QAMH: Queensland Alliance for Mental Health

QLD: Queensland

QMHC: Queensland Mental Health Commission

QNADA: Queensland Network of Alcohol and Other Drug Agencies

RACF: Residential Aged Care Facility

Secondary care: care provided by medical specialists. Secondary care providers can include psychiatrists and psychologists.

Service provider: a person, business or organisation who delivers services (in this context, these are services primarily in mental health, suicide prevention and/or alcohol and other drug).

Social and Emotional Wellbeing (SEWB): Refers to the Aboriginal and Torres Strait Islander view of health. This view is holistic and includes mental health and other factors such as the social, spiritual, and cultural wellbeing of people and the broader community.

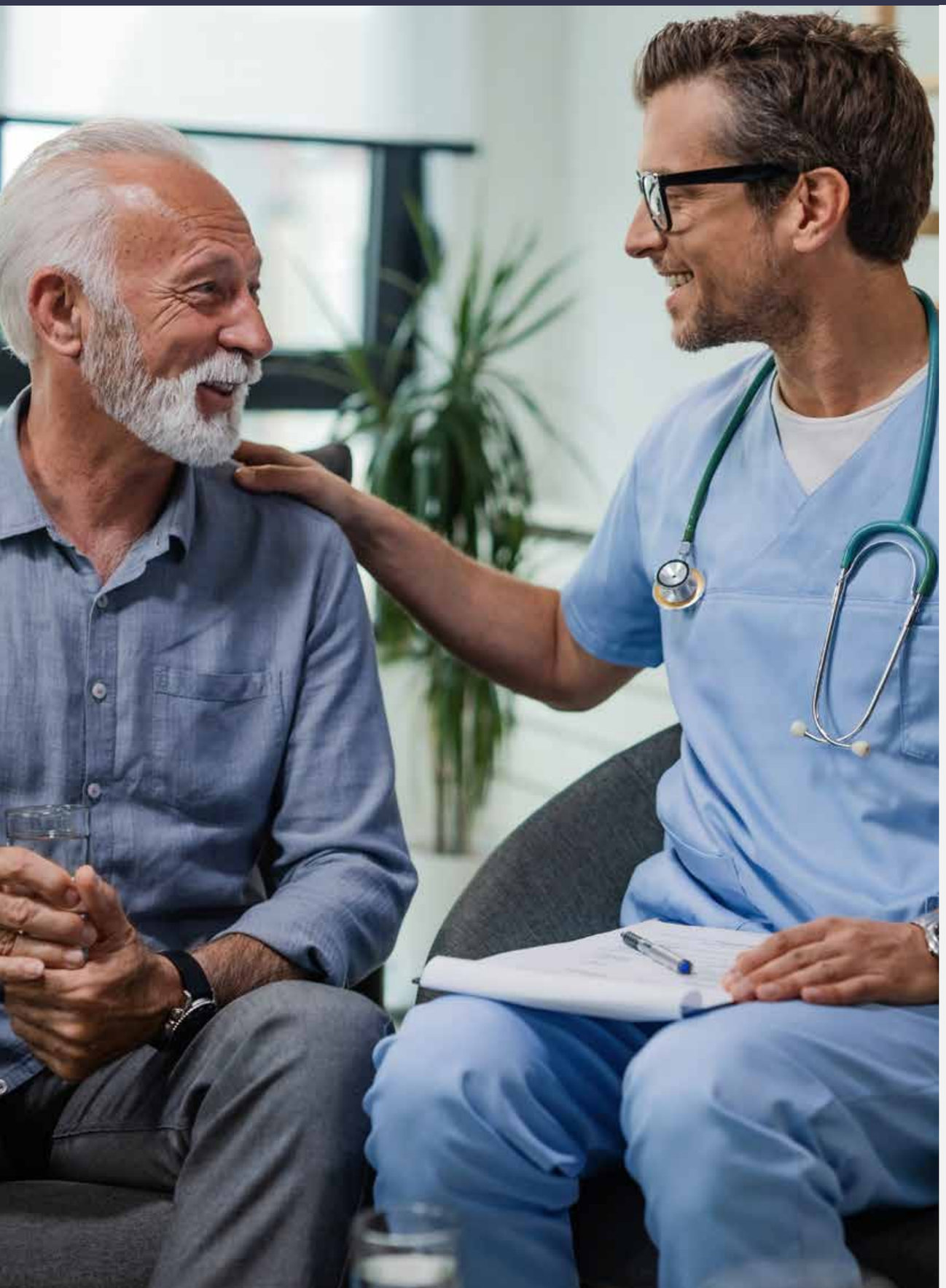
SP: Suicide Prevention

Stepped care: an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to an individual's needs. A Stepped care approach promotes person-centred care which targets the needs of the individual.

Tertiary care: specialised medical care that typically involves complex treatments, often in hospital settings.

TPT: Targeted Psychological Therapies

WHO: World Health Organisation



9.
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