PLANNING FOR WELLBEING

A Regional Plan for North Brisbane and Moreton Bay focusing on mental health, suicide prevention and alcohol and other drug treatment services

Revised 2020–2025

Sponsored by

Brisbane North PHN and **Metro North Hospital and Health Service**

Development of this Plan has been sponsored through a partnership between Brisbane North PHN and Metro North Health. This activity has been supported by funding from the Australian Government under the PHN Program.

We thank the following people and organisations for their contributions to this Plan:

- The many people and organisations in Brisbane North who offered their valuable time and expertise by participating in consultation through meetings, workshops, steering committees and surveys. Without you we would not have been able to prepare this Plan.
- People with a Lived/Living Experience, and those who care for them, who contributed their valuable insights and perspectives through consultation.
- The Peer Participation in Mental Health Services (PPIMS) Network and delegates who led and conducted specific consultations with Consumers/ Carers and People with a Lived/Living Experience.
- Staff from Brisbane North PHN and Metro North Health who worked on the Plan.
- The Institute of Urban Indigenous Health who conducted much of the consultation on Aboriginal and Torres Strait Islander healthcare needs for the Plan and Anton Clifford-Motopi who prepared the background paper presenting research and consultation on Aboriginal and Torres Strait Islander social and emotional health and well-being.
- Karen Wing from KW Consulting Group who prepared the Plan in conjunction with staff from Brisbane North PHN.

Forward

Dr. Kathryn Turner

Libby Dunstan

The *Fifth National Mental Health and Suicide Prevention Plan* was endorsed by the Australian Government and by State and Territory health ministers in August 2017 and, together with the National Drug Strategy 2017-2026, establishes the context for work on regional plans by Primary Health Networks and Hospital and Health Services.[i]

This revised regional plan, *Planning for Wellbeing* (the Plan), continues our focus on the critical healthcare areas of mental health, suicide prevention and alcohol and other drug treatment services. It presents our organisations with the opportunity, not only to lead work on ensuring those needing healthcare can access the right services at the right time in the right place, but to engage stakeholders across Brisbane North in identifying shared objectives for the future. The commitment shown by stakeholders to the development of this Plan has been demonstrated by the sheer quantum of participants, with over 90 consultation events engaging attendees from across Brisbane North.

The PHN and Metro North Health sponsored development of this revised Plan and developed it in partnership with other healthcare providers and practitioners, People with a Lived/Living Experience, Families (including loved ones) and Carers. As before, the next five years of this Plan establishes future directions for the region as a whole, not just for our two sponsoring organisations, and has been endorsed by the Strategic Coordination Group, tasked with overarching governance of the Plan.[a]

The ground swell of feedback from the many and diverse stakeholders who engaged with us on developing the Plan, paints a clear picture of a complex service system and the need for service Consumers, Families and Carers, government and non-government healthcare providers and our own organisations to lead and implement the changes proposed in this Plan.

Two overarching messages emerged clearly from consultation. Firstly, that people in Brisbane North who access healthcare services, need us as healthcare leaders and providers to work together to ensure services are connected and well-integrated. Secondly, stakeholders emphasised that those seeking support to improve their mental health, to prevent suicide or to address problematic use of alcohol and other drugs, experience a myriad of challenges, not all of which are related to mental health or alcohol and other drug use, but which are essential to improving their wellbeing. This presents a broader challenge for those working in healthcare, not only to work together, but to support people to access options that mean better physical health, care for children and families, housing, training and employment.

We take this opportunity to thank those who have contributed to this Plan, either by making their valuable perspectives and insights available to us through consultation, or as part of the team working on the Plan.

It is with great pleasure that we present to you our update to *Planning for Wellbeing*. We look forward to continuing to work with you to realise future directions in mental health, suicide prevention and alcohol and other drug treatment services.

Libby Dunstan
Chief Executive Officer Brisbane North PHN

Dr Kathryn Turner
A/Executive Director
Metro North Mental Health
Metro North Hospital and Health Service

a. See chapter 13 for more information on the Strategic Coordination Group

Contents

List of abbreviations and acronyms

Aboriginal Community Controlled Health Services	ACCHSs
Australian Drug and Alcohol Services Planning Model	DASP model
Borderline personality disorder	BPD
Brisbane North Primary Health Network	the PHN
Consumers and Carers	C&C
Emergency Departments	EDs
Full-time equivalent	FTE
Health needs assessment	HNA
Lesbian, gay, bisexual, transgender, intersex, and/or questioning people	LGBTIQ+ people
Medicare Benefits Schedule	MBS
Metro North Hospital and Health Service	Metro North Health
National Disability Insurance Scheme	the NDIS
National Mental Health Service Planning Framework	NMHSPF
Non-government organisations	NGOs
Peer Participation in Mental Health Services Network	PPIMS Network
People with a Lived/Living Experience	PLE
Pharmaceutical Benefits Scheme	PBS
Primary Health Networks	PHNs
Queensland Alcohol and Other Drug Treatment Service Delivery Framework	QAODTSDF
World Health Organisation	WHO

Executive summary

National and Queensland context

Over recent years, significant reforms have occurred in delivery of mental health, suicide prevention and alcohol and other drug treatment programs and services both nationally and in Queensland (Appendix One). Since 2012, a National Mental Health Commission has been established and tasked with driving national change.[2] At the same time, design and roll out of the National Disability Insurance Scheme (NDIS) has been occurring, bringing fundamental change to how many Australians with a disability, including some people with an ongoing psycho-social disability, will access support.[3] In 2017, the *National Drug Strategy* was released, outlining a national framework identifying priorities relating to alcohol, tobacco and other drugs.[4]

In August 2017, *The Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan)* was endorsed by the Australian Government and by State and Territory health ministers establishing new national directions for responding to mental health and preventing suicide.[5] This Plan has been established within the context of the Fifth Plan and the National Drug Strategy. It reflects the responsibility the Australian Government has tasked PHNs, including Brisbane North PHN, with – integrating healthcare and focusing on priority areas including mental health, suicide prevention and alcohol and other drug treatment services.

In addition, Metro North Health is committed, through the Queensland Government's commitment to the Fifth Plan, to the production of this Plan. As Australia's largest health service, Metro North Health works to lead development of responsive, accessible, innovative health services[6] inclusive of the areas this Plan covers – mental health, suicide prevention and treatment services responding to the harmful effects of alcohol and other drug use.

This Plan also commits to active engagement and involvement by Consumers, Families, Carers and People with a Lived/Living Experience in development and implementation. Embedding Consumer and Carer engagement in the commissioning cycle has been set out in guidelines developed by the department of Health in 2016. In 2019 the National Mental Health Commission funded and produced 'Practical Guidelines for Consumer and Carer Engagement'[7] which provides a clear framework and a set of principles of best practice in relation to Consumer and Carer engagement and participation.

This Plan is also shaped by substantial reform to delivery of mental health, suicide prevention and alcohol and other drug treatment services in Queensland. In 2013, the Queensland Mental Health Commission was established to drive ongoing reform[vii] and its work has pointed to the need for substantial changes in delivery of mental health, suicide prevention and alcohol and other drug treatment services.[8]

This Plan is also established within the context of Queensland Health's Connecting care to recovery 2016–2021, a plan for Queensland Government funded mental health, alcohol and other drug services[9], which has been established within the common purpose and investment strategy outlined in Queensland Health's My health, Queensland's future: Advancing health 2026.[10]

Connecting care to recovery brought with it a substantial increase to the Queensland Government's investment in mental health and alcohol and other drug treatment services of an additional $350 million over five years.[11]

The Productivity Commission conducted a review into mental health services in 2020.[12] The findings from this review and the government's response will be incorporated into the next review and update of *Planning for Wellbeing*.

Scope

The Plan operates within the broader context of healthcare and includes three discrete and complementary areas of work: mental health; suicide prevention; and alcohol and other drug treatment services. At times, there is overlap between these areas and at other times, the three areas are quite discrete. We incorporate all three areas in this Plan to better align our planning approach with that of both Queensland Health and the Queensland Mental Health Commission.

This rolling five-year Plan, *Planning for Wellbeing*, identifies significant opportunities for service and system improvement, including service improvements by existing services and enhancements to commissioning approaches by commissioning agencies. These objectives and actions are clearly within the Plan's scope. Other actions outlined in the Plan encourage broader take up of new approaches across the region, for example in general practice, and in these areas, we will focus on informing, educating and working in partnership to progress these actions. The Plan outlines opportunities and priorities for expanding, diversifying and extending service delivery when funding is available. Chapter 15 presents an overview of the current resourcing of services in the region. We commit to the development of a comprehensive regional plan that will consider new and extended services proposed in the Plan, in conjunction with data from planning tools that project future demand.

The catchment area for both Metro North Health and the PHN forms the region to which this Plan relates. It incorporates Brisbane City Council suburbs north of the Brisbane River; all of the Moreton Bay Regional Council's catchment area; and parts of the Somerset Regional Council's catchment area around Kilcoy.

How we developed this Plan

The PHN and Metro North Health have sponsored development of this Plan and have developed it in partnership with other healthcare providers and practitioners, People with a Lived/Living Experience, Families and Carers. This Plan establishes future directions for the region as a whole, not just for our two sponsoring organisations. Rather than being a Plan that will be the sole responsibility of sponsoring organisations, the Plan reflects instead both the results of broad-based consultation and stakeholders' proposed commitment to shared objectives and to actions to be undertaken over the next five years. Over 90 consultation events involving many attendees from across Brisbane North informed the plans initial development, with over 50 per cent of attendees estimated as People with a Lived/Living Experience or those who care for them (Appendix three). In 2020 stakeholders were invited to refresh objectives and actions in the Plan, taking account of recent developments and progress in implementation. These refreshed actions and objectives have been incorporated into this iteration of *Planning for Wellbeing*.

Our Plan

In **Part A** of the Plan we describe the future we want to create through a vision statement and outcomes we will strive towards. We outline principles that have underpinned development of the Plan, and which will shape its implementation, and the frameworks that will be fundamental to all we do: stepped care for mental health services; *LifeSpan* for suicide prevention services; and the Queensland Alcohol and Other Drug Treatment Service Delivery Framework for alcohol and other drug treatment services.

In **Part B** of the Plan we establish our overarching commitment to change in six broad healthcare areas and, for each area, we outline shared objectives and actions developed by funders, service providers, People with a Lived/Living Experience, Families and Carers working together. In the table below, we provide examples of consultation feedback and summarise our shared objectives for each of these areas. Further detail is provided in chapters one to six. The initial (pre-refresh) consultation feedback has been attached as Appendix Two.

Healthcare area	Consultation feedback	Shared objectives
People with a Lived /Living Experience leading change	• 'nothing about us, without us' • strengthen the collective voice of People with a Lived/Living Experience • make it easier for People with a Lived/Living Experience to be active partners in planning, co-designing, delivering and evaluating services • make services accountable to People with a Lived/Living Experience • must support each other and be informed • need stronger participation and collaboration mechanisms • strengthen participation by People with a Lived/Living Experience in the workforce, both in peer work and in broader roles	• strengthen and diversify the collective voice of People with a Lived/Living Experience to drive service improvements • make available training and capacity building for People with a Lived/Living Experience and the mental health service system to work collaboratively and in partnership • establish more authentic opportunities for People with a Lived/Living Experience to participate in planning, delivery and evaluation of mental health, suicide prevention and alcohol and other drug treatment services • establish and sustain a consistent region-wide approach to participation by People with a Lived/Living Experience in mental health, suicide prevention and alcohol and other drug treatment services • advocate for an expanded and more diverse regional Lived/Living Experience workforce, across all levels of the system
Supporting Families and Carers	• Carers and family members are not included, supported and welcomed by service providers • communication between service providers, Families and Carers is lacking • financial hardship experienced as a result of caring role • Carers are not clear on benefits those they care for are entitled to	• provide information, resources and skills building to support Families and Carers • better care for Families and Carers • Families and Carers are listened to and involved in services • providers of mental health services are trained to be more responsive to the needs of Carers and Families • services are more responsive to the needs of people and Carers

Healthcare area	Consultation feedback	Shared objectives
Sustaining good mental health	• building people's resilience is critical • insufficient investment in mental health promotion and prevention activities and no one driver • prevention is important, but services are not funded to do it	• build the resilience of individuals, Families and communities • prevent stigma • make better use of existing resources to promote mental health and prevent mental illness • improve the physical health of people with a mental illness • support Families and Carers more effectively
Commissioning services	• commissioning approaches vary between funding bodies • need better funding outcomes and stronger Consumer outcomes • move to integrated delivery, reporting and evaluation	• align commissioning approaches between funding bodies • improve commissioning approaches
Delivering integrated services	• new and different services are needed • new thinking must support our stepped care framework • better alignment between services is needed • need to support our workforce to deliver great services, including our peer workforce	• expand, diversify and better target services • improve our service delivery • align and integrate services • skill up and diversify our workforce

Healthcare area	Consultation feedback	Shared objectives
Responding to diversity	• respect people from different backgrounds and respond to their specific needs • improve access by all to services • deliver high quality services to people from different backgrounds • address stigma and discrimination	**People from culturally and linguistically diverse backgrounds** • improve access to services for people from culturally and linguistically diverse backgrounds • facilitate better connections to healthcare for new arrivals and migrants • address affordability issues for those ineligible for healthcare through Medicare • improve the physical health of people from culturally and linguistically diverse backgrounds experiencing poor mental health
		LGBTIQ+ People • improve system functioning so that mental health, suicide prevention and alcohol and other drug services respond effectively to the needs of LGBTIQ+ people • build capacity of LGBTIQ+ community-led organisations, services and peer-based supports to provide sustainable quality mental health, suicide prevention and alcohol and other drug services and support for LGBTIQ+ people • tailor specific suicide prevention efforts for LGBTIQ+ people and communities, with a key focus on sub-populations who have higher risks, including transgender, intersex, HIV, Aboriginal and Torres Strait Islander communities
		Older People • expand and diversify mental health services for older people • deliver high quality mental health and suicide prevention services for older people • support those caring for older people to sustain good mental health • develop early intervention and prevention strategies focused on the social determinants of health

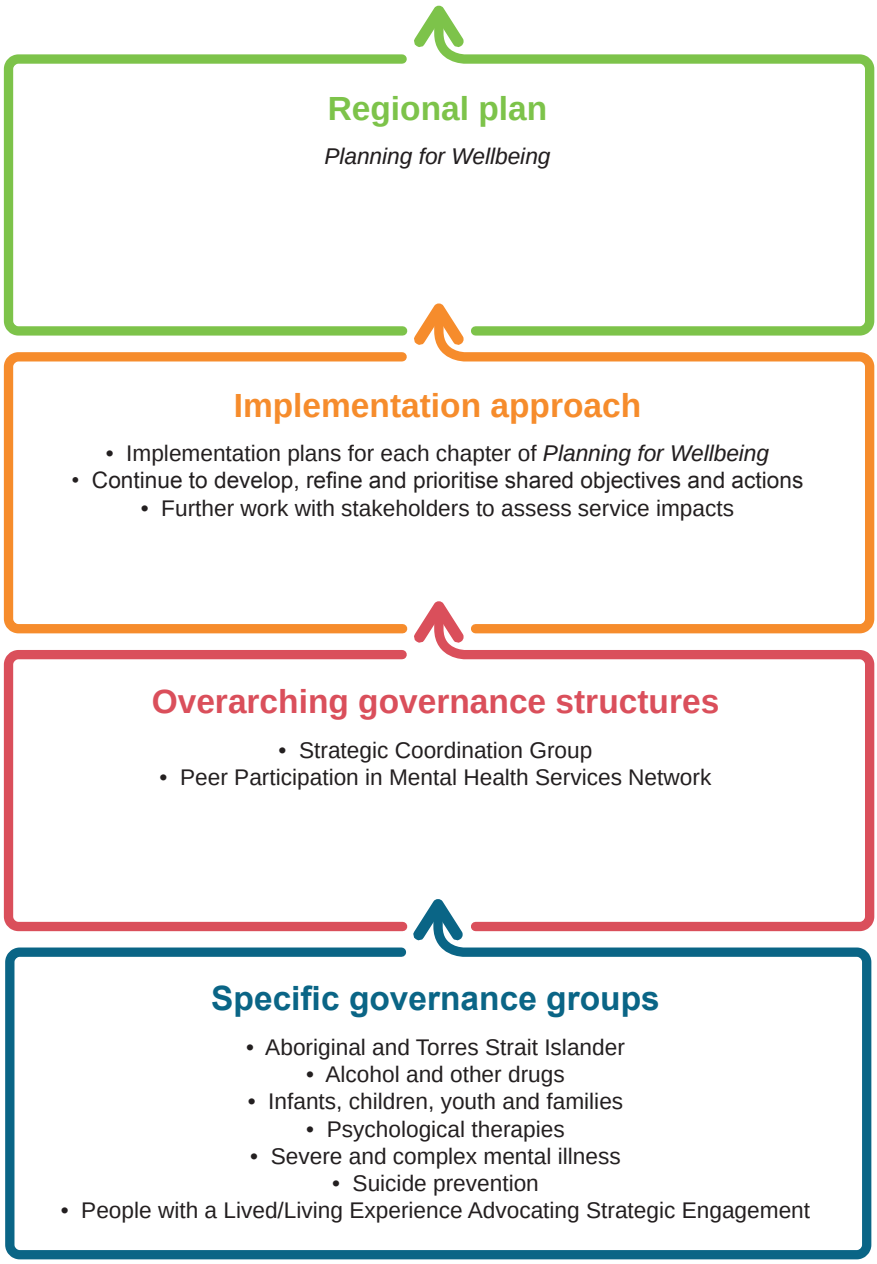
In **Part C** of the Plan, we outline our commitment to change in six focus areas, relating either to specific population groups or particular types of service delivery and, for each area, we outline shared objectives and actions developed by funders, service providers, People with a Lived/Living Experience, Families and Carers working together. In the table below, we provide examples of consultation feedback and summarise our shared objectives for each of these areas. Further detail is provided in chapters seven to twelve.

Focus area	Consultation feedback	Shared objectives
Aboriginal and Torres Strait Islander (Indigenous) social and emotional wellbeing	• good mental health for Aboriginal and Torres Strait Islander peoples is about a 'whole of life view' considering relationships, kin and community • holistic care led by Aboriginal and Torres Strait Islander peoples is critical • reconciliation and addressing the negative impact of racism improves mental health • Aboriginal and Torres Strait Islander peoples experience access barriers and service gaps	• foster Aboriginal and Torres Strait Island leadership and engagement in planning, delivery and evaluation of services • increase cultural responsiveness • improve access to mental health services • strengthen integration between services • proactively support reconciliation • recognise that racism impacts on healthcare • respond to service gaps • invest in an evidence base for services
Alcohol and other drug treatment services	• greater collaboration between alcohol and other drug treatment services is needed • people using alcohol and other drugs experience stigma that prevents them from accessing services • workers are addressing complex service Consumer needs • increased number of mental health diagnoses, alongside problematic use of alcohol and other drugs	• improve collaboration between alcohol and other drug treatment services • challenge stigmatising and discriminatory practices • skill up our workforce • support effective alcohol and other drug service delivery responses • improve services for at risk groups

Focus area	Consultation feedback	Shared objectives
Infants, Children, Young People and Families	• some children and young people do not receive supports, or receive inappropriate support because they fall between mild/ moderate and severe/complex eligibility criteria • community based organisations have a culture of risk aversion and do not feel resourced and supported to take responsibility for holding risk • the system and services are not oriented to support the development and maintenance of enduring relationships • when a child or young person is receiving a service not designed for their needs, they exit without positive outcomes and re-enter the system again at a crisis point or avoid engaging despite a continued need • a fragmented and siloed system creates inefficiencies, disruptive transitions for Consumers, and is difficult to navigate for Consumers and service providers alike • children and young peoples' needs are nested in the needs of a complex family. However, services are generally built to support one person, not the needs of a complex family • children and young people trust adults and the system to take them to the right place and right support. The system is failing to meet these expectations.	• improve system functioning so that all Infants, Children, Young People and their Families in the Brisbane North PHN region are serviced across the stepped care continuum and don't 'fall through the gaps' • establish a supportive and effective system that responds to suicide risk amongst children and young people in the community • improve relationships across the service system, between services and with children, young people and their families • work in partnership with children, young people and families to create services that are responsive to their individual needs • improve system functioning so that children, young people and their families can more easily access the right support when they need it • continue to develop the perinatal and infant mental health continuum of care in collaboration with Consumers and stakeholders • intervene early to reduce duration and severity of mental health difficulties
Psychological therapies	• little is known about Consumer preferences • more effective responses are needed for people in disadvantaged circumstances • limited information on outcomes is available • greater service integration is needed • geographic access to services is inequitable • need to destigmatise access to psychological therapies	• better align services with Consumer preferences and needs and with our stepped care framework • improve integration with other services • develop, diversify and geographically redistribute the psychological therapies workforce • increase services in high need areas • improve evidence base and the use of evidence informed approaches • advocate for broader system supports that improve psychological therapy uptake and delivery

Focus area	Consultation feedback	Shared objectives
Severe and complex mental illness	• greater integration of responses to physical health needs is required • transition to the NDIS impacting on service Consumers and service providers • people often have difficulty in obtaining and sustaining safe, secure and affordable housing • people are experiencing social and economic isolation • better services needed for people experiencing borderline personality disorder	• improve the physical health of people experiencing severe and complex mental illness • assist people to access and sustain safe, secure and affordable housing • support successful transition to the NDIS • foster community connections by people experiencing severe and complex mental illness • establish alternatives to hospital Emergency Departments (EDs) • improve the experience of people transitioning between hospital and community • improve services for people experiencing borderline personality disorder
Suicide prevention	• no clear pathways to care for people experiencing a suicidal crisis or who have been bereaved by suicide • changes are needed to ED responses for people who have attempted suicide • inadequate follow up care after suicide attempts • better suicide prevention services are needed	• improve and integrate suicide prevention responses • improve care and follow up at EDs and after hospital discharge • establish new suicide prevention models • increase accessibility of care after a suicide attempt for vulnerable population groups • increase community knowledge about suicide prevention • better equip GPs and other professionals to identify and support people at risk of suicide • advocate for delivery of school-based suicide prevention programs for young people

In **Part D** of the Plan, we outline our commitment to robust governance and performance measurement. We do this by outlining our governance approach, how we will monitor progress against the Plan, our approach to measuring individual and service system outcomes and our commitment to refreshing and reviewing the Plan. Our implementation and governance arrangements are summarised in the diagram below. In this section we also outline the current resourcing of services in the region, identify gaps and present priorities for future investment.



Introduction

National and Queensland context

Over recent years, significant reforms have occurred in delivery of mental health, suicide prevention and alcohol and other drug treatment programs and services both nationally and in Queensland. Since 2012, a National Mental Health Commission has been established and tasked with driving national change and has undertaken a far-reaching review of mental health programs and services, proposing substantial reforms to delivery of these services and programs, as well as changes to the roles of key stakeholders.[13] At the same time, design and roll out of the NDIS has been occurring, bringing with it fundamental change to how many Australians with a disability, including some people with an ongoing psycho-social disability, will access support.[14] In 2017, the *National Drug Strategy* was released, outlining a national framework identifying priorities relating to alcohol, tobacco and other drugs and a national commitment to harm minimisation.[15]

More recently, in August 2017, *The Fifth National Mental Health and Suicide Prevention Plan* (*the Fifth Plan*) was endorsed by the Australian Government and by State and Territory health ministers establishing new national directions for responding to mental health and preventing suicide.[16]

This Regional Plan has been established within the context of the Fifth Plan, and the National Drug Strategy, and reflects the responsibility the Australian Government has tasked PHNs, including Brisbane North PHN. It aims to improve the coordination and integration of healthcare as well as focusing on priority healthcare areas including mental health, suicide prevention and alcohol and other drug treatment services.

Metro North Health has committed, through the Queensland Government's commitment to the Fifth Plan, to production of this Plan. As Australia's largest health service, Metro North Health works to realise the opportunity to lead development of responsive, accessible, innovative health services[17] inclusive of the areas this Plan covers – mental health, suicide prevention and treatment services responding to the harmful effects of alcohol and other drug use.

This Plan is also shaped by substantial reform to delivery of mental health, suicide prevention and alcohol and other drug treatment services in Queensland. In 2013, the Queensland Mental Health Commission was established to drive ongoing reform focusing on a service system for mental health and substance misuse that is more integrated, evidence-based and recovery-oriented.[18] Since then, the Commission's strategic plan, *Improving mental health and wellbeing: Queensland Mental Health, Drug and Alcohol Strategic Plan 2018-2023* has pointed to the need for substantial changes in delivery of mental health, suicide prevention and alcohol and other drug treatment services and has outlined shared commitments to change.[19]

Within the context of this national and state-wide reform, Queensland Health's Connecting care to recovery, a plan for Queensland Government funded mental health, alcohol and other drug services[20],commits to continue building more person-centred and recovery-oriented services and was established within the common purpose and investment strategy outlined in Queensland Health's *My health, Queensland's future: Advancing health 2026* [21].Connecting care to recovery brought with it a substantial increase to the Queensland Government's investment in mental health and alcohol and other drug treatment services with an additional $350 million over five years to be invested.[22]

A review into mental health services was conducted by the Productivity Commission in 2020.[23] The findings from this review and the government's response will be incorporated into the next review and update of *Planning for Wellbeing* by June 2022.

Scope of the Plan

Mental health, suicide prevention and alcohol and other drug treatment services

This Plan operates within the broader context of healthcare and its scope includes three discrete and complementary areas of work: mental health; suicide prevention; and alcohol and other drug treatment services. At times, there is overlap between these three areas and at other times, the three areas are quite discrete and do not overlap. We take the approach of incorporating all three areas in this Plan to better align our planning approach with that taken by both Queensland Health and the Queensland Mental Health Commission.

Working in partnership

The PHN and Metro North Health have sponsored development of this Plan and have developed it in partnership with other healthcare providers and practitioners, People with a Lived/Living Experience, Families and Carers. This five-year Plan, Planning for Wellbeing, establishes future directions for the region as a whole, not just for our two sponsoring organisations.

The Plan establishes shared objectives that have been developed in partnership and that reflect the future commitment to action of healthcare practitioners and organisations across the region, as well as the contribution that will be made by People with a Lived/Living Experience, Families and Carers who are engaged in work to shape and improve mental health, suicide prevention and alcohol and other drug treatment services. Rather than being a Plan that will be the sole responsibility of sponsoring organisations, the Plan reflects instead both the results of broad- based consultation and stakeholders' commitment to shared objectives and actions to be undertaken over the next five years.

Service and system improvement

The Plan identifies significant opportunities for both service and system improvement that have been the subject of comprehensive consultation with stakeholders. Many of these actions involve improvement of service delivery approaches by existing services as well as enhancements to commissioning approaches by commissioning agencies. These objectives and actions are clearly within scope of the Plan. Other actions outlined in the Plan encourage broader take up of new approaches across the region, for example in general practice, and in these areas, we will focus on informing, educating and working in partnership to progress these actions.

New and additional services

The Plan outlines opportunities and priorities for expanding, diversifying and extending service delivery when funding is available. Chapter 15 estimates the level of mental health need in the region using projections from the National Mental Health Service Planning Framework (NMHSPF), These projections, when mapped alongside existing investment enables us to predict and identify gaps in mental health resourcing in Brisbane North and Moreton Bay and present priorities for future investment.

A Plan for Brisbane North

The catchment area for both Metro North Health and the PHN forms the region to which this Plan relates. It incorporates Brisbane City Council suburbs north of the Brisbane River; all of the Moreton Bay Regional Council's catchment area; and parts of the Somerset Regional Council's catchment area around Kilcoy. Our region is home to over 1,046,494 people,[24] with this population projected to increase to 1,272,370 residents by 2036, making Brisbane North a large, densely populated and growing region encompassing diverse communities and population groups.[25]

How we developed this refreshed Plan

Considerable consultation from stakeholders, People with a Lived/Living Experience and their families informed the first iteration of the Plan, which led to the identification of a series of objectives and actions, including the following:

Shared Objectives	Actions over the next 5 years
14.4 Refresh and review the Plan	• Identify and realise opportunities to 'refresh' and update the Plan • Undertake a mid-term 'review' of the Plan

During the first 12 months of implementation, a small number of changes to the Plan were identified by stakeholders. In January 2020, the Strategic Coordination Group endorsed a consultation approach to suggest any headline changes to refresh the Plan. The refresh was to include:

- edits to actions due to changed external factors
- follow up actions to those that were completed as a first step (such as those beginning with explore… identify…scope…); and
- addition of new and important actions.

In addition to recommending necessary edits to actions, consultation also identified priority needs or gaps impacting negatively on people in the region. Whilst we were not aware of new funds that would flow into the region, there was value in ensuring our collective understanding remained current regarding these important issues and the Strategic Coordination Group commits to planned advocacy in an attempt to address these needs, where possible. The updated suite of priority needs has been included in our regional resourcing plan, added in **Part D** of this refresh.

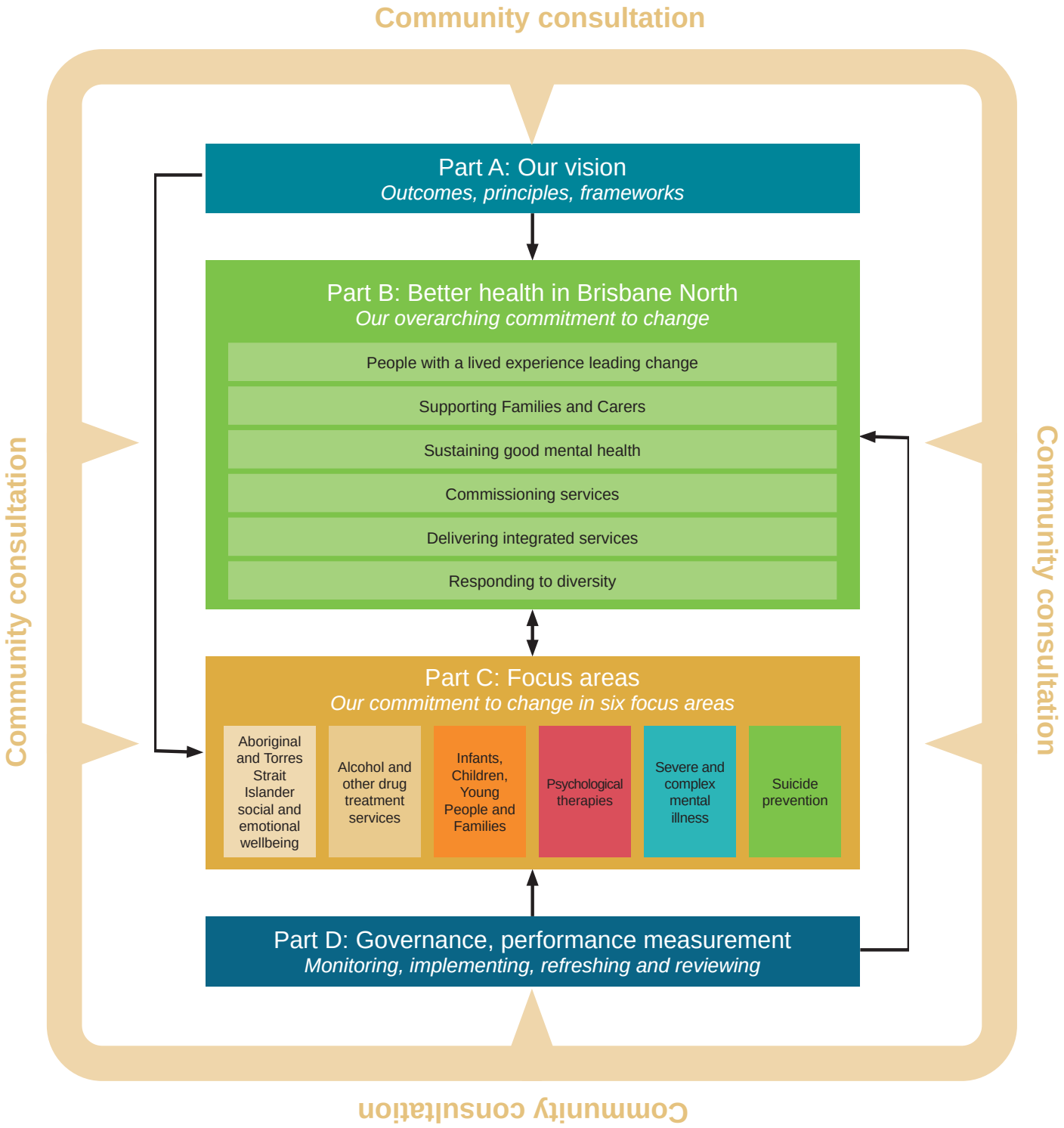
Linkages to other Brisbane North planning tools

This Plan must be seen in connection with other planning tools that have been developed to shape and drive healthcare nationally, across Queensland and within Brisbane North. A brief overview of key national and statewide strategic drivers and plans is included in Appendix One. Regional plans and planning tools that this Plan connects with are listed in the table below.

Brisbane North – regional planning tools		
Organisation	Planning resource	Overview
Metro North Health	*Connecting for Health: Strategy for inclusive engagement, involvement and partnerships 2016-18*[26]	Outlines a roadmap for engagement with Consumers and communities to ensure care is person-centred, integrated and respectful.
	Health Service Strategy 2015–2020: 2017 Refresh[27]	Establishes overarching priorities and a forward strategy for providing healthcare services in Brisbane North.
	Mental Health Clinical Services Plan 2018-2023[28]	Describes Metro North Health's commitment to delivering care through public mental health and alcohol and other drug services, in line with Metro North Health's overarching regional direction.
Brisbane North PHN	*Needs Assessment Report, 2019-2022*[29]	A planning tool that outlines population health data and health and service needs within the region, including for mental health and alcohol and other drug use.
Metro North Health and Brisbane North PHN	*A five year health care plan for older people who live in Brisbane North: 2017-22*[30]	A joint plan establishing future directions and actions to guide and enhance service delivery for older people.

How to use this Plan

The Plan is presented in four parts, which are described in the diagram below.



Brisbane North and Moreton Bay snapshot

Brisbane North

1,046,494

Brisbane North is home to over 1,046,494 people[1] and this is projected to increase to over 1,200,000 people by 2036.[2]

Pine Rivers, Moreton Bay North and Redcliffe-North Lakes have significantly higher levels of socioeconomic disadvantage, poorer health outcomes and limited access to health services.[3]

People who were born overseas represent almost 1/4 of Brisbane North's population.[4]

10% of Brisbane North residents speak a first language other than English.[5]

37%

In 2016, more than 20,000 people in Brisbane North identified as Indigenous, an increase of over 37% from 2011.[6]

Mental health in Brisbane North

70,513

Between 2011 and 2013, there were an estimated 70,513 adults in Brisbane North with high or very high psychological distress.[7]

The highest rate (11.9%) of adults with high or very high psychological distress live in Moreton Bay North, an area with a shortage of services.[8]

3%

The number of people in Brisbane North commencing a mental health plan with their GP increased by 3% each year between 2012/13 and 2014/15.[9]

The prevalence of mental health issues in Brisbane North has increased over the last 5 years, particularly among younger people.[10]

Suicide prevention

25-59 YEARS

The number of suicide deaths in Brisbane North is higher in people aged between 25 and 59 years.[11]

Life events most commonly suspected as events precipitating suicide were relationship problems, alcohol and/or drug use and mental or physical illness.[12]

The highest numbers of suicides in Brisbane North suburbs were in Caboolture, Deception Bay, New Farm, Morayfield, Redcliffe and Burpengary.[13]

Use of alcohol and other drugs

7.4% of recent drinkers in Australia put themselves or others at risk of harm while they were under the influence of alcohol in the last 12 months.[14]

In 2013, 22.6% of people in the inner city in Brisbane North had recently used an illicit drug, compared with 13% Queensland-wide.[17]

Illicit drug use in the last 12 months was far more common among homosexual or bisexual Australians and ecstasy and meth/ amphetamine use in this group was 5.8 times that of heterosexual people.[18]

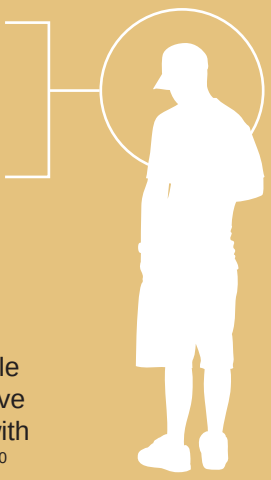
1 in 8 Australians aged over 14 years of age smoke every day.[15]

1 in 8

used at least one illicit substance and 1 in 20 misused a pharmaceutical drug in the last 12 months.[16]

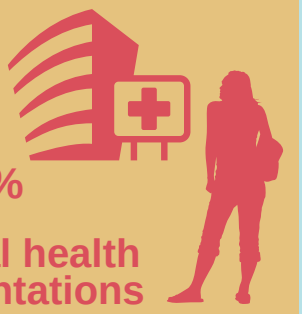
Indigenous social and emotional wellbeing

The leading contributor to the burden of disease for Indigenous people in Brisbane North is mental disorders, including substance use disorders, constituting 29% of the total burden of disease.[19]



3,140 Indigenous >15 yrs

It is estimated that 3,140 Indigenous people over 15 years of age in Brisbane North have high or very high psychological distress, with almost 2 in 5 living in Moreton Bay North.[20]



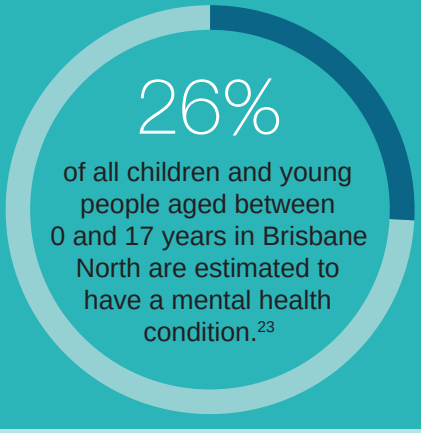
5.2% mental health presentations

5.2% of people presenting at Brisbane North hospital EDs for mental health related conditions in 2013-15 FY identified as Indigenous.[21]

Children and young people

5,456 people 0-17 years

In 2018, an estimated 5,456 children and young people 0-17 years are expected to experience severe mental illness and require treatment.[22]



Part A

OUR VISION

In this part of the Plan we describe the future we want to create through a vision statement and outcomes we will strive towards. We outline principles that have underpinned development of the Plan, and which will shape its implementation, and the frameworks that will be fundamental to all we do: stepped care for mental health services; *LifeSpan* for suicide prevention services; and the Queensland Alcohol and Other Drug Treatment Service Delivery Framework for alcohol and other drug treatment services.

Vision statement

We commit to the vision statement developed by the Queensland Mental Health Commission in their Strategic Plan:

> *A fair and inclusive Queensland where all people can achieve positive mental health and wellbeing and live lives with meaning and purpose.*[31]

Outcomes

The PHN and Metro North Health have consulted with People with a Lived/Living Experience, Consumers, Families, Carers and other stakeholders to identify ten long-term outcomes that we will work towards in our community in response to the challenges posed by mental illness and the prevalence and impacts of suicide and problematic use of alcohol and other drugs. These outcomes will help us to steer our work and allow us to measure our progress against the Plan.

Together we seek to build a community in Brisbane North where people:

1. have the resources and supports to create and maintain healthy, meaningful lives
2. are free from stigma and discrimination
3. are in charge of their own recovery, and services and supports respond to what they need
4. achieve their desired outcomes, assisted by services and supports when needed
5. know about and are connected to the right services and supports at the right time and in the right place
6. seamlessly access different services and supports as their needs change.
7. are understood holistically so that they can be connected to broader health and community services that address the social determinants of health
8. provide an active Lived/Living experience voice in all levels of policy, planning, delivery and evaluation
9. contribute Lived/Living experience to inform services and supports and drive service innovation and quality improvement, as part of an evidence-informed approach
10. have confidence in services and supports that are appropriately resourced, work collaboratively, and maintain a stable, skilled workforce, including peers and carers

Principles

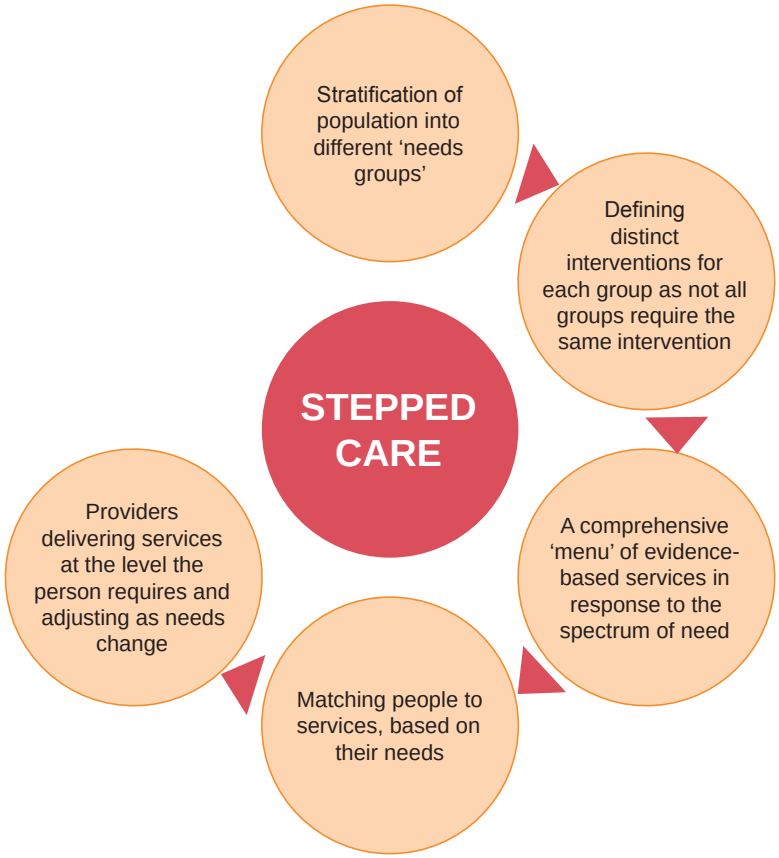
As part of work on this Plan, we have identified five principles that have shaped development of the Plan and that will underpin our future work to achieve the outcomes, objectives and actions outlined in the Plan. These principles are outlined below.

Our stepped care framework for mental health services

Defining stepped care

The Australian Government Response to the National Mental Health Commission's Review of Mental Health Services and Programs commits the Government to introducing a stepped care approach that serves to refocus the mental health system, including through primary mental healthcare funding provided to PHNs.[32]
A stepped care approach seeks to:[b]

- emphasise self-care and early intervention
- increase the use of digital mental health services
- match the level of service to service Consumers' needs and adjust services in response to these changing needs
- shift the focus to services that help prevent the need for acute and crisis intervention
- offer a full continuum of services from low intensity through to high levels of care
- ensure service Consumers can choose from a broader range of services that are better targeted to their needs
- reduce under-servicing and over-servicing of some service Consumers
- strengthen support for GPs undertaking assessment to ensure people are referred to the right service or services.



b. This stepped care framework applies to mental health services and, in part, to suicide prevention services. A different approach is taken to alcohol and other drug treatment services, as outlined in Department of Health's *National Drug Strategy 2017-2026*.

In a stepped care approach, a person seeking support accesses the services that meet their needs and, as their needs change, the services change with them. Stepped care utilises a person-centred approach and so a person does not need to access any particular type of service initially, but will instead access the type of service that is right for them. In the diagram on the previous page, we outline the five core elements that together constitute stepped care.

Identifying needs groups

To help people to connect to the mental health service or services that are right for them as part of stepped care, we must understand their needs and circumstances through discussion, assessment tools and/or screening and triage processes. Based on the range of mental health needs and circumstances that can be seen in the overall population, it is possible to describe the following eight needs groups:

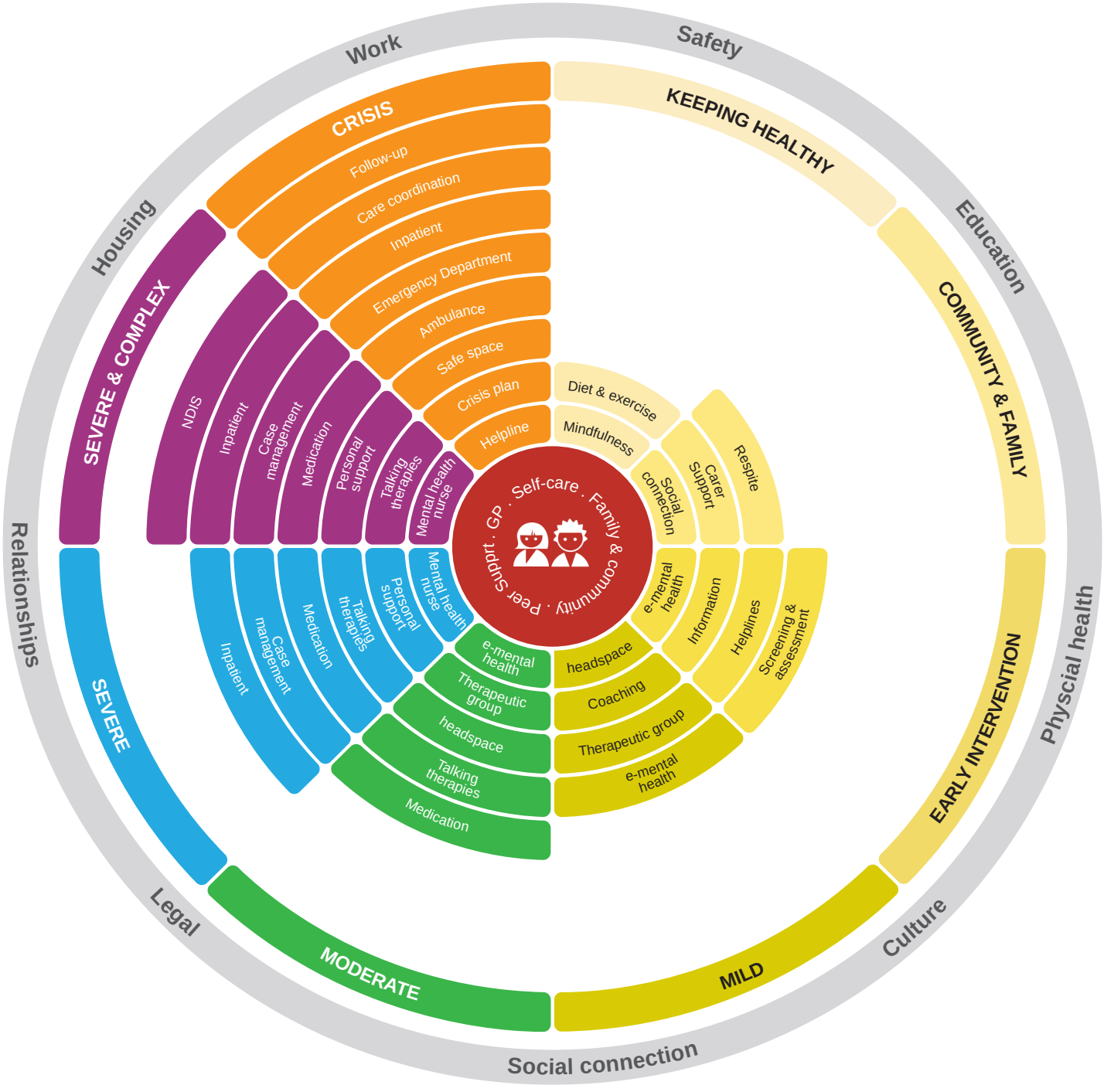
1. **Sustaining good mental health.** The whole population can benefit from being physically and mentally healthy throughout their lives.
2. **Community and family.** Much support comes from family, friends and other natural supports in the community and those providing this support may have their own support needs as Carers.
3. **Early intervention for people at risk.** People with signs of distress, including from traumatic life events such as a relationship breakup or job loss, may be at risk of developing a mental illness if support isn't provided early. This group is estimated as constituting 23.1 per cent of the population.[33]
4. **People with mild mental illness.** People in this group experience mental illness, including feelings of depression or anxiety, that impacts on wellbeing and functioning to a level that is concerning, but not overwhelming, and is of less than 12 months duration. This group is estimated as constituting 9 per cent of the population.[33]
5. **People with moderate mental illness.** People in this group experience moderate mental illness which causes significant disruption to daily life, wellbeing and functioning and can be of over 12 months duration. This group is estimated as constituting 4.6 per cent of the population.[33]
6. **People with severe mental illness.** People in this group experience mental illness which is very disruptive to daily life, wellbeing and functioning. The illness may also include risks to personal safety and is considered to be either persistent or episodic. This group is estimated as constituting 3.1 per cent of the population.[33]
7. **People with severe and complex mental illness.** People in this group experience mental illness which is severe in its impact on wellbeing and functioning and which brings with it additional complexities such as difficulties with housing, employment and daily living. This group is estimated as constituting 0.4 per cent of the population.[33]
8. **People in crisis.** This group includes people with or without a diagnosed mental illness who are in crisis and who require immediate assistance. These crises may have occurred as a result of breakdown of a relationship, self-destructive behaviour and suicidal behaviours or harm to self or others.

It is important to note that people's needs can change over time, and a holistic and integrated approach to support that considers the circumstances of the individual and addresses the social determinants of health is key to ensure people get the support that they need in the right place at the right time.

Outlining our framework

The diagram below outlines our overarching stepped care framework by describing:

- four core types of support – self-care, family and community, peer support and general practice
- examples of services and service types for each of the eight defined needs groups (those listed are illustrations only, and are not intended to provide an exhaustive list)
- some critical life domains (e.g., relationships, housing and work) that contribute to good mental health.



In this approach to stepped care, people can access the services and supports they need at that time in their lives. For example, a person can continue to benefit from less intense services even if they require more intense services at the same time to fully meet their needs. As people's needs increase, they can increase the range and intensity of services they access. Conversely, when things get back on track, they can decrease the range and intensity of services they access.

Stakeholder roles and responsibilities

A range of stakeholders in Brisbane North have roles and responsibilities relating to the provision of services to people experiencing mental illness and so will interact with our stepped care approach. The roles and responsibilities of key stakeholders include:

- Queensland Health utilises Queensland Government funding to commission mental health, suicide prevention and alcohol and other drug treatment services across Queensland, including in Brisbane North.
- Metro North Health, particularly through its Metro North Mental Health Service, is a key provider of mental health and alcohol and other drug treatment services. In mental health, Metro North Health's focus is on treatment for people experiencing severe and complex mental illness, including through community and bed-based services.
- The PHN commissions a range of mental health, suicide prevention and alcohol and other drug treatment services utilising Australian Government funding. It focuses largely on primary mental health care for people experiencing mild and moderate mental illness; on suicide prevention services; and on alcohol and other drug treatment services.
- Other stakeholders in Brisbane North include People with a Lived/Living Experience, private healthcare practitioners, ranging from psychiatrists and GPs through to allied health practitioners, and non-government organisations (NGOs) who offer a range of services and supports to people experiencing mental illness.

Implementing our stepped care framework

We will use a range of strategies to implement our stepped care framework in Brisbane North:[c]

- **Commissioning services.** Brisbane North PHN, and other commissioning agencies, commission mental healthcare services for people with low, moderate and high intensity needs. Over time, all commissioned services will be mapped against the eight needs groups outlined earlier in this section.
- **Initial assessment and referral.** The electronic triage and referral tool for mental health called 'rediCASE' will support people to get connected to the service that is right for them. rediCASE has been purchased and will initially be further developed for use by GPs, and, over time, will be made available for use by other referring agencies, healthcare practitioners and service Consumers. The Initial Assessment and Referral (IAR) tool within rediCASE uses an algorithm that suggests programs and service providers that best match the needs of the client based on demographic information, the client's level of mental distress and other information. Selecting a service provider will initiate an electronic referral, alert the selected service provider and allow them to accept the referral and contact the person referred. Service providers will also be able to assist people to '*step up*' or '*step down*' to other services as their needs change, by initiating a further referral.
- **Minimum data set.** A new national minimum data set for primary mental healthcare has been developed by the Australian Government's Department of Health and all mental health services funded by the PHN provide this data to the PHN using rediCASE. The PHN, together with providers, can use this non-identifying data to better understand and analyse services provided, including whether people were connected to the right service the first time and the outcomes people achieve at each level of service. Over time, this data set, as well as other data, will help providers to improve their service and support commissioning agencies such as the PHN to plan for a better mental health system.

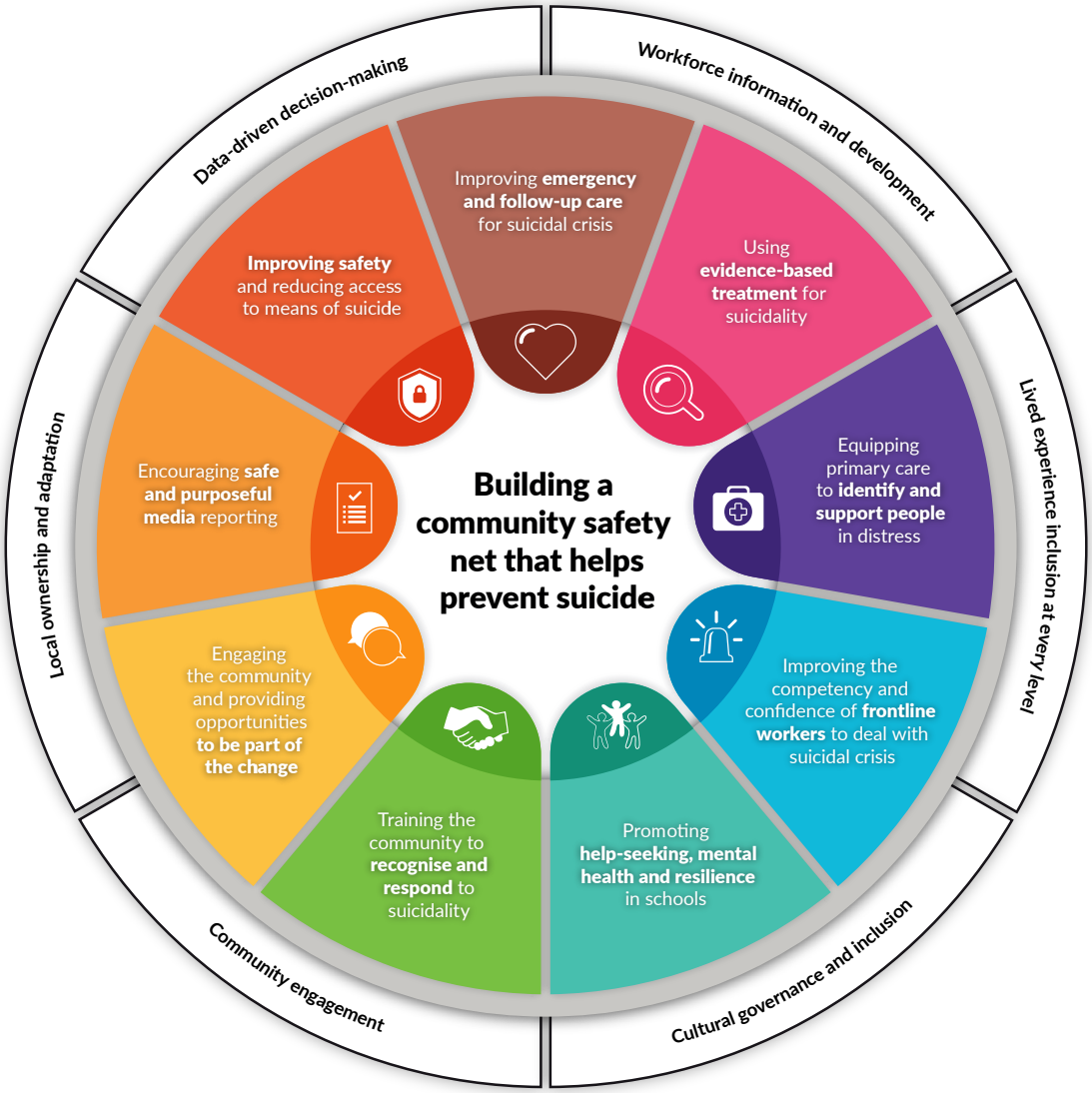
c. These strategies are also reflected as actions in appropriate chapters of this Plan.

Our systems approach to suicide prevention services

Overseas evidence points clearly to the benefits of combining suicide prevention strategies into an integrated, systems-wide approach recognising that multiple, concurrent strategies are likely to generate greater effects than separate implementation of individual strategies.[34] There are various evidence-informed systems approaches to suicide prevention, including Zero Suicide in Healthcare, *European Alliance Against Depression*, the *World Health Organisation's (WHO's) Preventing Suicide A Global Imperative* and the *LifeSpan* model. We have adopted the systems-wide approach developed by the Black Dog Institute, *LifeSpan*, to shape and guide our regional approach to suicide prevention. *LifeSpan* is data driven and evidence-informed and its development involved extensive collaboration and input from partners across the sector as well as representatives of People with a Lived/Living Experience. The Black Dog Institute estimates that the implementation of the *LifeSpan* model will prevent 21 per cent of suicide deaths and 30 per cent of suicide attempts.

The core features of *LifeSpan* include:

- nine evidence-informed interventions ranging from the population level to the individual level that are outlined on the following page
- data driven decision-making to ensure a focus on local priorities
- a focus on activities demonstrated to have an impact on suicidal behaviour
- selection of local interventions based on the best available evidence and on their appropriateness for the target audience
- strategies that are implemented simultaneously within a localised region and tailored to the specific needs of the region
- a universal approach that works for all ages
- use of a lived experience framework
- community ownership of suicide prevention activities that encourages community members to have an active role in the planning, development, implementation and maintenance of suicide prevention activities.[34]



The *LifeSpan* model[d] is constantly evolving and is not designed to be a '*one size fits all*' approach. Black Dog Institute acknowledges that *LifeSpan* in its current form is a framework for the general population and requires cultural adaptation to meet the needs of priority population groups (e.g. Aboriginal and Torres Strait Islander peoples, LGBTIQ+ people and veterans).

d. You can find out more about the *LifeSpan* framework by going to https://www.blackdoginstitute.org.au/research/lifespan

Our harm reduction approach to alcohol and other drug treatment services

The *Queensland Alcohol and Other Drug Treatment Service Delivery Framework (QAODTSDF)* describes the 'common ground' underpinning delivery of alcohol and other drug treatment services in Queensland.[35] It outlines the mission, aims, objectives, values, understandings, established tools, therapeutic approaches, practice principles and standards that inform the state's alcohol and other drug treatment services sector. QAODTSDF has been developed in partnership by statewide alcohol and other drug treatment policy and service delivery organisations, and workforce development organisations, based on direct input, feedback and research by providers of alcohol and other drug treatment services from across Queensland.

In Queensland, alcohol and other drug treatment services are provided by: public health Mental Health and Alcohol, Tobacco and Other Drug Services (MH-ATODS) and public hospitals; NGOs, including Aboriginal and Torres Strait Islander community-controlled organisations; and GPs and other private healthcare providers.[36]

The diagram below is derived from QAODTSDF and locates key alcohol and other drug treatment types across each domain of healthcare. It also attempts to match these service types against changing levels of substance-related harm and suggests that alcohol and other drug treatment can take many forms, occur in a variety of settings, have varying levels of intensity and take varying lengths of time. Together, these services comprise a diverse and comprehensive alcohol and other drug treatment system ranging across primary health sector, early intervention, acute care, community-based and longer-term rehabilitation services.[37]

There is an important difference between generalist services who offer some alcohol and other drug related support as part of their service mix and specialist alcohol and other drug treatment services. Due to the complex nature of problematic substance use, a distinct standalone treatment services system is essential to ensure clients receive an appropriate and effective treatment response. This type of care is not always able to be provided in primary health care, general practice or mental health care settings. Whilst specialist alcohol and other drug treatment services can respond to a range of issues, addressing the client's substance use is the primary focus and concern of these services. Once the level of risk or harm has been addressed, transition to another service or exit usually occurs.[38]

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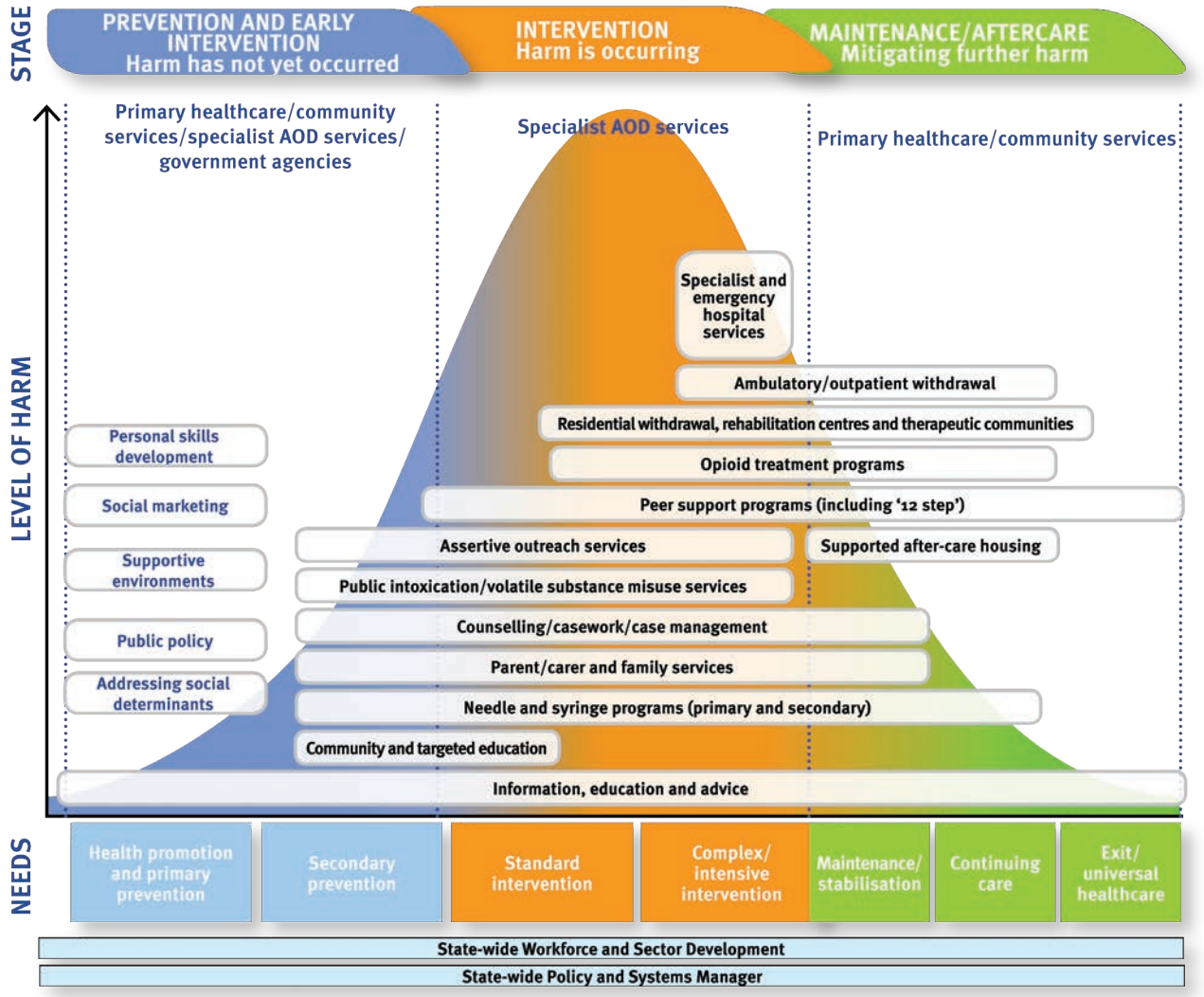

STAGE
PREVENTION AND EARLY INTERVENTION
Harm has not yet occurred
INTERVENTION
Harm is occurring
MAINTENANCE/AFTERCARE
Mitigating further harm
LEVEL OF HARM
Primary healthcare/community services/specialist AOD services/ government agencies
Specialist AOD services
Primary healthcare/community services
Specialist and emergency hospital services
Ambulatory/outpatient withdrawal
Residential withdrawal, rehabilitation centres and therapeutic communities
Opioid treatment programs
Peer support programs (including '12 step')
Supported after-care housing
Assertive outreach services
Public intoxication/volatile substance misuse services
Counselling/casework/case management
Parent/carer and family services
Needle and syringe programs (primary and secondary)
Community and targeted education
Information, education and advice
Personal skills development
Social marketing
Supportive environments
Public policy
Addressing social determinants
NEEDS
Health promotion and primary prevention
Secondary prevention
Standard intervention
Complex/ intensive intervention
Maintenance/ stabilisation
Continuing care
Exit/ universal healthcare
State-wide Workforce and Sector Development
State-wide Policy and Systems Manager

Part B

BETTER HEALTH IN BRISBANE NORTH

In this part of the Plan we establish our overarching commitment to change in six broad areas: People with a Lived/Living Experience leading change; supporting Families and Carers; sustaining good mental health; commissioning services; delivering integrated services; and responding to diversity. We set out shared objectives and actions developed by funders, service providers, People with a Lived/Living Experience and Carers working together to improve quality, coordination and integration.

1. People with a Lived/Living Experience leading change

The PPIMS network is in its fourth year and led the development of this chapter on People with a Lived/Living Experience leading change.

Achievements to date:

- Over 300 members and a Facebook page with representation from a range of high level strategic committees at regional, state and national level
- Capacity building initiatives available to representatives and the Lived/Living Experience workforce
- Embedded co-design process within Planning for Wellbeing
- Formation of the Queensland Lived Experience Workforce Network (QLEWN)

Priorities:

- Collective voice
- Reform processes
- Authentic engagement
- Lived/Living Experience and peer workforce development

Introduction

Authentic participation by, and collaboration with, People with a Lived/Living Experience, including both Consumers and their Families (including loved ones) and/or Carers, enriches our work in planning and delivering mental health, suicide prevention and alcohol and other drug treatment services. This participation and collaboration will inform assessing needs, planning for the future, commissioning, co-designing and delivering services and evaluating the outcomes our services achieve. National, state and regional policy drivers reinforce the need to embed participation and collaboration in our work, including when we are commissioning services.[39]

Since the 2018 iteration of the Plan, the Peer Participation in Mental Health Services (PPIMS) network has overseen its implementation and review. The People with Lived Experience Advocating Strategic Engagement (PLEASE) refresh working group consisting of People with a Lived/Living Experience (PLE) who are represented on other partnership groups within this Plan has been established and contributed to both the co-design of this refreshed chapter and the broader plan. Both PPIMS and PLEASE meet monthly and play an ongoing role in the co-design process.

Since 2018, PPIMS has also undertaken strong capacity building initiatives, including regular scholarship rounds for Certificate IV in Mental Health Peer Work; local, state and national participation including submissions to policy and decision makers.

What you told us

Consultation participants emphasised there is more to do across the region to achieve the goal of '*nothing about us without us*'. They were strongly of the view that no policy or practice should be decided or delivered by any service or service system without direct participation by, and collaboration with, those affected by that policy or practice, in this case People with a Lived/Living Experience.

They also reinforced the need for a central, readily-accessible point for People with a Lived/Living Experience to find out about, and get involved in, participation and collaboration opportunities. Building the capacity of people working in the mental health, suicide prevention and alcohol and other drug treatment sectors through education and training delivered by People with a Lived/Living Experience was also highlighted, with consultation participants emphasising the importance of making this education and training available to front line, managerial and executive staff. In addition, consultation participants discussed the importance of increasing the accountability of the sector to those who access services.

Strengthening the collective voice of People with a Lived/Living Experience, so they can shape the service system they access

services through, was an important consultation theme. Consultation participants proposed that People with a Lived/Living Experience need opportunities to support each other to build this voice; to connect face-to-face; and to have access to regular updates on services, participation and collaboration opportunities, training and events.

Contributing to co-design opportunities and having the opportunity to engage in discussion of emerging issues were also seen as central to full participation. In addition, consultation proposed the need for a more diverse group of people with a lived experience to be included in planning and delivery of mental health, suicide prevention and alcohol and other drug treatment services, including Aboriginal and Torres Strait Islander peoples, young people, older people, LGBTIQ+ people and people experiencing problems related to the use of alcohol and other drugs.

Consultation also highlighted that the mental health and suicide prevention sectors in Brisbane North need to strengthen participation and collaboration mechanisms, including moving from informing and consulting people with a lived experience towards creating more meaningful involvement by focusing on collaboration and empowerment. There was also interest in a more deliberate and documented region-wide approach to participation and collaboration by People with a Lived/Living Experience.

In addition, it is important to note that, while it was not a clear theme from consultation, there is further work to do in strengthening participation mechanisms for people experiencing problems related to the use of alcohol and other drugs, considering the inherent challenge in accessing the voice of illicit drug users.

An important consultation theme revolved around participation by people with a lived experience in the workforce, both in terms of peer work and broader roles. The merits of peer work are well documented, including by Health Workforce Australia,[40] but consultation indicated that it is also important to diversify the nature of roles people with a lived experience hold in the mental health sector.

Shared objectives	Actions over the next five years
1.1 Strengthen and diversify the collective voice of People with a Lived/Living Experience that drives service improvements.	• continue to support and resource the PPIMS Network to expand and build a consistent, independent and diverse voice that is a partner in the governance of the Plan • support and contribute to the building of a state-wide and national network of People with a Lived/Living Experience through peak body, professional development opportunities, co-design and advocacy • actively recruit a diverse group of People with a Lived/Living Experience into membership and leadership roles to participate in planning, delivery and evaluation of services, ensuring reach and engagement with People with a Lived/Living Experience in underserviced and hard-to-reach groups, including those who lack strong community connections
1.2 Make available training and capacity building for People with a Lived/Living Experience to support the service system and build the capacity of the broader workforce.	• continue to investigate, collaborate and leverage off availability of subsidies, co-contributions and collaborative opportunities at a local, regional, state and national level • contribute to the development of mentoring, coaching, supervision and co-reflection opportunities for all • develop a register of People with a Lived/Living Experience available as speakers, educators, trainers, supervisors/mentors and researchers to support the service system and build the capacity of the broader workforce

Shared objectives	Actions over the next five years
1.3 Establish more authentic opportunities for People with a Lived/Living Experience to participate in planning, delivery and evaluation of mental health, suicide prevention and alcohol and other drug treatment services.	• identify and share best practice ideas, case studies, resources and tools that support the system to undertake authentic engagement occurring at the needs assessment, design, delivery, review and evaluation stages of the commissioning cycle. • develop an online communications strategy to link a wider audience of People with a Lived/Living Experience and services to promote participation and co-design, information sharing, evaluation and networking opportunities • provide oversight and advice to the Plan's governance groups, ensuring that actions that relate to the engagement and involvement of People with a Lived/Living Experience are meaningful, genuine, authentic and embedded throughout implementation • identify, inform and gain feedback from People with a Lived/Living Experience and experiences with the National Disability Insurance Scheme (NDIS)
1.4 Establish and sustain a consistent region-wide approach to participation by people with a Lived/Living Experience in mental health, suicide prevention and alcohol and other drug treatment services.	• review, research and continue to develop regional coordination • develop a clearinghouse of best practice resources on engagement of People with a Lived/Living Experience, Consumers, Carers and Families • sustain and strengthen existing peer participation and collaboration mechanisms through mentoring, supervision, peer reflection and self-care initiatives • review, share and utilise existing plans, research and guidelines from all levels of government and industry relevant to People with a Lived/Living Experience's role in service delivery and commissioning
1.5 Advocate for an expanded and more diverse regional Lived/Living Experience workforce, across all levels of employment.	• promote and participate in local, regional, state and national research to better understand the existing profile of peer work emerging issues, commitment and culture • promote and contribute to national and state-wide initiatives aimed at building the Lived/Living Experience peer workforce, including the QLD framework for Lived Experience Workforce and National Guidelines for Peer Workforce • contribute towards broader workforce development strategies being developed at a national and state level, and use this to co-design and implement a local and regional response towards a Lived/Living Experience workforce • identify and promote a comprehensive range of workplace roles for People with a Lived/Living Experience in the mental health, suicide prevention and alcohol and other drug treatment services sectors • identify opportunities for peer workers to become service providers through the NDIS • identify and contribute to shaping organisational readiness that embeds people with Lived/Living Experience and supports good mental health and wellbeing in the workplace.

Progressing this work

This work will be steered by the PPIMS Network. An Implementation Plan for this chapter will guide the work and report on it, as well as identify appropriate strategies for resourcing the PPIMS Network to steer implementation work. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

2. Supporting Families and Carers

Introduction

Families (including loved ones) and local community supports are typically the first responders to people with mental illness, suicide risk and problematic drug and alcohol use. Much of the care that happens in Australia is provided by family members or loved ones, although they often don't see themselves as a formal 'Carer.' People providing care, whether formal or informal, will themselves have support needs and their caring role may have negative impacts on parts of their own lives. As a result, some individuals may consider themselves as both a 'Consumer' and a 'Carer'. The Carers and Family members support sector is currently going through significant reform, with the Australian Government having introduced a new model of support for Carers and Families. The 'Integrated Carer Support Service,[41] which has been developed in consultation with Carers, Family members and other stakeholders. The first stage of these new arrangements is the release of the Carer Gateway website, currently providing online access to information and services for Carers and Families, and allow them to access a range of new digital services through an expanded Gateway, including phone and online counselling, online peer support, online coaching and educational resources. In September 2019, the Australian Government established a new network of regional delivery partners to help Carers and Families access new and improved local services including financial support packages, in-person counselling, coaching and peer support, local information and advice, crisis support and local service navigation.

What you told us

Consultation highlighted that Carers and Families feel that service providers do not fully include them in the care of their loved ones and at times do not feel supported or welcomed by providers. Too often, Carers and Families are having to check-up on the work of providers to ensure their loved ones are getting the support they need and deserve. Communication between providers and Carers can be lacking and supports are not offered to the Carer/Family. Carers and Family members talked about the impact that their Carer duties have on their own lives. Many experience significant financial hardships, due to a combination of not being in full-time work and various out-of-pocket expenses.

In addition, Carers and Family members were not clear on what benefits they and their loved ones are entitled to, nor on the range of services available to support them.

The overriding message was that Carers and Families seek better services for their loved ones, and for themselves, so that they may remain loving family members and not have to bear the burden of formal care.

Shared objectives	Actions over the next five years
2.1 Provide information, resources and skills building to support Families and Carers.	• all providers to promote the Carer Gateway and regional Integrated Carer Support Service to Carers and Families and ensure specific mental health carer advocacy, information and capacity building support is available for Carers in relation to mental health, suicide prevention and Alcohol and Other Drugs
2.2 Better care for Families and Carers.	• review the generic Carer pathway for Carers and review inclusion of Carer information and supports in HealthPathways every 12 months • encourage providers to nominate a named contact person for Carers, such as a peer worker or Carer liaison role • develop a platform for the promotion of services and supports providing income and employment support to Carers, particularly in peer worker roles
2.3 Families and Carers are listened to and involved in services.	• all providers to encourage the incorporation of approaches such as the '*Triangle of Care*'[42] model where Consumers, Carers/Families and providers work together as partners • Brisbane North PHN and Metro North Health continue involvement with the Carers Gateway, to ensure it meets the needs of Carers and Families of people experiencing mental illness, suicide risk and people experiencing problems related to the use of alcohol and other drugs • review the full and effective involvement of Carers in the NDIS, both at an individual and policy level • continue the involvement of Carers and Families in PHN and Metro North Health service planning, delivery and governance structures and extend this approach to other providers
2.4 Services are more responsive to the needs of People with a Lived/Living Experience and Families and Carers.	• providers commit to active engagement and participation in education and training on the perspectives of Carers and on family-inclusive practice • ensure all health practitioners have the requisite qualifications for their role and are matched to the level of need of the service Consumer, Carers and Families • facilitate improved access to mental health, suicide prevention and alcohol and other drug treatment services when and where service Consumers need it, with providers sharing outcomes and learnings of improvements
2.5 Services are more responsive to the needs of Carers and Families	• strengthen Consumer and Carer-centred practice, particularly at time of diagnosis, intake or admission to a service, by actively referring Carers to support options. Services providing information for Carers regarding participants clinical or support information is done with the consent of the Consumer • strengthen the early involvement of Carers in discharge and transition planning, working within privacy policies and procedures • providers commit to the incorporation of appropriate standards and approaches such as the six partnership standards for working with Carers and to undertake any associated self-assessment processes

Progressing this work

This work will be steered by the Strategic Coordination Group. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

3. Sustaining good mental health

Introduction

This chapter focuses on mental health promotion and the prevention of mental illness – that is, on how promotion and prevention strategies can help us to keep healthy by sustaining good mental health. Prevention of suicide is covered in chapter 12 and prevention of harmful alcohol and other drug use is outside the scope of this Plan.[e]

In this context, we consider good mental health to be a broad concept that includes dimensions relating to emotional, social, cultural and spiritual wellbeing as well as connection to community.

To shape our approach to promotion and prevention, we use aspects of the Hunter Institute of Mental Health's *Prevention First* framework.[43] Prevention First defines promotion as "*enhancing social and emotional wellbeing and quality of life*" and prevention as "*reducing risk factors and enhancing protective factors*."[44] The diagram below lists the components of promotion of wellbeing described in Prevention First.[45]

What you told us

Consultation on promotion and prevention emphasised the importance of building people's resilience so they are better equipped to face distressing life events. Our responses to, and ability to bounce back from, these events, depends on our resilience. Consequently, it is critical to build resilience in individuals, families and communities to improve responses to life's challenges and strengthen coping strategies. For some people, for example those surviving family and domestic violence, the option of support to build and sustain their resilience may be particularly important.

In addition, the stigma around mental illness can prevent people from seeking help until they are very unwell. Stigma also impacts on Families, Carers and service providers.

Feedback from consultation participants indicated clearly that not only is there insufficient investment in mental health promotion and prevention activities, but that there is no one driver or coordination point for these activities. Many consultation participants recognised promotion and prevention as important, but felt services were not funded to deliver such activities.

e. The National Drug Strategy outlines prevention priorities in relation to problematic use of alcohol and other drugs. The scope of this Plan does not include prevention of misuse of alcohol and other drugs. Alcohol and other drug treatment services only are within scope for this Plan.

People experiencing a mental illness have poorer physical health and are more likely to die earlier than the general population.[46] Many of these early deaths are due to physical diseases such as cardiovascular disease, cancer, diabetes and respiratory disease.[46] Given this, consultation participants identified promoting good physical health as an important priority.

Families and Carers are the 'frontline' responders to someone experiencing a mental illness. Consultation proposed that more is done to support them in their role as carers as well as to optimise their own health and wellbeing.

Shared objectives	Actions over the next five years

3.1 Build the resilience of individuals, Families and communities.	• promote and support delivery of peer to peer school-based programs that help students and young people, particularly those at risk of mental ill health, to build their resilience and coping skills, including:
	  • promoting strengths-based / role modelling approaches that empower students to help themselves and others
	  • publishing and promoting a directory of schools-based resilience building programs in Brisbane North to help schools and teachers achieve the mental wellbeing objectives in the National Curriculum
	• promote evidence-informed resilience building interventions, including:
	  • resilience-based research or intervention evaluation, including longitudinal approaches that explore the relationship between resilience and other individual, social and/or demographic variables.
	  • strengths based approaches to resilience building (e.g. Positive Psychology/ PERMA models)
	  • evidence based interventions that encapsulate the Beyond Blue definition of resilience
	• informed by the positive, local responses to build resilience and social inclusion as a result of the impact of COVID-19 and social isolation, promote and expand family, neighbourhood and peer natural support networks to work together with service systems to enable people to stay well rather than responding to illness in a crisis driven way
	• establish and support a North Brisbane and Moreton Bay Mentally Healthy Workplace Alliance to drive mental health and wellbeing in the workplace
	• promote availability of the 'Prospectus: Mental Health Recovery and Clinical Programs' to service providers through available channels and networks e.g. websites, Twitter, LinkedIn, Facebook, newsletters
	• facilitate opportunities for Domestic Violence and Family Violence services to develop and/or access referral pathways with PHN-funded mental health hubs
	• facilitate opportunities for Domestic Violence and Family Violence services to develop and/or access referral pathways with PHN-funded mental health hubs

3.2 Prevent stigma.	• implement targeted local/regional events and campaigns in Brisbane North which are aligned with and complement state-wide and national mental health anti-stigma campaigns through the regional mental health promotion and prevention action group • maximise community mental health sector opportunities for anti-stigma events • empower people whose mental wellbeing has been affected by the economic impact of COVID-19 to access support that is community based and targeted specifically to their needs

Shared objectives	Actions over the next five years
3.3 Make better use of existing resources to promote mental health and prevent illness.	• establish a regional mental health promotion and prevention action group, which includes cross-membership with members of the Equally Well Reference Group • identify upcoming state-wide and national campaigns, and develop complementary regional/local work which helps maximise impact through the regional mental health promotion and prevention action group • promote community mental health sector involvement in regional events for Mental Health Week, including innovative approaches e.g. online forums/ activities, and leverage the virtual forms of delivery that many organisations have strengthened during the COVID-19 pandemic
3.4 Improve the physical health of people experiencing mental illness.	• support Collaboration in Mind (CiM) to oversee the action plan for physical and mental health in the Brisbane North Region in accordance with the Equally Well Consensus Statement and advised by the Equally Well Reference Group • use the momentum generated by the response to COVID-19 to improve the service system to one with a stronger focus on natural supports, community-based services and staying well and offers real alternatives to ED presentations, hospital admissions and clinical responses
3.5 Support Families and Carers more effectively.	• informed by the positive, local responses to build resilience and social inclusion as a result of the impact of COVID-19 and social isolation, promote and expand family, neighbourhood and peer natural support networks to raise awareness of mental health and drive promotional messages and community based early intervention strategies • promote education, information and health literacy on the nature of Carer Reform across the Nation and how this impacts/changes carer support in Brisbane North – using and sharing this information consistently, so that correct messaging to, and engagement with, Families and Carers occurs • actively promote support services for Families and Carers widely, including via People with a Lived/Living Experience • meet with Regional Plan Action Group for Families and Carers to determine how we may be able to collaborate

Progressing this work

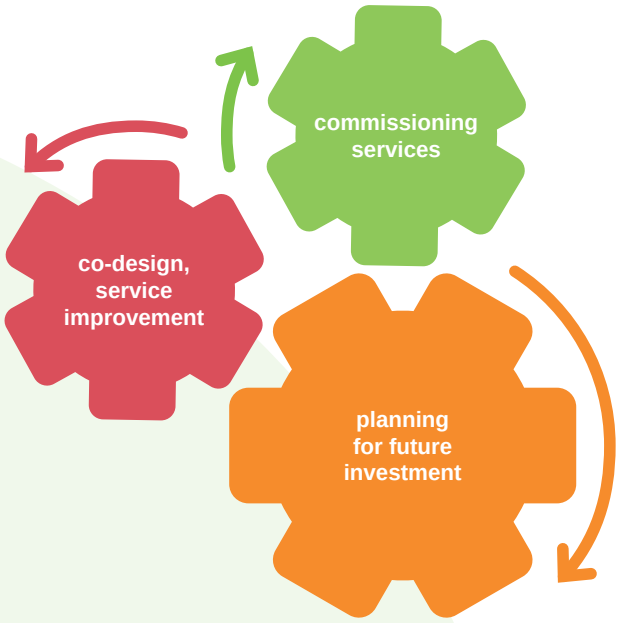
This work will be steered by the Strategic Coordination Group. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

4. Commissioning services

Introduction

The existing picture of mental health, suicide prevention and alcohol and other drug treatment services in Brisbane North is a complex one incorporating:

- service delivery by multiple organisations and healthcare practitioners from the private, public and NGO sectors
- several agencies commissioning and/or funding services including Australian Government agencies (Departments of Health and Social Services and the National Disability Insurance Agency); Queensland Government agencies (Queensland Health and the Queensland Mental Health Commission); regionally based agencies (the PHN and Metro North Health); private health insurers; and philanthropic organisations
- funding streams from the Australian and Queensland Governments, from health insurance purchased by individual healthcare Consumers and from philanthropic organisations
- delivery of a broad spectrum of services and programs.



Focus and scope of this Plan

Within this complex service delivery picture, the Plan identifies significant opportunities both for service and system improvement that have been identified through stakeholder consultation. Many of these actions involve service improvements by existing services or enhancements to commissioning approaches that will achieve person centred recovery outcomes and a more integrated service system. These objectives and actions are clearly within scope of this Plan. A number of the Plan's actions also encourage broader take up of new approaches across the region, for example in general practice, and in these areas, we will focus on strategies such as informing, educating and working in partnership to progress our objectives and actions.

Much of the Plan focuses on services funded by the PHN and funded and/or delivered by Queensland Health and Metro North Health. Given this, there are some parts of the service system described above that we have not focused on in the Plan at this stage including philanthropic funding; provision of healthcare subsidies

funded by the Department of Health through the Pharmaceutical Benefits Scheme (PBS) and Medical Benefits Schedule (MBS); and services utilised by healthcare Consumers through use of private health insurance. Consequently, our objectives and actions do not fully consider these types of services.

The Plan also outlines opportunities for expanding, diversifying and extending service delivery. The Plan makes no commitment to future funding for these additional services. Instead, we have developed a regional resourcing plan that uses data on existing funding coupled with outputs from service planning tools to determine gaps in mental health investment in the region.

What you told us

Consultation indicated that greater alignment of commissioning approaches between funding bodies would result in better funding outcomes and enhance integration of services. Discussion also supported outcomes-based funding that would enable delivery of improved person centred recovery outcomes.

In addition, consultation participants identified challenges associated with competitive tendering and the tension between these approaches and delivery of collaborative, connected services. Conventional procurement approaches were not always perceived as achieving the best outcomes, particularly when procuring services for specific population groups (e.g. Aboriginal and Torres Strait Islander peoples), as these approaches were reported as not taking into account cultural responsiveness on the part of organisations competing for funding. Consultation participants proposed use of commissioning approaches that better support the integrated delivery, reporting and evaluation of social and emotional well-being services for Aboriginal and Torres Strait Islander peoples, including through alignment with the Australian Government's Social and Emotional Wellbeing Framework.[47]

Planning for future need

The need for more connected, integrated services has significant implications for commissioning approaches, as do the proposals in this Plan for new models of service delivery or additional services. These factors point to new and more sophisticated ways of commissioning and greater collaboration between commissioning agencies and between commissioning agencies and funded organisations. In addition, the frameworks underpinning our service delivery (i.e., stepped care, *LifeSpan* and QAODTSDF) provide opportunities to better specify and understand commissioned services and the outcomes they achieve.

Given this, we commit to development of a regional resourcing plan for Brisbane North which will:

- map existing resources across the range of funding/commissioning agencies
- establish the priorities for future resourcing of service delivery in Brisbane North
- be informed by the directions outlined in this Plan and consider actions from the Plan that propose new and additional service delivery
- utilise planning frameworks that help us to better understand demand for services including:
  - The *National Mental Health Service Planning Framework (NMHSPF)* developed by the Australian Government Department of Health and licensed for use by Queensland Health and by PHNs. The NMHSPF is an integrated planning tool for mental health service delivery across all sectors and has been adopted by all states and territories. It provides a consistent planning methodology, supports a shared understanding of service types and informs the level and mix of mental health services required for any given population.
  - The *Australian Drug and Alcohol Services Planning (DASP)* model a planning tool that identifies the need for alcohol and other drug treatment services in all states and territories
  - The annual *Health Needs Assessment (HNA)* prepared jointly by the PHN and Metro North Health using a comprehensive process of data collation, analysis and stakeholder consultation

- be developed through collaboration between Queensland Health, the PHN, Metro North Health and People with a Lived/Living Experience to improve alignment of commissioning approaches between commissioning agencies.

Shared objectives	Actions over the next five years
4.1 Align commissioning approaches between funding bodies.	• utilise the NMHSPF tools consistently across Brisbane North to help project demand for mental health services and required service configuration • utilise national and jurisdictional data sets for primary mental healthcare and alcohol and other drug treatment services, joint PHN and Metro North Health needs assessments and other data, to collaboratively plan and co-design mental health, suicide prevention and alcohol and other drug treatment services • develop a joint regional resourcing plan between commissioning agencies that underpins and aligns commissioning • align funding approaches by key funding agencies, including scope, timing, service types, contract timeframes and reporting • explore the potential for coordinating commissioning between funding agencies
4.2 Improve commissioning approaches.	• further develop funding approaches that focus on strengthening Consumer outcomes • identify commissioning approaches that facilitate innovation and partner with people with a lived experience • reflect in budgets the full cost of service, including resources required for engagement and warm referral of all People with a Lived/Living Experience accessing services • explore more flexible commissioning approaches that better fit the nature of services required, maximise collaboration and mitigate challenges associated with competitive tendering, including for Aboriginal and Torres Strait Islander services • utilise funding agreements with providers to promote service improvements in the areas of Lived/Living Experience participation, social determinants of health, recovery framework, family-inclusive practice, trauma-informed care, engagement, warm referral, service accessibility and evaluation

Progressing this work

This work will be steered by the Strategic Coordination Group. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

5. Delivering integrated services

Introduction

Increasingly, healthcare policy drivers, including in mental health, suicide prevention and alcohol and other drug treatment services, call for a more coherent service system with better integrated services that can deliver improved responses to the diverse range of healthcare needs that service Consumers experience. For example, the Queensland Mental Health Commission's Strategic Plan proposes that "*integrated and holistic responses are best achieved through strong, effective and outcomes-focused partnerships.*"[48] As a key driver in healthcare at both a state and national level, service integration is critical to this Plan and is essential to effective delivery of our stepped care framework.

In addition, quality delivery of integrated mental health, suicide prevention and alcohol and other drug treatment services is not possible without a skilled and diverse workforce. This workforce is comprised of staff from government and NGOs, staff in public hospitals and private healthcare practitioners, with many professional disciplines and qualifications represented as well as a myriad of roles, including peer workers.

What you told us

Consultation indicated the need for additional, and new and different, services, as well as for ensuring services are targeted to those who need them most. In addition, consultation suggested there is considerable work to do to align with, and implement, a stepped care framework and that this will necessitate new thinking about how we deliver more flexible services reflecting service Consumers' changing needs and circumstances.

Service integration and better alignment between key services were prominent consultation themes, including a focus on shared systems and tools to make this possible. Consultation participants also proposed an integrated, streamlined national approach to reporting regimes both across mental health, suicide prevention and alcohol and other drug treatment services and between regions.

To enable delivery of these new and different services, consultation participants emphasised the importance of identifying training and development needs for the mental health, suicide prevention and alcohol and other drug treatment services workforce and of putting in place a strategy to ensure these needs are effectively met. Meeting these needs must result in a workforce that is well placed for the future and has the skills to support the new directions we outline in this Plan. Training and development also needs to be evidence-informed and take into account the diverse disciplines and roles of our workforce, including our peer workforce. In addition, consultation proposed that to ensure services are accessible to Aboriginal and Torres Strait Islander service users, there needs to be greater representation of Aboriginal and Torres Strait Islander peoples in our region's workforce.

More broadly, consultation participants highlighted that Consumer outcomes would be improved by training for generalist health, social services, justice and education workers in specific skills relating to mental health and alcohol and other drug use, including training provided by People with a Lived/Living Experience.

Shared objectives	Actions over the next five years
5.1 Expand, diversify and better target services.	• explore and leverage opportunities for expanding provision of community-managed mental health and alcohol and other drug treatment services • focus funding investment and service delivery on those groups in most need, including specific population groups, geographic communities and diagnosis groups
5.2 Improve our service delivery.	• expand virtual and/or physical 'hubs' for people seeking mental health support and referral, including options incorporating peer service navigators • expand implementation of the electronic triage and referral tool for mental health (rediCASE) to support GPs and service providers to connect people to the services that are right for them • trial the Initial Assessment and Referral protocols for PHNs, to support GPs and service providers to connect people to the services that are right for them • using our stepped care framework, ensure regular review of needs of People with a Lived/Living Experience accessing mental health services and connect Consumers to services that best meet their changing needs and circumstances • strengthen our approaches to service delivery in the areas of recovery, harm minimisation and trauma-informed practice • explore and develop approaches to shared clinical governance mechanisms to allow for agreed care pathways, referral mechanisms, quality processes and review of adverse events

Shared objectives	Actions over the next five years
5.3 Align and integrate services.	• review and align My Mental Health, and HealthPathways, in the context of Head to Health, to ensure services are well promoted and readily accessible • explore the development of an electronic shared record that can be accessed by service Consumers, Metro North Health, primary healthcare practitioners and NGOs • review and further develop a clinical care pathway for people experiencing both mental illness and substance use issues • explore the need for establishing a care pathway for people experiencing mental illness and intellectual disability or autism • develop and implement a mechanism for the mental health, suicide prevention and alcohol and other drug treatment sectors to effectively and efficiently engage with broader health and human service sectors • advocate for an integrated, streamlined national approach to reporting regimes both across mental health, suicide prevention and alcohol and other drug treatment services and between regions • explore options for working with organisations delivering responses to eating disorders to inform and further develop regional service delivery models
5.4 Skill up and diversify our workforce.	• conduct a Brisbane North workforce needs assessment for the mental health, suicide prevention and alcohol and other drug treatment services sectors, including for the peer workforce • develop and implement a strategy addressing the above workforce's identified needs • facilitate access by the above workforce to discipline-specific, evidence-informed training, including on trauma-informed care, recovery-oriented practice, harm minimisation and family-inclusive practice • create opportunities for the above workforce to network, build relationships, improve referral approaches and work in partnership • expand and develop the Aboriginal and Torres Strait Islander workforce and peer workforce in mental health, suicide prevention and alcohol and other drug treatment services • facilitate access to training for generalist health, social services, justice and education workers in specific skills relating to mental health and alcohol and other drug use (e.g., Certificate IV in Mental Health, Certificate IV in Mental Health Peer Work or Mental Health First Aid)

Progressing this work

This work will be steered by the Strategic Coordination Group. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

6. Responding to diversity

Introduction

Brisbane North is a diverse community that is home to over 1,046,494 people.[49] A range of population groups are well represented as part of this diverse population and getting the right services, in the right place, at the right time, to these population groups is critical.

As at the 2016 Census, more than 20,000 people in Brisbane North identified as Aboriginal and Torres Strait Islander, an increase of over 40 per cent from the 2011 census. Over 40 per cent of this population lives in the Moreton Bay North subregion.[50] People who were born overseas represent almost one quarter of Brisbane North's population.[51] While there is little accurate data identifying the number of LGBTIQ+ Australians, LGBTIQ+ people are estimated to constitute up to 11 per cent of our population[52] making it likely that up to 105,000 LGBTIQ+ people reside in Brisbane North. Over 13 per cent of Brisbane North's population is aged 65 years and over, totalling over 129,000 people. This number has increased from 107,000 people in 2010 and the trend will continue, with the number of people aged 65 years and over expected to increase to 185,000 people by 2026.[53]

This chapter focuses on mental health and suicide prevention responses for these population groups, with the exception of responses meeting the needs of Aboriginal and Torres Strait Islander peoples, which are outlined in chapter seven and responses to the needs of diverse population groups requiring alcohol and other drug treatment services, which are outlined in chapter eight.

People from culturally and linguistically diverse backgrounds

What you told us

Consultation participants emphasised that the experience of people from culturally and linguistically diverse backgrounds of mental health issues are underpinned, and at times exacerbated by broader issues of cultural differences, language barriers and racial discrimination. On a more specific level, consultation indicated the need for better access to a range of services, including for new arrivals who have experienced torture or trauma. Issues such as difficulty in communicating needs, lack of use of interpreter services, a dearth of culturally diverse healthcare practitioners, services that are not culturally responsive and challenges around privacy and confidentiality were all cited as barriers to ready access.

The need for greater connection with community for people from culturally and linguistically diverse backgrounds was also reported, including the need for greater social support, the impact of social isolation and the need to learn about, and become connected with, necessary services and supports. The lack of affordability of services for people ineligible for assistance through Medicare was also raised by consultation participants. Challenges associated with the need for nutritional education and improved physical health were also seen as exacerbating issues associated with poor mental health.

Shared objectives	Actions over the next five years
6.1 Improve access to mental health services for people from culturally and linguistically diverse backgrounds.	• develop and implement a strategy to address poor access to mental health services by people from culturally and linguistically diverse backgrounds, including: – activities to improve the mental health literacy of people from culturally and linguistically diverse backgrounds; – education and training to service providers to improve the quality of services provided to people from culturally and linguistically diverse backgrounds; and – develop and implement strategies to incorporate routine screening for mental illness, alcohol and other drug use, and suicide risk within other health services • encourage providers across Brisbane North to adopt approaches such as the Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery • improve access to interpreter services by people from culturally and linguistically diverse backgrounds and their Families and Carers
6.2 Facilitate better connections to healthcare for new arrivals and migrants.	• empower culturally and linguistically diverse communities to develop community leaders who will support new arrivals to connect with mental health services • explore options for improving responses to mental health issues for new arrivals who have experienced trauma and/or torture
6.3 Address affordability issues for those not eligible for healthcare through Medicare.	• identify and promote mental health services that do not charge a fee for people from culturally and linguistically diverse backgrounds who are ineligible for Medicare • continue to explore opportunities to grow and expand free or affordable mental health services for people from culturally and linguistically diverse backgrounds who are ineligible for Medicare

Shared objectives	Actions over the next five years
6.4 Improve the physical health of people from culturally and linguistically diverse backgrounds experiencing poor mental health.	• encourage culturally and linguistically diverse service providers to promote physical health-related activities in the '*Prospectus: Mental Health Recovery and Clinical Programs*'[54] • increase the knowledge of GPs and mental health services about the physical healthcare needs of people from culturally and linguistically diverse backgrounds and services responding to these needs

LGBTIQ+ people

What you told us

Feedback from consultation participants centred around two aspects of improving mental health and suicide prevention services for LGBTIQ+ people: improving LGBTIQ+ people's access to these services; and improving the quality of these mental health services. The need to ensure services effectively engage LGBTIQ+ people and that access barriers are removed were highlighted. The theme of delivering higher quality service delivery focused on ensuring appropriate, non-discriminatory approaches are in place; mapping available services; strengthening the financial viability of some LGBTIQ+ groups; and more effectively responding to the adverse mental health impacts experienced by older HIV positive people impacted on by early drug treatment regimes.

Building inclusive communities without stigma and discrimination was also a prominent theme. Research indicates that 35 per cent of LGBTIQ+ people have had suicidal thoughts, compared to 13 per cent of heterosexuals, and 13 percent have attempted suicide, compared to three per cent of heterosexuals.[55] Given this, the need for improved suicide prevention was a clear priority for consultation participants with a call for better integrated referral and service delivery approaches for those at risk and those in hospital after a suicide attempt and for active and effective follow up after discharge from hospital.

Shared objectives	Actions over the next five years
6.5 Align and improve the response of mental health, suicide prevention, and alcohol and other drug treatment services to effectively address the needs of LGBTIQ+ people	• improve and maintain the quality of web-based and referral databases information that facilitates LGBTIQ+ people's access to appropriate mental health, suicide prevention, alcohol and other drug services, and LGBTIQ+ peer based supports • provide education and training to mental health, suicide prevention, and alcohol and other drug services and practitioners in appropriate, inclusive, non-discriminatory frameworks and methodologies appropriate for working with LGBTIQ+ people, including sub-populations that have specific needs (i.e. transgender, intersex, HIV, Aboriginal and Torres Strait Islander, etc.) • facilitate the promotion, distribution and consistent application of relevant LGBTIQ+ health standards of care, practice frameworks, research, information and health promotion resources • create timely, seamless referral pathways for LGBTIQ+ people to access the mental health, suicide prevention and alcohol and other drug services and support that they require, including LGBTIQ+ peer based supports
6.6 Build capacity of LGBTIQ+ community-led organisations, services and peer-based supports to provide sustainable quality mental health, suicide prevention and alcohol and other drug services and support for LGBTIQ+ people.	• resource and support LGBTIQ+ community led organisations, services, and peer based supports to deliver mental health, suicide prevention, and alcohol and other drug services and supports to LGBTIQ+ people and communities. • ongoing review and assessment of the resourcing needs and service delivery capacity of LGBTIQ+ organisations, services, and peer based supports • build and strengthen relationships within and between LGBTIQ+ organisations, services and peer based supports, and mental health, suicide prevention, and alcohol and other drug services • provide mental health, suicide prevention and alcohol and other drug professional development education and training to staff and volunteers working in LGBTIQ+ organisations, services, and peer based supports
6.7 Tailor specific suicide prevention efforts for LGBTIQ+ people and communities, with a key focus on sub-populations who have higher risks, including transgender, intersex, HIV, Aboriginal and Torres Strait Islander communities.	• LGBTIQ+ people accessing mental health, suicide prevention, and alcohol and other drug services are informed about LGBTIQ+ peer based supports and are supported to access these if they wish • increase awareness, knowledge and skills of LGBTIQ+ people and communities to recognise, respond to, and provide care to LGBTIQ+ people at risk of suicide • identify and address structural stigma within mental health care settings that impact on LGBTIQ people's access to services, and their health and wellbeing outcomes • develop responses to that address underlying social determinants of health that impact on the increased risk of suicide of LGBTIQ+ people, such as social isolation, stigma, prejudice and discrimination

Older people: Improving responses for older people in Brisbane North

In 2017, Metro North Health and PHN developed '*A five year health care plan for older people who live in Brisbane North*'[56] outlining our joint commitment to improving outcomes for older people in Brisbane North, including enhancing care for those who are most vulnerable, such as older people with a mental illness. In the table below, we include actions from this earlier Plan that focus on mental health to facilitate linkages between the two Plans. Progress on these actions will be reported and monitored through an Implementation Plan prepared jointly by Metro North Health and the PHN.

What you told us

Consultation reported that many older people lack connections with others and subsequently experience social isolation and mental illness. Participants also reported limited knowledge on the part of service providers accessed by older people about: available mental health care services; the relationship between physical and mental health issues for older people; and the need for greater integration of responses to mental and physical illness.

An overall shortage of mental health and suicide prevention services for older people was also described. Particular concern was expressed about older people living in residential aged care facilities being ineligible for Medicare rebates that subsidise psychological services (i.e. Better Access) for older people living in other types of accommodation and for the broader population.

The situation of those caring for older people, particularly as they themselves age, was also discussed, with an emphasis on the need to support these carers to sustain good mental health, including through accessing psychological services, peer support and other social supports.

Shared objectives	Actions over the next five years
6.8 Expand and diversify mental health services for older people.	• seek funding for and develop an evidence-based model of care to meet the sub-acute needs of psycho-geriatric People with a Lived/Living Experience and clients as well as Consumers and clients with challenging behaviours[57] • improve access to integrated specialist geriatric and psychiatric input for older people with mental illness[57] • explore options to support and expand the provision of mental health services to older people with mental illness, including depression, living in residential aged care facilities, ensuring activities are holistic and socially meaningful. • investigate development of ambulatory mental health services for older people that are co-located in the community setting and integrate medical, diagnostics and allied health together with providing support to navigate housing, social and finance matters[57]

Shared objectives	Actions over the next five years
6.9 Deliver high quality mental health and suicide prevention services for older people.	• develop a risk management approach for the detection of older people at risk of suicide, ensuring a holistic approach that considers: – broader social factors, – elder abuse, and – men over 85 years living in the community (who are at higher risk) • implement an education strategy for GPs on: factors that improve older peoples' mental health and prevent suicide; and referral pathways into mental health and suicide prevention services for older people. The strategy should consider the views of older people themselves, as well as carers, family members, in-home care staff and RACF staff • establish a forum where organisations with an interest in, and commitment to, improving care for older people with mental illness and/or cognitive impairment can meet to share information and ideas to improve service delivery and community support
6.10 Support those caring for older people to sustain good mental health.	• implement strategies to better support carers, particularly ageing carers, using psychological services, peer support and other social supports • develop carers' skills in mental health and suicide prevention through targeted training
6.11 Develop early intervention and prevention strategies focused on the social determinants of health.	• enhance service navigation and promote access to services and supports for older people, including through local council, sports clubs, community activities, community transport, construction and rural programs • address the mental health stigma experienced by older people, including self-stigma and encourage conversations to facilitate help-seeking behaviour

Progressing this work

This work will be steered by the Strategic Coordination Group. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

Part C

FOCUS AREAS

In this part of the Plan we outline our commitment to change in six focus areas, relating either to specific population groups or particular types of service delivery. For each focus area, we give an overview of the results of consultation and set out shared objectives and actions developed by funders, service providers, People with a Lived/Living Experience and Carers and Families working together to improve quality, coordination and integration.

7. Aboriginal and Torres Strait Islander social and emotional wellbeing

FACTS AND FIGURES

30.1% of Aboriginal and Torres Strait Islander adults report high or very high levels of psychological distress, **nearly 3 times** the rate reported by other Australians.[1]

GPs report they are **2 to 3 times more likely** to manage mental health problems related to substance use in Aboriginal and Torres Strait Islander patients than in other patients.[2]

The national suicide rate for Aboriginal and Torres Strait Islander Australians is **twice** that of non-Indigenous Australians.[3]

For Aboriginal and Torres Strait Islander Australians between 15 and 19 years of age, the suicide rate is **5 times higher** than for non-Indigenous Australians.[4]

Aboriginal and Torres Strait Islander peoples with substance use, and/or mental health disorders, require a **greater number of episodes of care** to effectively treat their condition.[5]

Introduction

The strategic context for delivering services supporting improved Aboriginal and Torres Strait Islander (First Nations) social and emotional wellbeing is well-established at both a national and a Queensland level. The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* emphasises the holistic and whole-of-life definition of health held by Aboriginal and Torres Strait Islander peoples and provides a resource to support organisations delivering culturally and clinically appropriate mental health services for First Nations peoples.[58]

At a Queensland level, Queensland Health's *Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021* aims to eliminate the gap in mental health outcomes between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders.[59] In addition, the *Queensland Mental Health Commission's Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan 2016-18: Proud and Strong* commits to actions to build inclusive communities, thriving and connected Families and resilient people.[60]

What you told us[f]

Social and emotional wellbeing is the foundation for physical and mental health for Aboriginal and Torres Strait Islander peoples. It is about a '*whole of life view*'[61] taking into account relationships between individuals, family, kin and community and recognising the impact on the individual of connection to land, culture, spirituality and ancestry.

Consultation emphasised that this understanding of social and emotional wellbeing necessitates holistic treatment and care that is led by Aboriginal and Torres Strait Islander peoples, is consistent with cultural and spiritual beliefs and practices and is inclusive of traditional healers, Elders and other cultural healers. Consultation also highlighted the importance of '*culturally tailored care*' that extends beyond a Consumer-centred approach to incorporate family, culture and community.[62] Consultation participants proposed that to effectively deliver this holistic, integrated care, health and community services need to work together to address the physical, mental health, social and emotional needs of Aboriginal and Torres Strait Islander peoples and to provide care that spans medical, psycho-social and cultural support.

There has been insufficient attention to establishing an evidence

f. Consultation for this chapter was conducted through collaboration between Brisbane North PHN and the Institute for Urban Indigenous Health (the Institute). We take this opportunity to acknowledge and thank the Institute for this work. We also acknowledge the contribution of Anton Clifford-Motopi who prepared the background paper presenting research and consultation on Indigenous social and emotional health and well-being

base for Aboriginal and Torres Strait Islander health programs and interventions focusing on social and emotional well-being.[63]Given this, consultation confirmed the strategic need to build this evidence base by establishing a research agenda taking into account factors such as cultural responsiveness and community participation.[64]

Reconciliation is about unity and respect between Aboriginal and Torres Strait Islander and non-Indigenous Australians[65] and can be achieved through proactively building positive relationships, respect and trust. Racism has a negative effect on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples and is experienced by a significant proportion of First Nations peoples in daily life.[66] Consultation highlighted that improving unity and respect between Aboriginal and Torres Strait Islander Peoples and non-Indigenous Australians will help to address racism and improve health outcomes for First Nations peoples.

Consultation also identified service gaps for Aboriginal and Torres Strait Islander people including: culturally responsive residential rehabilitation services for Aboriginal and Torres Strait Islander people experiencing problematic substance use; outreach models providing a broader range of services; transport to access healthcare services; safe accommodation for homeless Aboriginal and Torres Strait Islander peoples living with mental health and alcohol and other drug issues; and services responding to the needs of First Nations children and young people experiencing mental health issues, and to their families.

Shared objectives	Actions over the next five years
7.1 Foster Aboriginal and Torres Strait Islander leadership and engagement in planning, delivery and evaluation of services and programs.	• actively attract and support appropriate representation of Aboriginal and Torres Strait Islander people on Brisbane North PHN's partnership and governance groups • establish additional avenues for input to services by Aboriginal and Torres Strait Islander People with a Lived/Living Experience and their Carers • review Consumer satisfaction survey processes within PHN-commissioned mental health services to make them more culturally responsive and encourage other organisations to improve the cultural responsiveness of their Consumer satisfaction surveys
7.2 Increase cultural responsiveness amongst services and healthcare practitioners.	• support the further development of social and emotional wellbeing teams within Aboriginal Community Controlled Health Services (ACCHSs), Metro North Health and NGOs • require PHN-commissioned services working with Aboriginal and Torres Strait Islander People to embed the *Cultural Respect Framework*[67] and *Social and Emotional Wellbeing Framework*[68] into their organisational systems and processes and encourage providers across the region to adopt these or similar approaches • provide cultural responsiveness training to GPs, other medical practitioners, mainstream service providers and healthcare practitioners working in forensic settings • identify and promote best practice case studies of cultural responsiveness • continue to develop specific mental health, suicide prevention and alcohol and other drug care pathways for Aboriginal and Torres Strait Islander People in HealthPathways and ensure they are culturally responsive.
7.3 Improve accessibility of mental health services for Aboriginal and Torres Strait Islander peoples.	• work with relevant organisations and services to review and improve the NDIS's processes for Aboriginal and Torres Strait Islander peoples • explore options for making '*soft entry*' available through a greater number of mainstream mental health services, including through use of an Aboriginal and Torres Strait Islander worker as first point of contact for Aboriginal and Torres Strait Islander peoples who use services • strengthen partnerships between ACCHSs and general practices offering after hours care • review eligibility criteria for PHN-commissioned mental health services to identify and resolve any access barriers for Aboriginal and Torres Strait Islander peoples
7.4 Strengthen integration between services working with Aboriginal and Torres Strait Islander peoples.	• strengthen work across services and sectors and between clinical and non-clinical services, including through referral, assessment and joint case management, to ensure holistic, person-centred care that takes into account issues such as transport, housing and income • establish linkages between ACCHSs and mainstream mental health services, including community mental health, alcohol and other drug treatment services, primary healthcare practitioners and psychiatrists • increase the range of primary healthcare services readily accessible by Aboriginal and Torres Strait Islander peoples by improving provider partnerships

Shared objectives	Actions over the next five years
7.5 Invest in an evidence base for mental health, social and emotional wellbeing services and programs for Aboriginal and Torres Strait Islander people.	• review the methodology for the regional population health survey to explore opportunities for culturally responsive data collection on mental health and wellbeing of Aboriginal and Torres Strait Islander peoples • strengthen the focus on services delivered to Aboriginal and Torres Strait Islander peoples by better harnessing available data on Aboriginal and Torres Strait Islander health, including from Metro North Health's integrated health information system • ensure investments in new or existing Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing services are appropriately evaluated and enable community-led research; use of culturally responsive measurement methods; and participatory action research methods
7.6 Reconciliation between Aboriginal and Torres Strait Islander and non-Indigenous Australians.	• PHN and Queensland Health funded mental health services are to demonstrate effective strategies for improving cultural responsiveness and accessibility to services by Aboriginal and Torres Strait Islander peoples • hold regular networking and best practice forums for Aboriginal and Torres Strait Islander and non-Indigenous healthcare staff • establish an interchange program between mainstream and Aboriginal and Torres Strait Islander health services
7.7 Recognise that racism and discrimination are key social determinants of health for Aboriginal and Torres Strait Islander peoples.	• promote implementation of appropriate organisational processes within mental health services to identify, report and act on racism and discrimination and educate service Consumers and staff about these processes • use regional publications and newsletters to educate people about the effects of racism on healthcare for Aboriginal and Torres Strait Islander peoples
7.8 Respond to service gaps for Aboriginal and Torres Strait Islander peoples.	• identify options for culturally responsive residential rehabilitation services for Aboriginal and Torres Strait Islander peoples experiencing substance abuse and for support to successfully transition people exiting these facilities into the community • explore the potential to extend existing outreach models delivered by mental health services to provide Aboriginal and Torres Strait Islander peoples with support about living skills • investigate options for safe places for those living with people with alcohol and other drug dependence and/or mental health issues • assess national models for patient transport services and available existing local resources that assist with transport to improve access to healthcare • explore options for services that better respond to the needs of Aboriginal and Torres Strait Islander children and young people experiencing mental health issues, and to their Families • advocate for increased funding to improve and expand safe accommodation for homeless Aboriginal and Torres Strait Islander peoples living with mental health and alcohol and other drug use issues

Progressing this work

This work will be steered by the Aboriginal and Torres Strait Islander Engagement Steering Group. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

8. Alcohol and other drug treatment services

FACTS AND FIGURES

1 in 8 Australians aged over 14 years of age smoke every day.[1]

Individuals who are socioeconomically disadvantaged are **more likely to smoke**.[2]

17.4% of recent drinkers in Australia put themselves or others at risk of harm while they were under the influence of alcohol in the last 12 months.[3]

In the last 12 months, approximately **1 in 8 Australians** used at least 1 illicit substance and 1 in 20 misused a pharmaceutical drug.[4]

Illicit drug use in the last 12 months was **far more common** among homosexual or bisexual Australians and ecstasy and meth/amphetamine use in this group was **5.8 times** that of heterosexual people.[5]

In 2013, **22.6%** of people in the inner city in Brisbane North had recently used an illicit drug, compared with **13%** Queensland-wide.[6]

Introduction

The strategic setting for alcohol and other drug (AOD) treatment services varies from that for mental health and suicide prevention with national priorities drawn from the *National Drug Strategy 2017-2026*.[69] These specialist AOD treatment services work in a harm minimisation framework to support people experiencing a range of alcohol and other drug related harms to improve their psycho-social functioning and physical and mental health.

At a state level, the Queensland Mental Health Commission's *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-23* provides the strategic setting for Queensland's AOD treatment services alongside Queensland Health's *Connecting care to recovery*.[70] The Commission is leading the development of a renewed approach to alcohol and other drugs in Queensland as part of *Shifting Minds*; a consultation process is underway at time of publication.

What you told us

Consultation indicated that cohesive, integrated policy and program approaches are needed from government agencies whose policies impact on people requiring alcohol and other drug treatment services. For example, when treatment for problematic use of alcohol and other drugs is mandated by statutory authorities (e.g., Centrelink and child protection agencies), these authorities should ensure individuals are linked with treatment services and other supports. When this occurs, statutory authorities and/or funding agencies should also consider the capacity of alcohol and other drug treatment services to respond to these referrals and to any additional investment required to meet this additional demand.

Provision of greater connectivity between AOD treatment services and the establishment of assertive referral pathways between Adis 24/7 Alcohol and Drug Support and specialist alcohol and other drug service providers was highlighted. The use of assertive referrals aims to enhance AOD service connectivity and improve client navigation of AOD treatment options by sharing client information with participating service providers so that clients do not have to repeat their story.

People experiencing problematic substance use often face stigma and discrimination that prevents them from seeking assistance. The consultation revealed that this is particularly the case for people using illicit drugs or whose substance use is exacerbated by other factors such as mental illness, domestic violence, poverty or homelessness.

It is further compounded for LGBTIQ+ people, people from culturally and linguistically diverse backgrounds and Aboriginal

FACTS AND FIGURES

Use of illicit drugs continued to increase among older age groups, driven by the highest levels of cannabis use since 2015.[7]

People who identify as gay, lesbian or bisexual have **higher proportions of substance use than people who identify as heterosexual**. Daily smoking and drinking at risky levels has been on the decline in these populations, however the proportion indicating recent illicit drug use is more than double that of heterosexual people (36% v.16.1%).[8]

and Torres Strait Islander people. General practitioners are invariably the initial point of contact for many people seeking assistance to address problematic use.

Consultation discussions noted that, whilst the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) have incentivised specialised alcohol and other drugs training for general practitioners, a whole-of-practice approach is required. This requires training all staff within the practice to address elements of stigmatising and discriminatory approaches towards people accessing support from general practice.

A foundation of comprehensive data collection and analysis is critical to evidence-informed delivery of alcohol and other drug treatment services. Consultations proposed facilitating links between research facilities and service providers to allow for improved data analysis and research to further understanding of substance use, treatment access patterns and service gaps. In addition, it would create opportunities for innovation.

Problematic substance use by people because of their sexuality, gender identity, culture or ethnicity or in response to circumstances such as homelessness or poverty, needs to be better understood to improve access to services by these groups. Consultation proposed strategies for addressing inequities in the health of marginalised groups including peer support and awareness-raising on the part of health and welfare staff. Improved collection of baseline data to ascertain the needs of these groups and their service utilisation was also suggested.

Shared objectives	Actions over the next five years
8.1 Improve collaboration between alcohol and other drug treatment services.	• coordinate planning across Brisbane North to improve referral pathways and facilitate seamless access and transitions across the alcohol and other drug treatment services spectrum of care • deliver an education campaign for GPs on the use of HealthPathways, and the Adis – 24 hour alcohol and drug support, in assisting them to support patients experiencing problems related to the use of alcohol and other drugs
8.2 Build a region-wide commitment to challenging stigmatising and discriminatory practices.	• engage with media on use of inappropriate language in media coverage • build commitment of healthcare organisations and practitioners to delivery of a high standard of care for people using alcohol and other drugs and to addressing the stigma attached to people impacted by problematic use of alcohol and other drugs

Shared objectives	Actions over the next five years
8.3 Skill up our workforce.	• collaborate with the tertiary education sector to improve the skills base of undergraduate and postgraduate professionals in delivery of alcohol and other drug treatment services, including in mental health issues experienced by people with alcohol and other drug issues, and appropriate use of language • investigate and implement methods that ensure research insights flow into the development of the AOD workforce • revive communities of practice for front-line alcohol and other drug treatment services' workers • increase investment in professional development that builds capability to respond to complex alcohol and other drug use and mental health issues • build capability of school staff to recognise and respond to alcohol and other drug issues for students and colleagues
8.4 Support effective alcohol and other drug service delivery responses.	• use service delivery data to increase understanding of Consumer needs and improve service delivery • undertake a population survey profiling alcohol and other drug treatment services and assessing demand for services, service accessibility and treatment options responsive to specific population groups • support family inclusive approaches to delivery of alcohol and other drug treatment services • advocate for inclusion of gender identity and sexuality data in the *Alcohol and Other Drug Treatment Services National Minimum Data Set*
8.5 Improve services for at risk groups.	• support integrated, culturally responsive alcohol and other drug services • support collaboration and referrals between the community controlled sector and mainstream alcohol and other drug treatment services • identify current system responses, barriers and gaps for people with alcohol and other drug issues when they are in, or exiting, prison or youth detention • work with key government and non-government stakeholders to improve referral of Young People and Families experiencing problems related to the use of alcohol and other drugs • improve service responses and support by linking youth with alcohol and other drug treatment services to build capability in providing services to young people experiencing problems related to the use of alcohol and other drugs • provide LGBTIQ inclusion training to mainstream treatment providers and explore opportunities for LGBTIQ peer services

Progressing this work

This work will be steered by the Alcohol and Drug Partnership Group. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

9. Infants, Children, Young People and Families

FACTS AND FIGURES

In 2020/21, an estimated **5,456 children and young people** in Brisbane North are expected to experience severe mental illness and to require treatment for this.[1]

An estimated **30,007 children and young people** in Brisbane North are expected to experience moderate or mild mental illness in 2020/2021.[2]

80% of children and young people experiencing moderate mental illness and 50% experiencing mild mental illness will require treatment.[3]

In 2016/17, **1 in 13 students** aged between 12 and 17 who participated in the *Young Minds Matter* survey reported seriously considering suicide, with a third of those attempting suicide.[4]

The 2010 *Australian National Infant Feeding Survey* showed that **20% of mothers** of children aged 24 months or less had been diagnosed with depression, with **more than half of these mothers** reporting being diagnosed during the perinatal period.[5]

Introduction

Increasingly, governments, policy makers and researchers recognise the importance of getting a good start in life. A focus on early intervention and improving the wellbeing of infants, children, young people and their families is becoming critically important.

In addition, supporting and enhancing wellbeing in infants, children, young people and their families intersects closely with many other human services, including child development, family support and child protection services, early years and childcare centres, schools and services supporting families through the perinatal period, making an integrated approach between healthcare and other services and sectors essential.

What you told us

In 2019 we took a deeper dive into the child and youth mental health system to further develop our Regional Plan. The insights that emerged through this process reflect the conflict between the drivers and constraints of the child and youth mental health system, as well as the needs of service providers, children, young people and their families that are currently not being met.

There continues to be children and young people who do not receive supports, or who receive inappropriate support, because they fall outside of eligibility criteria for services. In particular, consultations highlighted that there is a 'missing middle' of young people who are too complex for headspace and private practice models yet are below the threshold for public mental health services. This gap has widened in recent years with the increase in demand for public mental health services.

For children and young people at risk of suicide, consultations revealed that a more supportive and effective system is needed. Furthermore, what 'crisis' looks like is very different from the perspective of different young people, families and service providers. A need to develop a common language of risk was identified, alongside a need to build the capacity of community-based organisations to respond to and manage risk appropriately.

Relationships are key to good outcomes, however the services and system are not oriented to support the development and maintenance of enduring relationships. Alongside the need to focus on relationships in the initial engagement and to establish good therapeutic alliance, stronger relationships amongst providers in the sector is also needed to ensure a better experience for children, young people and their families as they move through the system.

Consumer journeys developed through the consultation process revealed a common story of a child, young person or families' individual needs not being met through service provision, leading to disengagement from services without positive outcomes. They may then re-enter the system again at a crisis point or may avoid engaging despite a continued need. Service models need to be improved through targeting populations at higher risk of mental health difficulties, increased flexibility, and by implementing service models that place children and young people at the centre of care.

The fragmented and siloed child and youth mental health system creates inefficiencies, disruptive transitions and is difficult to navigate for both Young People with a Lived/Living Experience and service providers. Further, children, young people and families often have additional needs that fall outside the mental health care system and navigating between systems presents further challenges.

Consultation participants highlighted that the mental health of parents during the perinatal and infant period was crucial to the mental health outcomes of children and young people. Access to treatment and support for those experiencing perinatal mental illness, as well as opportunities to enhance parenting skills and build parent confidence during the perinatal period are crucial to early intervention and to improving mental health outcomes for infants, children and young people.

A focus on early intervention to reduce duration and severity of mental health difficulties and providing children and young people with strategies that increase protective factors against mental ill-health is important. Furthermore, children who are vulnerable through exposure to trauma need to be identified early and appropriate supports provided. Schools are well placed to identify and reach children and young people in need of support, however they also need to be better equipped to respond. This includes a more coordinated and integrated response between services and sectors to enable support services to be delivered to students.

Shared objectives	Actions over the next five years
9.1 Support all infants, children, young people and their families in the Brisbane North PHN region to access services across the stepped care continuum.	• develop a common language and understanding of key system concepts across the child and youth mental health sector • identify service and workforce gaps and develop responses to address these • use combined resources more flexibly and collaboratively to assist in bridging the gap between services, in particular between state and federally funded services • actively advocate for stakeholders to work collaboratively to meet needs of the cohort described as the 'missing middle'
9.2 Establish a supportive and effective system that responds to suicide risk amongst children and young people in the community.	• develop a shared common language of crisis and suicide risk across the child and youth sector • support and build the capacity of community-based organisations to respond to suicide risk • improve GP assessment and response to children and young people at risk of suicide • improve children, young people and families' experience when in crisis
9.3 Improve relationships across the service system, between services and with clients.	• improve the capacity of the service system to engage and build relationships with children, young people and families • support the development of enduring relationships between mental health services and with other relevant sectors

Shared objectives	Actions over the next five years
9.4 Work in partnership with children, young people and families to create services that are responsive to their individual needs.	• improve mental health services and supports for priority groups of infants, children and young people at higher risk of mental health issues • create better Lived/Living Experience engagement strategies at the service and systems level • implement service models that better respond to families with complex health needs, including better integration of adult and infant/child services
9.5 Improve system functioning so that children, young people and their families can more easily access the right support when they need it.	• when presented with opportunities, trial and evaluate innovative service delivery modalities that increase equitable access for children, young people and families, including telehealth and outreach • improve transitions for children and young people between children's and adults services • improve Consumer and service provider navigation of services and between service systems • implement implement integrated and coordinated service delivery models that place children, young people and their Carers at the centre of their care • support support GPs' central role in the child and young person's care

Progressing this work

This work will be steered by the Infant, Child and Youth Mental Health Partnership Group. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

10. Psychological therapies

FACTS AND FIGURES

An estimated **22,888 adults** (18 to 64 years of age) in Brisbane North are expected to experience severe mental illness in 2020/2021, all of whom are expected to require treatment.[1]

An estimated **97,500 adults** in Brisbane North are expected to experience moderate or mild mental illness in 2020/2021, with 26,200 adults expected to require treatment for moderate illness and 32,400 for mild mental illness.[2]

13,147 adults over 65 years of age in Brisbane North are expected to experience moderate or mild mental illness in 2020/2021.[3]

In 2011, an estimated **19% of adults over 65 years of age** in Brisbane North accessed PBS subsidised antidepressants, with 2.6% of the same group accessing MBS subsided GP mental health services.[4]

Introduction

This chapter focuses on delivery of structured psychological therapies, including low intensity psychological therapies. There are a range of providers of structured psychological therapies, with varying roles, in Brisbane North. In this chapter we focus primarily on community-based providers of psychological therapies, both private practitioners and NGO providers.

What you told us

There is little currently known about the preferences of People with a Lived/Living Experience accessing psychological therapies in Brisbane North, including about the modality or type of practitioner People with a Lived/Living Experience prefer or about where and when Consumers want to access services. For example, little is known about Consumer preferences for options such as low intensity services delivered by peer workers. Improving this understanding will enable providers in Brisbane North to better shape their services and the PHN to procure services that better meet the needs and expectations of People with a Lived/Living Experience who access services.

Consultation confirmed that psychological therapies must respond more effectively to the needs and preferences of people experiencing mental health conditions whose disadvantaged circumstances compound their mental health issues. These groups include: Aboriginal and Torres Strait Islander peoples; people who are marginalised due to their sexuality, gender, cultural background or occupation; people experiencing problematic alcohol and other drug use; people with an intellectual disability; and people who have experienced childhood trauma. A greater range of psychological therapies and providers that better address these diverse needs and preferences was proposed to achieve more equitable access and improve mental health outcomes.

We also lack regional information about the performance of psychological therapies with available data focusing on activities rather than on outcomes. Consultation participants proposed undertaking additional research to enable the shift to commissioning for outcomes, rather than for activities and outputs.

The results of consultation also reinforced the need for greater integration of psychological therapies with other services through mechanisms such as warm referrals, better pathways and Consumer plans that holistically consider Consumer needs. The context for this consultation finding is seen in the National Review of Mental Health Programs and Services which found that the mental health system is '*poorly planned and badly integrated*'.[70]

In addition, consultation participants highlighted the need for a more flexible workforce that is driven by Consumer demand; that focuses on competencies rather than on professional boundaries; and that can skilfully deliver a holistic approach connecting mental health specific supports to a broad range of human services. There is also a skewed distribution of the workforce delivering psychological therapies, resulting in inequitable geographic access to services. Improved geographic distribution of the workforce to support increased services in areas of greater need (i.e. Moreton Bay North) is proposed, as well as improved use of e- and tele-mental health services.

The stigma associated with accessing psychological services was an important theme from consultation, with discussion about how this stigma can serve to discourage people from disclosing their experience of mental health conditions or from seeking help, both of which are important steps towards improving mental health.

Shared objectives	Actions over the next five years
10.1 Better align psychological therapies with Consumer preferences and needs, including for specific population groups that cannot access appropriate options.	• research Consumer preferences and needs and promote findings of this research • align existing and newly-commissioned services with: – Consumer preferences and needs on modality of delivery, access hours and type of practitioner – the needs of specific population groups that cannot access appropriate options • develop, trial and evaluate an incentivised community-based service delivery model for specific population groups in Moreton Bay North • support a flexible approach to service delivery that emphasises client choice (i.e. combination of face to face and online options regardless of the client's geographic location with equal access to rebates) • better understand the impact of mental health care plans on people's willingness to access psychological therapies • improve client levels of technological literacy to maximise effective telehealth delivery • develop and promote Lived/Living Experience narratives that include how professional support can meet individual needs
10.2 Align with our stepped care framework through improved integration between psychological therapies and community services.	• develop an education strategy for GPs, other healthcare practitioners and NGOs on psychological therapies, including low intensity psychological therapies • build GP and public understanding about which style of therapist best meets different needs (i.e. difference between counsellors, psychologists, social workers, mental health nurses, brief therapy providers, etc.) • identify options for improving integration between community services and psychological therapies • promote examples enhancing integration between community services and psychological services • commission outcomes-focused practice models that achieve greater integration between psychological and community support services

Shared objectives	Actions over the next five years
10.3 Develop, diversify and geographically redistribute the workforce delivering psychological therapies.	• expand access to psychological therapies, including brief therapies, via phone, e-mental health, telehealth, face-to-face and groups, ensuring reach to high need communities. • improve use of e- and tele-mental health services in high need areas • increase the number of skilled peers and students delivering low intensity psychological services for hard to reach population groups • develop evidence informed *telehealth practice guidelines* (i.e. guidance and advice for providers on secure IT service delivery platforms, appropriate insurance, how to deliver services well online) • provide professional development opportunities for telehealth service delivery
10.4 Improve evidence base for effective psychological therapies.	• analyse service uptake and outcomes data to better understand the effectiveness of different service delivery options as a response for different population groups (e.g. for people experiencing mild, moderate and severe mental illness) • publish and share findings about effective use of psychological therapies as part of stepped care framework
10.5 Facilitate promotion and use of evidence-informed approaches addressing stigma associated with accessing psychological therapies	• identify low cost methods of effectively promoting evidence-informed approaches to reducing stigma across the community, including to different population groups • develop an approach to destigmatise and normalise the need to access psychological therapies (i.e. promote help seeking behaviours and Lived/ Living Experience narratives
10.6 Advocate for broader system supports that will improve psychological therapy service delivery and uptake	• MBS/NDIS access for counsellors • single-tier rebate for non-clinical psychologists • ongoing funding for telehealth service delivery • improve technological infrastructure and financial support to better enable telehealth delivery for both providers and users

Progressing this work

This work will be steered by the Psychological Therapies Advisory Group. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

11. Severe and complex mental illness

FACTS AND FIGURES

4 out of 5 people living with mental illness have a co-existing physical illness.[1]

People with severe mental illnesses are **particularly at risk** being **6 times more likely** to die from cardiovascular disease, **5 times more likely** to smoke and **4 times more likely** to die from respiratory disease.[2]

For people experiencing psychosis, there is a gap in life expectancy of **between 14 and 23 years**, compared with the general population.[3]

In 2018, an estimated **22,000 adults** (aged 18 to 64 years) in Brisbane North are expected to experience severe levels of mental illness. Approximately **33%** of this group will experience a severe mental illness that is persistent in nature, and a further **10%** will experience a severe and persistent mental illness, with enduring and disabling symptoms requiring service responses from multiple agencies.[4]

Introduction

This chapter focuses on responses to the needs of people experiencing severe and complex mental illness, who also often require services and supports from multiple agencies. Services for this group are delivered by a range of providers, including Metro North Mental Health Service and services provided by NGOs commissioned by a number of funding agencies including Queensland Health and the PHN. Given this, the objectives and actions set out in this Plan responding to the needs of people experiencing severe and complex mental illness must be seen alongside Queensland Health's commitment to this group through *Connecting care to recovery* and Metro North Health's commitment to delivering care to this group through public mental health and alcohol and other drug services, outlined in its *Mental Health Clinical Services Plan 2018-2023.*[72]

What you told us

Research demonstrates that people experiencing severe mental illness are more likely to experience health problems, to the extent that their death may be premature. The National Mental Health Commission proposes that, in response to this, the mental health system must respond to whole of life needs, including through reduction of risk factors such as smoking rates and obesity levels.[73] Consultation indicated that physical health related assessments and interventions are occurring in Brisbane North, but that lack of role clarity and of information sharing (with Consumer consent) between healthcare providers has resulted in limited integration of services, in service duplication and in service gaps.

Roll out of the NDIS commenced in some parts of Brisbane North in July 2017 and will conclude across the region on 30 June 2019. Some people experiencing severe and complex mental illness will be eligible to receive services from the NDIS and some will not. It is critical that people with an ongoing psycho-social disability who are not eligible for NDIS-funded services and supports, continue to access the services and supports they need. In addition, the NDIS will affect NGOs' business models and workforces. Consequently, consultation proposed that collaboration across the mental health sector is required to assist people with severe and complex mental illness to access the NDIS and to continue to meet the psycho-social needs of those who are not eligible for the NDIS. To continue to meet the psycho-social needs of those who are not eligible for the NDIS, three integrated mental health hubs have been implemented within the region.

The results of consultation highlighted that people experiencing severe and complex mental illness often have difficulty in obtaining and sustaining safe, secure and affordable housing.[g]

g. This is now even more problematic due to the closure of accommodation options including temporary housing, hostels and crisis accommodation during Covid-19.

Work to support people with severe and complex mental illness to obtain and sustain appropriate housing is occurring, but more needs to be done to improve consumer outcomes.

Consultation participants painted a picture of people with severe and complex mental illness often experiencing social and economic isolation. They indicated that while relevant responses addressing this isolation are delivered by the mental health sector in Brisbane North, there is duplication of effort in some areas and service gaps in others. Consequently, more work is needed to identify what service consumers need and want in this area, to explore responses that are better connected to the broader community and to identify realistic pathways into employment, with the objective of supporting people with a severe and complex mental illness to lead a '*contributing life*.'[74]

A further theme emerging from consultation was the need for better services for people experiencing borderline personality disorder. Issues raised included the lack of suitable treatment options along the continuum of care for this group, as well poor accessibility of existing services. Consultation participants proposed exploring best practice and identifying more suitable options.

Progress has already been made in Brisbane North on service system improvements benefiting people experiencing severe and complex mental illness. Priority areas have included work towards establishing 'safe spaces' for people experiencing severe and complex mental illness who are distressed and improving processes for hospital entry, hospital stays and discharge. This Plan commits to continued work in both these areas.

Shared objectives	Actions over the next five years
11.1 Improve the physical health of people experiencing severe and complex mental illness.	• develop an action plan in line with the Equally Well Consensus Statement to address the physical health needs of people with severe and complex mental illness in our region • support the delivery of programs/initiatives in the region that promote physical health (nutrition, diet and physical activity) and wellbeing for people living with severe and complex mental illness
11.2 Assist people experiencing severe and complex mental illness to access and sustain safe, secure and affordable housing.	• collaborate with the housing and homeless sector to improve referral pathways and identify systemic gaps to service access for people living with severe and complex mental illness • develop an action plan to improve access to safe, secure and affordable housing for people living with severe and complex mental illness
11.3 Employ an evidence-based approach to improving social, economic and community inclusion for people experiencing severe and complex mental illness.	• review existing qualitative and quantitative research to identify knowledge and service gaps, and explore the service needs of people experiencing severe and complex mental illness and social and economic inclusion • develop an evidence based action plan to address the social and economic inclusion of people with severe and complex mental illness
11.4 Establish alternatives to hospital EDs for people experiencing severe and complex mental illness who are distressed.	• identify and promote existing alternatives to hospital Emergency Departments (EDs) for people experiencing severe and complex mental illness who are distressed • secure funding to support implementation of the Safe Spaces three tiered model in line with the Safe Spaces implementation plan

Shared objectives	Actions over the next five years
11.5 Improve the experience of people living with severe and complex mental illness who are transitioning between hospital and the community.	• evaluate recommendations implemented from Discharge Transition Action Group (DTAG) on improving admissions, hospital stays and discharge planning • design and implement a project that supports clients preparing for discharge in their transition from hospital to community living
11.6 Improve services for people experiencing borderline personality disorder (BPD).	• develop a best practice model to provide a full range of services across the continuum of care

Progressing this work

This work will be steered by Collaboration in Mind, the partnership group focusing on severe and complex mental illness. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

12. Suicide prevention

FACTS AND FIGURES

Suicide remains the leading cause of death for Australians aged between 15 and 44 years.[1]

Men are approximately three times more likely to die as a result of suicide than women. However, women are more likely to be hospitalised for intentional self-harm.[2]

Suicide rates among Indigenous Australians are **at least twice** that of non-Indigenous Australians.[3]

People who identify as LGBTI+ are more likely to attempt suicide, to have thoughts of suicide and to have engaged in self-harm.[4]

Aboriginal and Torres Strait Islander youth under 25 years of age accounted for **41% of all suspected suicides** by Aboriginal and Torres Strait Islander Queenslanders.[5]

Adopting a systems approach

The *Fifth National Mental Health and Suicide Prevention Plan* describes the personal impact of suicide in Australia as profound, with a significant impact on families, communities and society as a whole. This profound impact is demonstrated by an increase of over 20 per cent in the number of deaths by suicide in Australia over the last decade. Overseas evidence points clearly to the benefits of combining suicide prevention strategies into an integrated, systems-wide approach recognising that multiple, concurrent strategies are likely to generate greater effects than separate implementation of individual strategies.

There are various evidence-informed systems approaches to suicide prevention, including *Zero Suicide in Healthcare, European Alliance Against Depression, the WHO's Preventing Suicide A Global Imperative* and the *LifeSpan* model. We have adopted the evidence-informed, systems-wide approach developed by the Black Dog Institute, *LifeSpan*, to shape and guide our regional approach to suicide prevention.[75]

What you told us

Community members told us that we lack clear pathways to care for people in Brisbane North who are experiencing a suicidal crisis, have attempted suicide or have been bereaved as a result of suicide. Consequently, community members, GPs, hospital staff, healthcare practitioners and service providers do not have a well-developed understanding of which services to refer to, resulting in people often not receiving the right care in the right place at the right time. In response, documented pathways to assist both health professionals and community members to find their way to the right service for their needs have been developed and are available to members of the North Brisbane community.

People who have attempted suicide often present to hospital EDs for support and care. However, we know that the noise and pace of an ED is not always the best place for a person in crisis. Our consultation participants recommended the following changes to improve the care provided in ED to people at risk of suicide:

- enhanced suicide prevention training for ED staff, including mandatory training
- improved attitudes on the part of ED staff when working with people who are suicidal
- expertise from People with a Lived/Living Experience as a core component of the available skill set in EDs
- appropriate alternatives to EDs such as accessible 'safe spaces' for those who do not require hospital admission or assistance through ED, and who find presenting at ED distressing.

FACTS AND FIGURES

Significant life events are often reported as co-occurring with suicide including:[6]

- Relationship separation and conflict (in 42.5% of suicides)
- Financial problems (18.3%)
- Interpersonal or familial conflict (15.7%)
- Bereavement (13.2%)
- Recent or pending unemployment (12.7%)
- Pending legal matters (11.6%)
- Work or school problems (8.9%)

Over half (51.5%) of Queenslanders who died by suicide between 2014 and 2016 reportedly had **one or more diagnosed mental health condition**. Over one-third (38%) of those who died by suicide showed evidence of an **untreated mental health condition**.[7]

Timely follow up care provided within the first 24 hours, first week and first few months after a suicide attempt or crisis is crucial to keep people safe. However, consultation participants reported frequently needing to wait at least a few days, and up to a few weeks, before they can access counselling or support. Community members told us that the mental health system does not have sufficient follow up capacity; that people must wait to access a GP for referral to a counsellor and services that can respond to factors contributing to a suicide attempt, such as job loss, housing issues or relationship breakdowns, are not always readily available. In response, an after-care follow up service is now in place across Redcliffe and Caboolture to ensure prompt follow up (within 24 hours) and ongoing care (for up to three months) of a person following a suicide attempt or crisis. The development of a similar service closer to the centre of Brisbane will be in place in 2021.

The need for suicide prevention services that offer more person-centred, comprehensive and coordinated care was also reported by consultation participants. Holistic services and supports, including case management, need to be in place to respond to all the needs and life circumstances contributing to an individual's suicide risk. Suicide prevention services must also be available of an evening and over the weekend and more accessible information about suicide prevention services is required. In addition, consultation indicated that it is vital that any responses outlined in this Plan, including innovative new models, be well connected with existing services and supports, rather than operating in parallel to them. Brisbane MIND has responded to these challenges and people can now access dedicated suicide related psychological support services across the region with evening and weekend availability.

When a person experiences a suicidal crisis, has attempted suicide or has been bereaved as a result of suicide, they need to be skilfully supported by people with specific expertise and comprehensive knowledge of resources and services. Consultation participants indicated improved knowledge and expertise is needed by community members in contact with people who are suicidal (i.e. 'connectors'),[76] frontline mental health workers, GPs, schools and suicide prevention specialists. This improved knowledge and expertise needs to be underpinned by the systems approach adopted in suicide prevention and, where possible, be realised through joint educative approaches by relevant stakeholders. Comprehensive training has been rolled out across all of these audiences in recent years, but much work is still to be done.

Shared objectives	Actions over the next five years
12.1 Improve and integrate suicide prevention responses on a systems-wide basis in Brisbane North.	• continue implementation, delivery, monitoring and evaluation of initiatives and services funded through the *Australian Government's National Suicide Prevention Trial 2017-2019*[h] • identify suicide hotspots and high risk suburbs and high risk industries and explore opportunities to deliver suicide prevention focused initiatives in these areas • embed promotion of the HealthPathways[i] suicide prevention pathway in all relevant communications and collaborate with developers on strategies to enhance usage • develop, and promote to all Brisbane North organisations, a template for a suicide prevention and postvention plan that incorporates workplace wellness and postvention strategies
12.2 Improve care and follow-up provided on presentation at HHS EDs, and on hospital discharge, to people experiencing a suicidal crisis, or who have attempted suicide.	• implement the Zero Suicide framework in services/organisations that are funded as part of the HealthCare Multi-Site Collaborative[j] • investigate, identify and advocate for the use of evidence based guidelines for non-mental health staff, focused on the support of people at risk of suicide who present to hospital • support continued the roll out of the *Suicide Risk Assessment and Management in an Emergency Department Setting* (SRAM-ED) and regularly monitor evaluation findings to inform advocacy efforts • seek funding to test and evaluate evidence-informed approaches for involving People with a Lived/Living experience of suicide as a resource in EDs, including those approaches locating peer support workers in EDs • explore options to improve care pathways for people experiencing a suicidal crisis and who are currently arriving at ED by ambulance • trial 24/7 '*safe spaces*' or other alternatives to EDs for people experiencing a suicidal crisis who do not require hospitalisation (links with actions in chapter 11)
12.3 Establish innovative, assertive follow-up suicide prevention service delivery models that utilise lived experience.	• identify and prioritise funding for additional assertive follow-up services and for services providing holistic support • expand capacity of existing providers of specialist suicide prevention services to provide, and make referrals to, person-centred, comprehensive and coordinated support • develop suicide prevention service delivery models utilising peer service navigators
12.4 Increase accessibility of care after a suicide attempt for vulnerable population groups.	• prioritise the needs of vulnerable and hard-to-reach populations through support for and inclusion of mobile suicide prevention outreach services in suicide prevention initiatives • improve integration of, and connection between, existing services focusing holistically on social determinants of health and suicide prevention services • undertake service mapping to identify current suicide prevention support services and service gaps for veterans and their families • develop and fund specialised bereavement support groups for different cohorts, including for veterans and/or their families • explore strategies for how people experiencing relationship difficulties (i.e. the life event most frequently reported as associated with suicide) can be proactively supported

h. Brisbane North is a trial site for the Australian Government's National Suicide Prevention Trial 2017-2019.

i. This action aligns with the work of the Queensland Suicide Prevention Health Taskforce.

j. Funded by the Queensland Suicide Prevention Taskforce and implemented in ten HHSs across Queensland, including in Metro North HHS at Caboolture and Redcliffe.

Shared objectives	Actions over the next five years
12.5 Improve access to high quality local suicide prevention services, information and resources.	• enhance, and make more accessible, support for Families and Carers of people who are suicidal, and others bereaved by suicide • adjust service models to enable suicide prevention services to provide after hours and weekend services • develop a register of professionals who have successfully completed advanced suicide prevention training
12.6 Increase community knowledge about, and skills in, recognising and responding to suicidality.	• explore and develop a strategy to better support people who are engaged with the Family Court and have child custody issues, encompassing strategies that target the needs of clients and personnel • deliver community education on recognising, and responding to, someone who may be at risk of suicide • deliver training to frontline workers on recognising and responding to someone who is at risk of suicide • increase opportunities for community members to be involved in suicide prevention efforts by safely sharing their lived experience
12.7 Better equip GPs and other professionals to identify and support people at risk of suicide.	• facilitate opportunities for GPs to be regularly informed of evidence based recommendations for supporting people at risk of suicide who present to general practice • encourage GPs to utilise rediCASE (see pages 24) and the HealthPathways referral pathway to assist them to better match people at risk of suicide with the right services • promote a whole of practice approach to identifying and managing clients at risk of suicide who present to general practice, through the provision of information, training and resources • increase opportunities for suicide prevention knowledge and skill development for mental health professionals, to enable and promote evidence tailored responses to people experiencing suicidality
12.8 Advocate for delivery of school-based suicide prevention programs for young people.	• support providers to deliver evidence-informed suicide prevention programs in schools where these programs are not currently available • support the roll out of the National Education Initiative and identify training opportunities for school staff through the Initiative

Progressing this work

This work will be steered by the Suicide Prevention Strategic Partnership Group. An Implementation Plan for this chapter will guide the work and report on it. As part of implementation planning, further work will occur with key stakeholders to develop, refine and prioritise actions and to consider service system impacts.

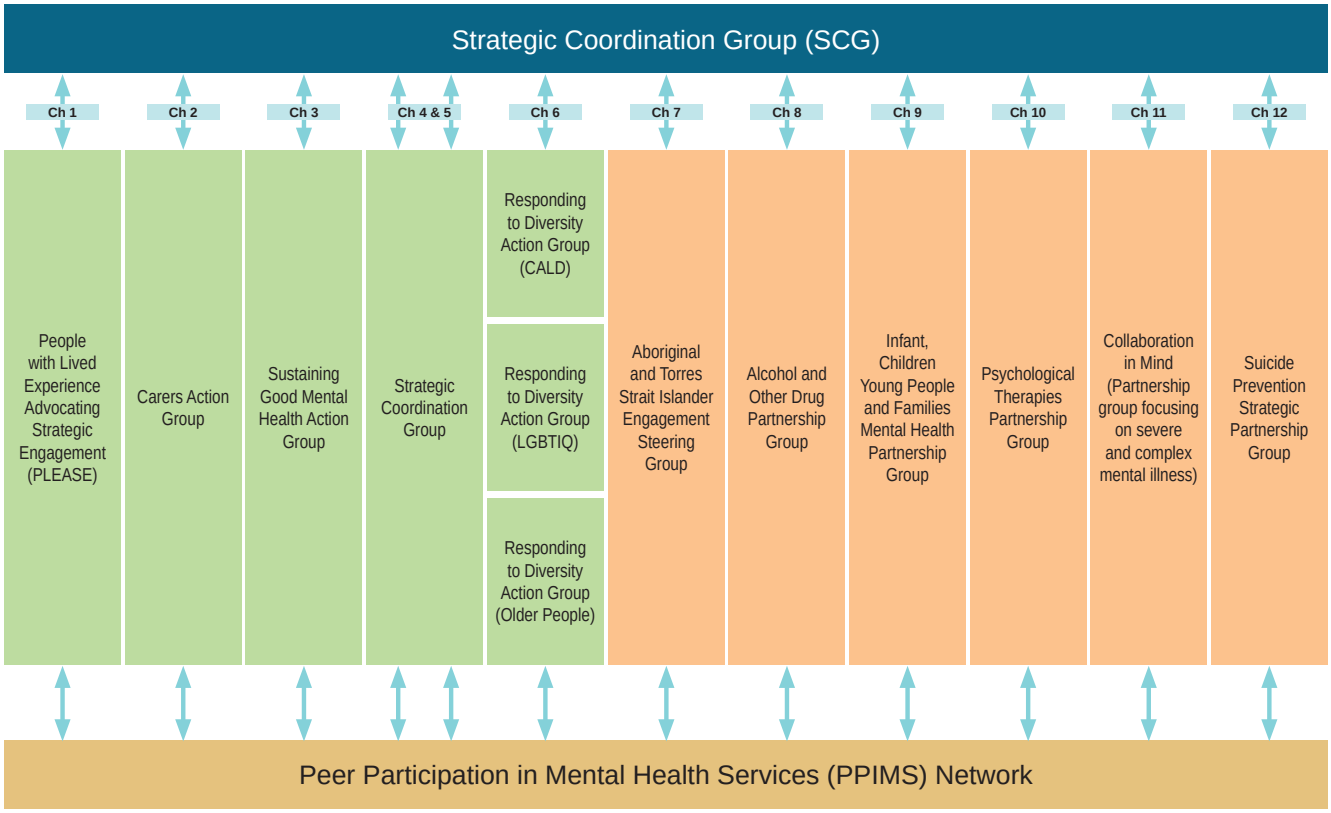
Part D

MEASURING, MONITORING, REPORTING

In this part of the Plan we outline our commitment to robust governance and performance measurement. We do this by outlining our governance approach, how we will monitor progress against the Plan, our approach to measuring individual and service system outcomes and our commitment to refreshing and reviewing the Plan.

13. Our governance approach

To ensure that we achieve the vision and outcomes we have described for this Plan, and effectively implement the actions we have committed to, we will establish a robust governance approach, combining new governance structures with the PHN's existing partnership groups. While development of this Plan has been auspiced by the PHN and Metro North Health, it is intended as a plan for the whole of Brisbane North. Membership of our governance structures will need to reflect this by engaging key stakeholders. We present below an outline of our proposed governance structures, followed by actions to support establishment of these structures.



These governance mechanisms will operate as follows:

- A **Strategic Coordination Group** will be established as the overarching governance mechanism for the Plan with members including People with a Lived/Living Experience, Brisbane North PHN, Metro North Health, Queensland Health, Queensland Network of Alcohol and other Drug Agencies and the Queensland Alliance for Mental Health. This Group will oversee the development, implementation, monitoring, review and evaluation of the Plan as a whole, as well as overseeing and monitoring work from chapters two to six of this Plan.
- The **PPIMS Network** will oversee work from chapter one of the Plan. The PPIMS Network will also have a role in ensuring that people with a lived experience are effectively engaged in implementing, monitoring, reviewing and evaluating the Plan as a whole.
- Six **focus area partnership groups** (listed in the diagram above) will together oversee work in chapters seven to 12 of the Plan, with each partnership group having responsibility for work relating to one focus area.

Shared objectives	Actions over the next five years
13.1 Establish and sustain a robust governance approach to oversee the Plan.	• establish a Strategic Coordination Group as the overarching governance structure • ensure that governance structures for the Plan provide authentic opportunities for participation of, and collaboration with, People with a Lived/Living Experience • establish and sustain multi-sector partnership groups in six key focus areas outlined above

14. Measuring outcomes, implementing, and reviewing the Plan

Measuring and monitoring outcomes

Consultation to develop this Plan identified the need to improve how we measure and evaluate individual and service system outcomes and to use this and other data to drive service improvement so that people in Brisbane North can access the right service in the right place at the right time. Strategies proposed in response to this need for improved outcomes measurement included: active involvement of people with a lived experience in developing and monitoring outcome measures; development and implementation of better outcome measures in mental health and alcohol and other drug treatment services; enhanced processes for use of data and evaluation findings to drive improvement; and establishment of a common Consumer experience tool across mental health, suicide prevention and alcohol and other drug treatment services.

Implementing and reporting against the Plan

To progress work outlined in each chapter of the Plan, work on Implementation Plans is well underway. Implementation Plans include more detail about work to realise the objectives and actions outlined in the Plan and establish responsibilities and timeframes. As part of implementation planning, work will continue with stakeholders to develop, refine and prioritise actions and to take into account other factors such as the work needed to realise actions and service system impacts.

Outcome measures and a reporting approach will also be developed. This work will consider minimum data sets already in place for mental health and alcohol and other drug treatment services and work done by other agencies on measuring outcomes, including by the Queensland Mental Health Commission and the Australian Government in *The Fifth National Mental Health and Suicide Prevention Plan* (see Appendix Four). The Plan will be monitored by the governance structures outlined in chapter 13 using this reporting approach and a report on progress against the Plan will be prepared and made available on an annual basis.

Refreshing and reviewing the Plan

Action 14.4 within the first iteration of *Planning for Wellbeing* committed us to undertake a mid-term review of the plan. The refresh for this iteration of the plan began 18 months into implementation, in January 2020. Whilst many actions were yet to begin or still underway, a significant number had already been completed. A summary of the achievements from the first 12 months of implementation has been prepared, and has been made publically available on the Planning for Wellbeing website – www.planningforwellbeing.org.au

Shared objectives	Actions over the next five years
14.4 Refresh and review the Plan.	• identify and realise opportunities to ‘refresh’ and update the Plan • undertake a mid-term review of the Plan

During the first 12 months of implementation, a small number of changes to the plan were identified by stakeholders. In January 2020, the Strategic Coordination Group endorsed a consultation approach to suggest any headline changes to refresh the Plan. The refresh was to include:

- Edits to actions due to changed external factors
- Follow up actions to those that were completed as a first step (such as those beginning with explore… identify…scope…); and
- Addition of new or important actions that were not included in the first iteration of the Plan

In addition to recommending necessary edits to actions, the Strategic Coordination Group also invited the partnership and stakeholder groups for each chapter in this plan to identify the priority need or gap impacting negatively on people in the Brisbane North and Moreton Bay region. Whilst we were not aware of new funds flowing into the region, we saw value in ensuring that our collective understanding remained current regarding these important issues. This updated suite of priority needs has been used in conjunction with existing funding data and projections from service planning tools to highlight gaps in mental health investment in the Brisbane North and Moreton Bay region.

In early 2020, the Strategic Coordination Group agreed that *Planning for Wellbeing* would be a 5-year rolling plan, with a commitment to review and refresh the plan every three years. Therefore, this refreshed iteration of the Plan will remain active for the period 2020 – 2025, with another planned review to occur again in 2023.

In addition to reviewing and refreshing the plan, this iteration of *Planning for Wellbeing* has committed to the following objectives and actions over the next 5 years:

Shared objectives	Actions over the next five years
14.1 Measure and report on our progress against the Plan.	• prioritise the development of success and outcome measures and measure progress against the Plan • establish a reporting approach, using Implementation Plans, to support governance groups to monitor performance against the Plan
14.2 Strengthen our outcomes approach.	• develop impact and outcome evaluation indicators for mental health at the individual, service and system levels • implement the Queensland alcohol and other drug outcomes framework
14.3 Drive service and system improvement through better use of data and evaluation.	• develop a process to collaboratively utilise data and evaluation to drive service and system improvement • identify and implement a common Consumer experience tool across Metro North Health, the PHN and community managed services
14.5 Develop a comprehensive Regional Plan.	• develop a comprehensive regional plan that considers new and extended services proposed in conjunction with data from planning tools that project future demand

Following the completion of this refresh, this Plan will prioritise the development of both a comprehensive regional resourcing plan (14.5), and a suite of success and outcome measures that measure the progress of this Plan over time (14.1).

15. Regional Resourcing Plan

Chapter 15 of this refresh is still in development, and will be added to this refresh in the coming months, as further resourcing information is made available.

This regional resourcing chapter will present an overview of our current resourcing of services in the Brisbane North region, outlining opportunities and priorities for expanding, diversifying and extending service delivery once funding is available. As per objective 14.5 above, this Plan commits to develop a comprehensive regional plan that considers new and extended services proposed in conjunction with data from planning tools that project future demand.

APPENDICES

Appendix One: Summary of strategic drivers

In the table below, we summarise national and statewide strategy and policy drivers that together constitute the context for this Plan. We do not endeavour to capture the detailed work incorporated in the policies and strategies we list, but instead provide only a high-level description. In addition, we have focused on overarching policy and strategy drivers only, rather than those relating to specific population groups or types of service delivery.

Summary of strategy and policy drivers		
Source	Policy/strategy document	Examples of key messages
Australian Government	*National Mental Health Commission, Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services (Vol. 1).*	• The mental health service system has fundamental structural shortcomings. • The impact of this poorly planned and badly integrated system is a drain on people's wellbeing and participation in community. • The mental health service system should be redesigned based on three components: person-centred design principles; a new system architecture; and shifting funding to more efficient and effective 'upstream' services and supports (including prevention and early intervention). • Funds for people with severe and persistent mental health problems must be repackaged to become integrated packages of services. • The system needs to move to one which is easily navigable; involves People with a Lived/Living Experience, and their Families and Carers, in decisions; focuses on outcomes; responds to whole-of-life needs; and is proactive and strategically aligned.[77]
	Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Services and Programs.	• Points to "*fragmentation, inefficiency, duplication and a lack of planning and coordination at a local level*" in the mental health service system. • Proposes service integration and an approach that is about: thinking nationally, acting locally; delivering services within a stepped care approach; and shifting the balance to provide the right care when it is needed. • Outlines nine interconnected areas of reform: 1. Locally planned and commissioned mental health services through PHNs. 2. A new digital mental health gateway. 3. Refocusing primary mental health services to support a stepped care model. 4. Joined up support for child mental health. 5. An integrated and equitable approach to youth mental health. 6. Integrating Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing services. 7. A renewed approach to suicide intervention. 8. Improving services and coordination of care for people with severe and complex mental illness. 9. National leadership in mental health reform.[78]

Summary of strategy and policy drivers		
Source	Policy/strategy document	Examples of key messages
	The Fifth National Mental Health and Suicide Prevention Plan.	• Vision is for a mental health system that enables recovery; prevents and detects mental illness early; and ensures all Australians with a mental illness can access treatment and support, allowing them to participate in the community. • The Plan establishes eight priorities: 1. Achieving integrated regional planning and service delivery. 2. Effective suicide prevention. 3. Coordinating treatment and supports for people with severe and complex mental illness. 4. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. 5. Improving the physical health of people living with mental illness and reducing early mortality. 6. Reducing stigma and discrimination. 7. Making safety and quality central to mental health service delivery. 8. Ensuring that the enablers of effective system performance and system improvement are in place.[79]
	National Drug Strategy 2017-2026.	• The Strategy aims to build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms among individuals, families and communities. • The Plan proposes a balanced approach across the three pillars of harm minimisation: demand reduction; supply reduction; and harm reduction. • Priority actions are to: 1. Enhance access to evidence-informed, effective and affordable treatment. 2. Develop and share data and research, measure performance and outcomes. 3. Develop new and innovative responses to prevent uptake, delay first use and reduce alcohol, tobacco and other drug problems. 4. Increase participatory processes. 5. Reduce adverse consequences. 6. Restrict and/or regulate availability. 7. Improve national coordination. • People with mental health conditions are one of the priority populations identified by the Strategy.[80]

Summary of strategy and policy drivers		
Source	Policy/strategy document	Examples of key messages
Queensland Government	*Improving mental health and wellbeing: Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019*.	• The vision articulated by the Plan by the Queensland Mental Health Commission is for "*A healthy and inclusive community, where people experiencing mental health difficulties or issues related to substance use have a life with purpose and access to quality care and support focused on wellness and recovery, in an understanding, empathic and compassionate society*." • The Plan establishes four pillars of reform: 1. Better services for those who need them, when and where they need them. 2. Better awareness, prevention and early intervention to reduce the incidence, severity and duration of problems. 3. Better engagement and collaboration to improve responsiveness to individual and community needs. 4. Better transparency and accountability to ensure the system is working as intended and in the most effective, efficient way possible. • Eight shared commitments are also established to address immediate priorities: 1. Engagement and leadership priorities for individuals, Families and Carers. 2. Awareness, prevention and early intervention. 3. Targeted responses in priority areas. 4. A responsive and sustainable community sector. 5. Integrated and effective government responses. 6. More integrated health service delivery. 7. Mental Health, Drug and Alcohol Services Plan. 8. Indicators to measure progress towards improving mental health and wellbeing.[81]
	Queensland Health, *My health, Queensland's future: Advancing health 2026*.	• *My health, Queensland's future: Advancing health 2026 (My health)* was developed by Queensland Health to guide Queensland Government investment into health and to reorient the Queensland health system to be flexible and innovative and take account of new technologies, while improving health care for Queenslanders. • It establishes a vision, indicating that '*by 2026 Queenslanders will be among the healthiest people in the world*' and is underpinned by five principles: sustainability; compassion; inclusion; excellence; and empowerment. • My health establishes four directions: 1. Promoting wellbeing. 2. Delivering healthcare. 3. Connecting healthcare. 4. Pursuing innovation. • For each of these four directions, focus areas are established as well as headline success measures.[82]

Summary of strategy and policy drivers		
Source	Policy/strategy document	Examples of key messages
	Connecting care to recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services.	• Through *Connecting care to recovery*, Queensland Health aims to embed the directions outlined in *My health, Queensland's future: Advancing health 2026* and continue building more person-centred and recovery-oriented services in the mental health and alcohol and other drug services system by: » promoting wellbeing » delivering health care » connecting healthcare » pursuing innovation. • *Connecting care to recovery* aims to reform and improve the mental health and alcohol and other drug treatment service system in a manner consistent with the principles and directions outlined in *My health, Queensland's future: Advancing health 2026* by focusing effort across five priority areas: » access to appropriate services as close to home as practicable and at the optimal time » workforce development and optimisation of skills and scope. » better use of ICT to enhance clinical practice, information sharing, data collection and performance reporting » early identification and intervention in response to suicide risk. strengthening patient's rights under the *Mental Health Act 2016*.[83]

Appendix Two: Pre-refresh consultation feedback and objectives

Healthcare area	Consultation feedback	Shared objectives
People with a Lived/Living Experience leading change.	• 'nothing about us, without us' • strengthen the collective voice of People with a Lived/Living Experience • make it easier for People with a Lived/Living Experience to be active partners in planning, co-designing, delivering and evaluating services • make services accountable to People with a Lived/Living Experience • must support each other and be informed • need stronger participation and collaboration mechanisms • strengthen participation by People with a Lived/Living Experience in the workforce, both in peer work and in broader roles	• strengthen and diversify the collective voice of People with a Lived/Living Experience to drive service improvements • make available training and capacity building for People with a Lived/Living experience • establish better opportunities for participating in planning, delivery and evaluation of services • establish and sustain a consistent region-wide approach to participation in services • advocate for an expanded and more diverse regional Lived/Living experience workforce, across all levels of employment
Supporting Families and Carers.	• Families and Carers are not included, supported and welcomed by service providers • communication between service providers, Families and Carers is lacking • financial hardship experienced as a result of caring role • Carers are not clear on benefits those they care for are entitled to	• provide information, resources and skills building to support Families and Carers • better care for Families and Carers • Families and Carers are listened to and involved in services • services are more responsive to the needs of people and Carers
Sustaining good mental health.	• building people's resilience is critical • insufficient investment in mental health promotion and prevention activities and no one driver • prevention is important, but services are not funded to do it	• build the resilience of individuals, families and communities • prevent stigma associated with poor mental health • use existing resources to promote mental health
Commissioning services.	• commissioning approaches vary between funding bodies • need better funding outcomes and stronger Consumer outcomes • move to integrated delivery, reporting and evaluation	• align commissioning approaches between funding bodies • improve commissioning approaches
Delivering integrated services.	• new and different services are needed • new thinking must support our stepped care framework • better alignment between services is needed • need to support our workforce to deliver great services, including our peer workforce	• expand, diversify and better target services • improve our service delivery • align and integrate existing services • skill up and diversify our workforce

Healthcare area	Consultation feedback	Shared objectives
Responding to diversity.	• respect people from different backgrounds and respond to their specific needs • improve access by all to services • deliver high quality services to people from different backgrounds • address stigma and discrimination	• improve access to services for people from culturally and linguistically diverse backgrounds • ensure services are inclusive of lesbian, gay, bisexual, transgender, intersex and/or questioning (LGBTIQ+) people and respond effectively to their needs • expand and diversify mental health services for older people

Appendix Three: Overview of consultation process

The table below provides an overview of consultation conducted to support development of this Plan by listing individual consultation events, describing the types of stakeholders who participated in each event and highlighting the total number of attendees at these events, including attendees with a lived experience.

Please note that, where an individual has participated in a number of consultation events (e.g. a series of meetings), each occasion on which they have participated will be counted in the numbers below. For a small number of events, there are no records of attendance numbers.

Consultation event	Number of attendees		Stakeholders participating
	Total no.	Est. no. of attendees with a lived experience	
Big Thinking; Local Planning Symposia – region wide consultation 2-part series March and June 2017	160	25	PHN, Metro North Health, government organisations, service providers, healthcare practitioners, carer and Consumer representatives.
Consumer and Carer 'Blue Sky' Symposia	50	50	Consumers, Families and Carers, peer workers.
International initiative for Mental Health Leadership Exchange	15	15	Peer workers.
Peer Delegates Regional Planning Working Group 8 x meetings	48	48	Consumers, Families and Carers, peer workers.
PHN Consumer and carer meeting	15	15	Consumers, Families and Carers.
Workforce development framework meeting	5	5	Deloitte, PHN, Metro North Health, Brook RED.
Peer Participation Network meeting	45	45	Consumers, Families and Carers, peer workers.
Lived Experience Forum	50	50	Queensland Mental Health Commission, Consumers, Families and Carers.
Health Consumers Queensland Annual Forum	200	Estimated as 180	Range of stakeholders.
Measuring Performance of System Peer Symposia	45	45	Consumers, Families and Carers, peer workers.
Workshop	10	10	Peer work students.
Priorities and actions workshop @ Peer Participation Network meeting	45	45	Consumers, Families and Carers, peer workers.
Consumer and carer engagement recommendations workshop @ Peer Participation Network meeting	45	45	Consumers, Families and Carers, peer workers.
Child and Youth Partnership Advisory Group meeting	125	10	Government agencies, Consumers, Families and Carers, service providers, healthcare practitioners.
Workshop at Peer Participation meeting	45	45	Consumers, Families and Carers, peer workers.

Consultation event	Number of attendees		Stakeholders participating
	Total no.	Est. no. of attendees with a lived experience	
Focus Group with Headspace Youth Reference Group	Unknown		Headspace Youth Reference Group.
North Coast Regional Child and Family Committee	Unknown		Government agencies, NGOs.
Suicide Prevention Forums	102	28	PHN, Metro North Health, state government agencies, NGOs, service providers, healthcare practitioners, Families and Carers, People with a Lived/Living Experience.
Suicide Prevention Strategic Partnership Group meetings 7 x meetings	140	14	PHN, Metro North Health, Queensland Suicide Prevention Health Taskforce, Queensland Mental Health Commission, government agencies, NGO service providers, Australian Institute for Suicide Research and Prevention, lived experience representation.
Lived experience of suicide focus groups 2 x focus groups	13	13	People with a Lived/Living Experience.
Brisbane MIND Service Providers Network meetings 4 x meetings	281	0	Brisbane MIND providers.
Brisbane MIND service provider meetings	52	Unknown	Brisbane MIND providers.
GP meetings (PHN Clinical Advisory Group, individual GP meetings)			GPs.
Consumer focus groups			Consumers.
Advisory Group including non-Brisbane MIND service providers			Service providers, healthcare practitioners.
Meeting with Australian Psychological Society	5		Industry association.
Low intensity online surveys and forum	78	Unknown	Consumers, Families and Carers, parents, service delivery agencies.
Severe Mental Illness Regional Planning Working Group 6 x meetings	90	12	PHN, Metro North Health, NGOs, GP representative, Consumer and Families and Carers.
Group consultation meeting	50	50	Families and Carers, Consumers.
Face to face interviews with key alcohol and other drug service providers.	12	1	Alcohol and other drug service providers.
Brisbane North Alcohol and other Drug Partnership Advisory Group	20	3	PHN, Metro North Health, Department of Health, NGOs, alcohol and other drug peak body, Consumers, carers.

Consultation event	Number of attendees		Stakeholders participating
	Total no.	Est. no. of attendees with a lived experience	
20 x Kitchen Table Yarns	31	31	Aboriginal and Torres Strait Islander community members.
2 x Yarning Circles	13	13	Aboriginal and Torres Strait Islander workforce.
1 x Yarning Circle	12	12	Aboriginal and Torres Strait Islander integrated care patients.
2 x community surveys	55	55	Aboriginal and Torres Strait Islander community members.
1 x clinic satisfaction survey	200	200	Aboriginal and Torres Strait Islander Consumers.
1 x community stakeholder workshop	10	10	NGOs, community members who have contact with methamphetamine users.
1 x survey	82	82	Methamphetamine users.
2 x Aboriginal and Torres Strait Islander suicide prevention community consultations	29	Unknown	Aboriginal and Torres Strait Islander community members, Aboriginal and Torres Strait Islander Elders, NGOs, government agencies.
Keeping Healthy Workshop	18	Unknown	NGOs, Consumers, Families and Carers.
Culturally and linguistically diverse groups workshop	6	1	NGOs, Consumers, Families and Carers.
LGBTIQ+ workshop	19	16	NGOs, Consumers, Families and Carers.
LGBTIQ+ suicide prevention community consultation	19	6	NGOs, People with a Lived/Living Experience of suicide, LGBTIQ+ people.
Older people's workshop	3	0	NGOs, Families and Carers.
Perinatal workshop	12	Unknown	NGOs, Consumers, Families and Carers.

Appendix Four: National and state indicators

The Fifth National Mental Health and Suicide Prevention Plan[84]
Healthy start to life
• proportion of children developmentally vulnerable in the Australian Early Development Index
Better physical health and living longer
• rate of long-term health conditions in people with mental illness
• rate of drug use in people with mental illness
• avoidable hospitalisations for physical illness in people with mental illness
• mortality gap for people with mental illness
Good mental health and wellbeing
• prevalence of mental illness
• proportion of adults with very high levels of psychological distress
• connectedness and meaning in life
Meaningful and contributing life
• rate of social/community participation amongst people with mental illness
• proportion of people with mental illness in employment
• proportion of carers of people with mental illness in employment
• proportion of mental health Consumers in suitable housing
Effective support, care and treatment
• proportion of Consumers and carers with positive experiences of service
• change in mental health Consumers' clinical outcomes
• population access to mental health care
• post-discharge community care
• readmission to hospital
• proportion of total mental health workforce accounted for by Consumer and peer workers
Less avoidable harm
• rates of suicide
• suicide of persons in inpatient mental health units
• rates of follow-up after suicide attempt/self-harm
• rates of seclusion in acute mental health units
• rate of involuntary hospital treatment
Stigma and discrimination
• experience of discrimination amongst people with mental illness

Queensland Mental Health, Drug and Alcohol Strategic Plan 2018–2023[85]

Outcome one – a population with good mental health and wellbeing

- age standardised percentage of people 18 years and over experiencing high or very high levels of psychological distress
- percentage of people aged 15 years and over reporting they live with a mental health condition
- percentage of people aged 15 years and over who report they or someone close to them has experienced a mental illness as a personal stressor in the last 12 months

Outcome two – reduced stigma and discrimination

- percentage of people aged 15 years and over living with a mental health condition who have experienced any discrimination or been treated unfairly
- percentage of people aged 15 years and over living with a mental health condition who have experienced discrimination as a personal stressor

Outcome three – reduced avoidable harm

- age standardised suicide rate per 100,000 people
- age standardised suicide rate for Aboriginal and Torres Strait Islander per 100,000 people
- age standardised suicide rate for areas outside greater Brisbane/capital cities per 100,000 people
- percentage of people aged 14 years and over who report drinking alcohol at life-time risky levels in the previous 12 months
- percentage of people aged 14 years and over who report drinking alcohol at single occasion risky levels in the previous 12 months
- percentage of people aged 14 years and over who smoke tobacco daily
- percentage of people aged 14 years and over who used an illicit drug in the previous 12 months
- percentage of people aged 14 years and over who misused pharmaceuticals in the previous 12 months
- average age of first use of alcohol
- average age of first use of tobacco
- average age of first use of any illicit drugs
- number of hospitalisations due to harm associated with substance use 2015–16
- age standardised rate of hospital separations per 100,000 persons as a result of intentional self-harm

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Outcome four – people living with mental health difficulties or issues related to substance use have lives with purpose

- age standardised percentage of people aged 16 to 30 years living with a mental/behavioural condition, who were employed and/or enrolled in study
- age standardised percentage of people aged 16 to 64 years living with a mental/behavioural condition who were employed
- percentage of people aged 15 years and over living with a mental health condition who have undertaken unpaid volunteer work
- percentage of people aged 15 years and over living with a mental health condition and who participated in social groups
- percentage of people aged 15 years and over living with a mental health condition who participated in community support
- percentage of people aged 15 years and over living with a mental health condition who participated in civic or political groups
- percentage of people aged 15 years and over living with a mental health condition and attended cultural and leisure activities
- percentage of people aged 15 years and over living with a mental health condition and who had face-to-face contact with family and friends outside the household daily
- percentage of people aged 15 years and over living with a mental health condition and who had face-to-face contact with family and friends outside the household at least once a week
- percentage of people aged 15 years and over living with a mental health condition and who were able to get support in times of crisis

Outcome five – people living with mental illness and substance use disorders have better physical and oral health and live longer

- age standardised percentage of people living with a mental/behavioural problem with cardiovascular disease
- age standardised percentage of people living with a mental/behavioural problem with cancer
- age standardised percentage of people living with a mental/behavioural problem with diabetes
- age standardised percentage of people living with a mental/behavioural problem with arthritis
- age standardised percentage living with a mental/behavioural problem who are obese or overweight
- age standardised percentage living with a mental/behavioural problem who are at risk of long-term harm from alcohol consumption
- percentage of people aged 15 years and over living with a mental health condition who participated in physical activity
- percentage of people living with a long-term mental health condition who saw a dental professional in the previous 12 months
- percentage of people living with a long-term mental health condition who saw a general practitioner in the previous 12 months

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Outcome six – people living with mental illness and substance use disorders have positive experiences of their support, care and treatment

- Consumer overall satisfaction with adult mental health inpatient treatment and care
- Consumer overall satisfaction with adult mental health extended treatment services
- Consumer overall satisfaction with adult community mental health and ambulatory services
- Consumer overall satisfaction with child and adolescent mental health inpatient treatment and care
- Consumer overall satisfaction with child and adolescent community mental health and ambulatory care
- number of paid full-time equivalent (FTE) Consumer workers per 1,000 FTE direct care, Consumer and carer staff in mental health services
- number of paid full-time equivalent carer workers per 1,000 FTE direct care, Consumer and carer staff in mental health services
- percentage of people aged 15 years and over experiencing a mental health condition and who have difficulty accessing service providers

Appendix Five: Glossary

Term	Definition
Cultural Respect Framework	A Framework that commits the Australian Government, and State and Territory governments, to embedding cultural respect principles into their health systems to support quality, culturally safe, responsive healthcare to Aboriginal and Torres Strait Islander peoples.[86]
Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery	This Framework assists services to evaluate their cultural responsiveness and develop action plans to enhance their service delivery to people from culturally and linguistically diverse backgrounds. You can find out more about it at http://www.mhima.org.au/framework/mhima-website[87]
rediCASE	A new electronic triage and referral tool for mental health called 'rediCASE' that has been purchased by the PHN. It will initially be further developed for use by GPs, and, over time, will be made available for use by other referring agencies, healthcare practitioners and service Consumers.
soft entry	Entry arrangements to a service that are designed to enhance the service's accessibility for service Consumers.
throughcare	Throughcare aims to support the successful reintegration of offenders returning to the community at the end of their sentence. Prisoner throughcare projects provide comprehensive case management for a prisoner in the lead up to their release from prison and throughout their transition to life outside and aim to make sure prisoners receive the services they need for successful rehabilitation into the community.[88]
Triangle of Care	Consumers, carers and service providers work together in a partnership model to provide care.[89]

Appendix Six: References

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